The Centre for Research in Early Childhood recently conducted a review looking at the evidence base for the impact of early years initiatives in social care, health and education in combatting social and economic disadvantage and underachievement, both in the UK and internationally.

This paper:

- summarises and evaluates the most recent research relating to good practice in early years across social care, health and education;
- summarises key interventions and actions and recent evaluative evidence on what has worked, including the impact of co-production in service design;
- identifies strategies to measure effectiveness and value for money;
- highlights key findings which will inform further action.

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Professors Tony Bertram and Chris Pascal, the authors of the review, have kindly agreed to make this paper available for download via the Early Education website.

For more information about the work of each organisation, see:

www.crec.co.uk

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Early Years Literature Review

Table of Contents

Executive Summary 4

Introduction 9

1. What is the extent and nature of the challenge? 13
   1.1 The growing extent of child poverty, social immobility, health and educational inequality leading to poor outcomes for children and families 15
   1.2 The extent and nature of early childhood inequality 19
   1.3 The potential for action in the early years 22

2. How far and in what ways can early years education and care, social care and health programmes counter socio-economic disadvantage? 26
   2.1 Maternal Health, Health Related Behaviours and Child Health 28
   2.2 Parenting 28
   2.3 Early Education and Care 29

3. What key interventions and actions and recent evaluative evidence is there on what has worked, including the impact of co-production in service design? 30
   3.1 Programmes that provide support to parents during pregnancy and early childhood 31
   3.2 Early health programmes for children from 0-5 years 32
   3.3 Programmes that combine parent support and early education and care for children 0-2 years 37
   3.4 Early education and care programmes for children 0-2 years 41
   3.5 Early education programmes for children 3-4 years 43

4. What particular aspects of best practice across early years social care, health and education does research evidence show are critical in improving outcomes for the disadvantaged? 44
   4.1 Systemic factors 44
   4.2 Structural factors 48
   4.3 Process factors 51

5. How might effectiveness and value for money be measured? 54
   5.1 The measurement challenge 54
   5.2 Outcome measures 55
   5.3 Benchmarking 58

6. How might early years services and programmes better adopt these successful strategies?: Recommendations for action and further innovation 59
   6.1 System developments 60
Early Years Literature Review

6.2 Structural developments 61
6.3 Process developments 62

7. What aspects of early education require more supporting evidence? 64

Bibliography 65
Appendices 73
Early Years Literature Review

Executive Summary

The Centre for Research in Early Childhood conducted a review looking at the evidence base for the impact of social care, health and education initiatives to combat social and economic disadvantage and underachievement, both in the UK and internationally.

This paper:

- summarises and evaluates the most recent research relating to good practice in early years across social care, health and education;
- summarises key interventions and actions and recent evaluative evidence on what has worked, including the impact of co-production in service design;
- identifies strategies to measure effectiveness and value for money;
- highlights key findings which will inform further action.

The review evidence has revealed the growing extent of child poverty, inequality and social immobility and the widening extent and nature of early childhood inequality, all key factors in underachievement. However, it also points to the potential for action in the early years. Drawing on best available evidence we can identify an array of early childhood policy schemes that offer the potential to close these early gaps. Research on these initiatives pinpoints three core areas for action in the early years. These areas include:

- Maternal Health, Health Related Behaviours and Child Health;
- Parenting;
- Early Education and Care.

Judged by the evidence, the core characteristics and delivery features of programmes that have successfully boosted the learning and development of disadvantaged children can be grouped into four types:

1. Programmes that provide support to parents during pregnancy and early childhood;
2. Early health programmes for children 0-5 years
3. Programmes that combine parent support, health and early education and care for children 0-2 years;
4. Early education and care programmes for children 0-2 years;
5. Early education programmes for children 3-4 years

Our analysis of recent research and evaluative evidence provides strong and convincing evidence of the qualities and features of successful early intervention programmes, and in particular, effective programmes aimed at supporting children’s outcomes. This evidence provides useful guidance for the development of early years programmes, including Children’s Centres, to enhance their capacity to boost early achievement for less advantaged children. We have divided these factors into three, interrelated aspects of early years’ policy and provision which demand continued attention:

- Systemic factors: factors which are shaped by the wider system in which early years programmes are placed;
- Structural factors: factors which shape the nature, scope and capacity of early years programmes;
Early Years Literature Review

- Process factors: factors which determine how early years programmes are experienced by those involved.

The last 10 years have seen the creation of a significant international and national knowledge base about the factors that are associated with early disadvantage and how early years programmes might work more effectively, both systemically and structurally, to promote better quality processes to close gaps in achievement and health outcomes, especially for the socially disadvantaged.

There is now little doubt that early years programmes for low income and ethnic minority children can contribute importantly to combating educational and health disadvantages if certain criteria are met. Evaluation evidence indicates that the design of programmes and the approach to service delivery is crucial to success. “Low intensive, low dose, late starting, mono-systemic approaches are less effective overall. Early starting, intensive, multi-systemic approaches that include centre-based education and the involvement of trained professionals as a core activity are superior, with impressive long term results and very favourable cost benefit ratios.” (EACEA 2009:38)

The problem is that many targeted early years programmes do not meet the criteria of quality and efficiency and many programmes are often temporary projects and vulnerable to economic trends. The policy challenge is to rebuild the current systems so that they meet the crucial design features; provide high early quality education and care for all children, and outstanding health and social care support for parents and families; are integrated, attractive and affordable to all families regardless of social class or minority status; yet, are sensitive to differing needs, working in a child and family centred way and able to compensate for early disadvantages. There are key areas of early years policy and practice which the evidence shows would benefit from further attention and development: systemic, structural and process elements all need attention but the evidence is convincing that this attention will bring significant dividends for the less advantaged.

**Recommendations for action and further innovation**

The current report more strongly makes the case to break down the barriers between schools that teach the youngest children and early years provision outside schools. It also argues that the best early years providers whoever they are, focus on helping children to learn. It provides evidence to show that the most successful Children’s Centres work to engage parents who don’t know how to support their children’s learning (teach) and give them the tools to be teachers too. It states that Children’s Centres can play a fundamental role in tackling disadvantage but acknowledges that realising this ambition will require greater clarity for this rapidly changing sector. It also argues that the contribution that schools and health colleagues can make, and the similarities between what schools do and what other early years providers do, should be clearer and better understood.

We have set out below three areas of early years policy and practice which the evidence shows would benefit from further development, listing fruitful actions in each area.
Early Years Literature Review

**System Developments**

- Continued and increasing investment in early childhood programmes, particularly those aiming to enhance parenting and healthy living skills and provide children with early access to high quality early education;

- More cohesion between the range of different early years services that children experience as they move from birth through infancy, to preschool and into schooling through the development of a common value base, vision, set of working principles and shared outcome measures which all providers and practitioners adhere to;

- Early education and care programmes working in closer alliance and partnership with wider early intervention programmes, especially those concerned with supporting parenting skills and maternal and child health enhancement;

- Greater and earlier engagement of health professionals and systems within the early years service delivery, to ensure information sharing and enhanced early intervention;

- More engagement and clearer articulation of the key role of health visitors and the potential of the Health Visitor Implementation Programme within the development of universal and targeted support services for vulnerable young children and families;

- The further development of locality systems which integrate all early years service providers systemically to ensure effective local coordination of multi-professional and multi-agency services to children and families;

- The development of LA supported but system led improvement strategy, building on a network or alliance of high performing early years settings, particularly outstanding Nursery Schools, and offering them capacity to extend their practice across the local area to upskill the workforce and improve quality across all settings;

- Greater emphasis and involvement of the responsibility of the school sector in the delivery of early years services, and in particular, a clear strategic and operational linkage between nursery and primary schools and Children’s Centres;

- The development of ‘enhanced service’ primary schools, which work closely with Children’s Centres and other early years services on a locality basis to ensure continuity of support for the less advantaged;

- Maintenance of policies beyond the short term to track impact and insist on rigorous evaluation of outcomes;

- Rigorous implementation and monitoring of the new statutory framework for early years providers, including greater accountability and support to improve performance.
Early Years Literature Review

- The development and implementation of a system wide, and carefully focused, framework of agreed early years outcomes for children and families, which provides cohesion and focus for the delivery of all early years services and an agreed strategy for measuring performance against these outcomes;

- Tighter specifications and greater support around the nature of high quality early years provision and how to improve poorly performing settings;

- Exploration of strategies to attract, recruit and positively reward high calibre, well qualified professionals to work in disadvantaged communities;

- Improvement of training for the early years workforce, including up-skilling current employees, and supporting and deploying those with graduate qualifications, and especially qualified teachers, to operate effectively as leaders within the local system. In addition, the development and delivery of advanced training for local system leaders.

Structural Developments

- Investment in early years leadership at all levels, and across early education, social care and health services to champion and promote the importance of early years services and ensure the development and delivery of an integrated high quality system;

- Favourable staff: child ratios should be encouraged, especially in health and education programmes which work with disadvantaged children;

- Reductions in group/case load size should be encouraged, especially in programmes that work with disadvantaged children;

- Development of well trained and qualified staff teams, including trained teachers, to work in integrated early years programmes, offering them access to ongoing staff development opportunities;

- Development of early learning (cognitive and executive functioning development) knowledge amongst all staff who work with young children and families, as well as knowledge and understanding of child development and an improvement of the child development content of both initial and continuing professional development for all early years practitioners;

- An active, play based pedagogic approach with young children in early education and care programmes which encompasses a blend of formal and informal teaching and learning experiences should be encouraged;

- A focus in the early years curriculum on both cognitive and non-cognitive aspects of early learning and, importantly, give the child a sense of their own capacity to be a successful learner.
Early Years Literature Review

with the prioritisation and measurement of executive functioning (PSED) and language development in early years provision;

- A stronger emphasis in all health, social care and education programmes to encourage parents to support and engage more actively in their children’s learning.

Process Developments

- Adoption of more sensitive, responsive and nurturing staff-child relationships;

- Adoption of family-focused relationships, with key workers who have consistency and deep knowledge of a family over time;

- Clarity about children’s right to be heard in all early years programme development and implementation, and the development of staff skills to listen more effectively to children’s voices at all times;

- Encouragement of ‘sustained shared thinking’ with the children which encourages dialogue, negotiation of meanings and co-construction of understandings;

- Work towards a more equal balance of child and adult initiated actions and encourage the development of self management, self regulation and critical thinking in children’s activities;

- Development of better training on diversity in all early childhood settings and for all early years staff;

- Encouragement of behaviour policies in which staff in health, social care and early education support children’s behaviour management through reasoning and talk.
Early Years Literature Review

Introduction

1. Background

Most regions in the UK have a mix of early years services, including nursery schools, nursery classes in mainstream schools, children’s centres and PVI (Private, Voluntary or Independent) settings all offering provision to under 5s, including early education and care, health and social care services for children and families. Currently, access to them is not equitable for children and is very much a lottery depending on where they live. The type of provision they have, as well as the quality, varies significantly, and spending on these services is not commissioned coherently or strategically to make sure all children get what they need and deserve. This literature review is intended to contribute to both the overall future design of children’s services and the development of the local early help offer.

The focus of the review is children aged 0-5. The premise of this review is that the purpose of these services is to:

- Improve educational and health outcomes
- Reduce child poverty
- Address inequalities in educational and health outcomes and ‘Narrow the Gap’

The Centre for Research in Early Childhood (CREC) was asked to lead a literature review of good practice across social care, health and education by bringing together the best ideas and practice from each professional discipline with due consideration for value for money. The review was informed by recent government guidance, good practice evidence and robust research to develop a shared view on what ‘good’ looks like, including the impact of co-production in service design and how to measure effectiveness.

2. Aims and Scope of Literature Review

The aims of the literature review are to:

1. summarise and evaluate research relating to good practice in early years across social care, health and education;
2. summarise key interventions and actions and evaluative evidence on what has worked, including the impact of co-production in service design;
3. to identify strategies to measure effectiveness and value for money;
4. highlight key findings which will inform further action.

The intention of the literature review is to help policy makers:

1. better understand the reasons behind the gap in educational and health outcomes, particularly in areas of deprivation;
2. learn the lessons from recent national and international initiatives and programmes which have aimed to alleviate poverty and enhance education and health outcomes;
3. set out a range of possible further actions to support sustained improvement in the areas of poorest performance.
Early Years Literature Review

In addition to the above mentioned criteria the following key questions will be considered in the review:

1. How can a locality based system of early years services mitigate the issues of poor education and health outcomes and reduce child poverty?
2. How can we ensure that there is strong political impetus and accountability for performance?
3. How do we get the best people into the institutions and areas that most need them? (health visitors, teachers, social care and family support workers, childcare)
4. How do we ensure that there is strong leadership of the services that most need it?
5. Where do we get the best value for public money? For example, if we don’t get it right in the early years, evidence shows that schools and colleges struggle to close the gap.

Children’s early years, otherwise known as the foundation years, are the time between birth and 31st August following their fifth birthday. The early education and care provision, health and social care services for this age phase is diverse and offered by a mix of public, private and voluntary providers. None of this provision is compulsory, unlike schooling, and many services incur charges for parents, which for some families can be a major item of expenditure. The services in scope for the review are:

- Children’s centres: all aspects including those delivered by partners, including early education, childcare, antenatal care, postnatal care, parent employment and training support
- Family support services in children’s centres: universal and targeted
- Parenting support – foundation years parenting support services and the incredible years
- Health visiting
- Nursery Schools
- Nursery Classes
- Early Education across all sectors for disadvantaged two year olds and all three and four year olds
- Day Care/Child Care – maintained
- Day Care/Child Care provided across Early Years sector – Nursery Schools and PVI
- Council support services in relation to statutory requirements for childcare
- The interface of early years services with health and housing services

3. Review Design

This evaluation will produce evaluative, meta-analytic research studies of:

- Books
- Academic, peer reviewed research
- Published evaluation reports of initiatives

Its parameters are:

- Research which is significant, published in a book or peer reviewed journal from the last 10 years
- Evaluative empirical work that has been carried out in England, or where relevant, other OECD countries
Early Years Literature Review

- Evaluations of major projects to counter disadvantage in England, (eg Sure Start and Children’s Centre evaluations, Rowntree Foundation, Sutton Trust), and in other OECD countries

This review summarises key messages from the research and development initiatives detailed in the bibliography and the appendices. In particular however, the following core documents and texts were used to inform this report:


Early Years Literature Review


1. What is the extent and nature of the challenge?

A central aim of this review is to analyse recent evidence which might support a better understanding of the extent and nature of the gap in educational achievement and health outcomes for socially disadvantaged children. This understanding is essential if we are to identify how far and in what ways early years services working across social care, health and education, as policy tools, can function more effectively to counter socio-economic disadvantage and improve educational and health outcomes for children.

Local early years services are dealing with many and rapid changes and there is a need to demonstrate with sound evidence the contribution made by services to the lives of children and their families. The Early Intervention Grant, introduced in 2011, subsumed a range of government funding streams for local authorities. Allied to a strong focus on localism, this has the potential to give local actors greater levels of choice about the way they invest funding in the early years and set priorities. At the same time the absence of a ring fence for early years funding, the very significant decreases in funding being experienced by local authorities, and the huge competing pressures, risk putting a strain on early years services.

The policy priorities for early years services have also shifted under the Coalition Government. There is a more explicit focus on ‘school readiness’, looking to Children’s Centres to act as the entry service into the education system, with schools being encouraged to focus more specifically on early years. This reflects a shift away from a broader developmental focus on the outcomes of the Every Child Matters agenda, which characterised policy in the 2000s. The Government has also recently re-launched the Troubled Families initiative, providing funding to councils to support a particular group of families. While the criteria for being a ‘troubled family’ does not focus specifically on early years there will be young children in some of these families who will be impacted by any new interventions and children’s services may play a role in supporting those families. All early years services face a changing economic and social context which impacts on their levels of resources, the extent of need and the demand for their services.

There has also been significant development on the delivery of early health programmes, including the Health Visitor Implementation Plan 2011-2015: A Call to Action (Department of Health 2011) which is changing the early years landscape. This Plan sets out to increase the number of health visitors employed by around 50% (4200 additional health visitors by 2015), to mobilise the profession and to align delivery systems with new NHS architecture and local government children’s services (including Sure Start Children’s Centres). The Implementation Plan requires that the new health visiting service should include delivery of the existing Healthy Child Programme (HCP) and integrate with services for children, families, mental health and public health.

At the same time as these developments are impacting, we can see growing levels of poverty across the UK, with a the reduction in the availability of services to support families at risk and an increase in risk factors such as unemployment, poverty and maternal mental health suggest that the needs of families may become more complex. As a recent report published by the Institute for Health Equity argued (Bowers et al 2014):
Early Years Literature Review

*Rising unemployment, poorer working conditions, depressed incomes and an inability to pay for decent housing and basic needs will all increase negative mental and physical health outcomes across the social gradient and especially for more vulnerable groups. Those unemployed for long periods of time will be more likely to be unemployed in the future, and higher levels of parental stress will lead to worse outcomes for many of the children of this generation.*

A series of national and international reports over the last five years provides a stark picture of the growing extent of poverty, inequality and social disadvantage in UK society and the impact of this on the educational attainment, life chances, health and social contribution of many of our children who are growing up in poor, socially disadvantaged families and communities. Parents are the most important influence but the quality of early years services matters considerably. Quality is rising but there is still much to do, as the recent Ofsted Annual Report (2014) reveals:

1. There are better outcomes for children overall but in 2013 only a little more than a third of children from low income backgrounds reached a good level of development and in some areas it was less than a fifth.
2. The best progress for children from low income families was where they were supported by highly qualified staff, with graduate qualifications. Nursery schools have high levels of graduate staff and perform as strongly in deprived areas as in more affluent areas.
3. Schools are important providers of early education and care but often this is not recognised.
4. Assessment of children’s development is not standardised and assessment data is not collected, published or made clear to parents.
5. Choice for parents is difficult and information for parents is not clear and simple enough, with complexity of terms and how quality is shown.
6. Inspection of Children’s Centres has found the sector characterised by turbulence and volatility with few centres doing well. Children’s Centres are changing rapidly, including reductions in numbers and changes in structures and organisation, with an ongoing debate about the purpose of Children’s Centres. More Children’s Centres are now organised in groups, and fewer of these groups have been judged to be good or outstanding as single centres. The accountability of Children’s Centres should be made clearer.

Collectively, these reports also identify some of the critical factors that contribute to the low educational attainment and health outcomes of these children. The evidence presented points to the definitive impact of experiences in the early years of life to long term progress, and thus to the potential and timeliness of early childhood interventions, including health, social care and early education, to making a significant difference.

The following emergent themes are used to frame this section of our report:

- the growing extent of child poverty, social immobility and social and health inequality leading to educational underachievement and poor health outcomes;
- the extent and nature of early childhood inequality;
- the potential for action in the early years.
Early Years Literature Review

1.1 The growing extent of child poverty, social immobility and health and educational inequality leading to poor outcomes for children and families

Child Poverty
A report from UNICEF, ‘Measuring Child Poverty’ (2012), acknowledges that there is almost no internationally comparable data available on the effect of recent economic downturn on child poverty. However, it is evident everywhere that front line services in the UK are under strain as austerity measures increase the numbers in need while depleting the services available. The UNICEF report pointed out in 2012 that ‘worse is to come’ and young children can be particularly vulnerable in times of recession. It demonstrates that there is always a time lag between the onset of an economic crisis and the full extent of its impact. Its analyses reveal that in the UK the economic crisis has begun to significantly threaten and reduce social protection and welfare programmes. Child benefits have been frozen and coverage reduced and child tax credits and other programmes designed to protect the poorest children have been cut back or reshaped. The report states that these changes are likely to throw into reverse the progress made on child poverty in recent years.

More recent figures (DWP, 2013) suggest that around 30% (1 in 3) of children are living in poverty, and even more seriously, there are concentrations of child poverty at a local level, with some local wards having as many as 50-70% of children growing up in poverty. It is also important to note that work has not guaranteed a route out of child poverty, with around two thirds of children growing up in poverty living in families where at least one member is working. The Government has retained its commitment under the Child Poverty Act (2010) to cut the level of child poverty to 10% by 2020, but the reality is that the child poverty rate in the UK is rising significantly again and reaching this target will be an enormous challenge. On current projections, the UK is heading towards a return to the relative child poverty levels of two decades ago. UNICEF states that these forecasts are the best available independent estimate of “what might happen to poverty under current government policies.” This immediate economic and social context sets an urgent, challenging and timely agenda for this review of the power and capacity of early years services to act as a counter to such disadvantage.

Social Mobility
Even before the recession, the evidence in each of the reports we examined indicates that in the UK, especially, parents’ socio-economic status continues to be the primary predictor of which children prosper in adult life. The data reveals that the UK remains at the bottom of international league tables for social mobility, as measured by income or earnings. Latest comparisons suggest British citizens are about half as socially mobile as people in Finland or Denmark, which means they are twice as likely to stay in the same income bracket as their parents when they become adults (see Figure 1).
UK social mobility is also significantly lower than in Canada and Australia, countries with whom we share much in common – economically, culturally and in the rich diversity of their populations. Amongst the G20 richest nations, only the USA has poorer social mobility than the UK. These findings challenge one of the fundamental assumptions of a meritocratic society; that large inequalities of income are acceptable as long as everyone has equality of opportunity to progress in life through their own talents and hard work. The UK’s low social mobility levels show that this is not being realised and that those at the bottom of the income ladder in early life are far less likely to earn higher incomes as adults, when compared to those in most other countries of similar wealth.

Inter-generational social mobility patterns in the UK, over time, whether classified by social class or income, reinforce the life patterns of individuals. Wealthier parents are able to provide their children with advantages that less affluent parents cannot afford and a cycle for the poor is perpetuated and becomes chronic. The evidence shows that the role of education, social care and health as a means to socio-economic levelling is clearly failing for the vast majority of children from less privileged backgrounds. Far from raising opportunities for all irrespective of background, our current systems in the UK, and, in particular our education system, seems to perpetuate inequalities.

Educational Inequality
As the Sutton Trust /Carnegie Corporation Summit Report (Waldfogel & Washbrook 2008) points out,
Early Years Literature Review

“It is clear that for a fortunate few, education, and particularly higher education, can be a driver of upward mobility. Yet, the few talents from humble origins that do go on to realise their potential often do so despite the system, not because of it. Not only is this unfair for individuals unlucky enough to find themselves on the bottom rungs of society: it represents a tragic waste of talent to the British economy in an increasingly global economy.”

Their figures show that stark, persistent gaps, widening from pre-birth to post-graduation, characterise the UK, with students from the highest social class groups being three times more likely to enter university as those from the lowest social groups (see Figure 2).

FIGURE 2: Higher Education Rates

![Higher Education Rates](image)

Reproduced from Sutton Trust Report (Corak et al 2012 p16)

Even starker gaps persist in entry to the elite academic institutions in the UK: less than one in five degree entrants in leading research universities come from the four lower class groups that make up half the UK population. This report continues by arguing that this is all the more concerning as education is now, perhaps more than ever, the gateway to better life prospects; this at a time when higher order skills and knowledge are increasingly the most valued commodities in the world’s rapidly evolving labour market. The persistence of this underachievement gap has been quantified in economic costs as imposing the equivalent of a permanent national recession (McKinsey and Company, 2009) and is estimated to reduce the GDP of a country by between 9-16%. The core question of how far early years services, including social care, health and early education, can improve mobility levels is an even more pressing issue amid an economic recession that will undoubtedly affect the lives of those on low incomes.
Our analysis of the evidence indicates that even the most successful education policy interventions when working in isolation from other policy areas such as health and social care, can only reduce and not eliminate disparities in educational outcomes across income, social class or race. The Sutton Trust /Carnegie Corporation Report suggests that the most successful interventions will improve educational outcomes by no more than a quarter of a standard deviation, enough to pass a cost benefit test but not enough to equalise educational opportunity for all children. They argue that this should not mean despair but rather that we should recognise that educational interventions by themselves should never be seen as a panacea for addressing deeply entrenched social class inequalities in the UK. Policy makers should be realists but not defeatists and, as we shall show, there are real differences which can be achieved with high quality early intervention strategies which cross social care, health and educational boundaries. In particular, the role of the health service as part of an integrated early years strategy seems to offer an important means to impact on early education and health inequalities.

Health Inequality
Health inequalities within the UK add a further dimension to our understanding of the impact of disadvantage on lower socio-economic groups. Despite having the most equitable health service in the world, inequalities in social and living conditions are driving inequalities in health. As the Marmot Review (2010) pointed out, there is a social gradient in health – the lower a person’s social position, the worse his or her health. This seminal report argued that action should focus on reducing the gradient in health and that health inequalities result from social inequalities. They stated that action on health inequalities requires action across all the social determinants of health and that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, Marmot believed that actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage, which they called proportionate universalism.

There is a growing knowledge of the complex interplay between psychosocial events and biological factors, and we now understand that events that occur as a foetus and in early life play a fundamental part in later life, and indeed in the lives of future generations. This inevitably leads us to the conclusion that early interventions and preventive measures such as immunisation, health checks and education do make a difference to outcomes. If we act early we can prevent harm. To address these issues, the DoH (2013) argues that we need to take a population health perspective – to think about what benefits the most. Key principles of public health are also fundamental. Health reports point to the potency proportionate universalism – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged groups - and identify that a combination of approaches are needed; those that target and those that are more universal. Universal approaches tend to be the most upstream i.e. those based around primary prevention through encouraging the adoption of healthy lifestyles and reducing risks e.g. vaccination programmes. Targeted approaches can be both preventative e.g. seeking to reduce risk, for example current Vitamin D supplementation to specific high risk groups, or secondary prevention, also known as early intervention – seeking to act once early signs are seen, e.g. speech and language interventions.
In summary, there is compelling evidence that a child’s experiences in his or her early years (0–5) have a major impact on their health and life chances. The early factors that can affect children’s health across their life span include low birth weight; exposure to drugs and alcohol before birth; obesity; and neglect. The Marmot Review (2010) set out six policy objectives to reduce health inequalities:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

In particular, policy recommendations for early years were:

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient
- Build the resilience and well-being of young children across the social gradient

These recommendations chime clearly with the wider evidence base revealed in this review.

1.2 The extent and nature of early childhood inequality

Early Health Inequality
The recent DoH Report (2013) identifies the evidence base which shows clearly that events that occur in early life (indeed in foetal life) affect health and wellbeing in later life. Whether this is through changes in genetic expression, how the brain is formed or emotional development, we have an increasing understanding that what happens in these years lays down the building blocks for the future. This is particularly the case at times of rapid brain growth in the early years (i.e. from birth to 2 years) and adolescence. Increasing investment in research in recent years is helping to explain the complicated links between psychology, sociology and biology. This understanding underpins the concept of the life course, that each stage of life affects the next. Therefore, to try to impact on the diseases of adult life that make up the greatest burden of disease, the case is made that it makes sense to intervene early. The 2013 report points out that acting early is underpinned by sound science and sound finance. There are increasingly good data on the return on investment and future cost savings from prevention and early intervention, for example a 6–10% annual rate of return on investment for spend on intervention in the early years.

Looking across England, it is clear that there are great variations in the health of our children and young people. This is not a recent observation; the Court Report in 1976 clearly identified this as a major issue facing child health, and many reports since then have further stressed this. Variation in health measures is complex; however, as a society there is increasing concern about those variations that seem preventable and this preventable variation is referred to as health inequality. Health inequality does not just affect those in the top or bottom 10%, as there is a gradient across the
population from better to worse health. Perhaps the most profound inequality is in healthy life expectancy. Furthermore it is increasingly clear that health inequality is bad not just for individuals and families, but also for wider society.

Within the evidence base is an increasing understanding of the long-term effects of early life events. Research in the late 1980s began to show that the nutritional status of the late foetus had long-term effects, and specifically that ‘under-nutrition’ creates changes in the foetus that in later life can lead to increased rates of coronary heart disease. This was revolutionary thinking showing that events which happen early in the life course, for example in foetal life, contributed independently to these disease types. Today it is widely accepted that ‘programming’, i.e. intrauterine events, affects the development of coronary heart disease, non-insulin dependent diabetes, hypertension, chronic obstructive pulmonary disease, some cancers and stroke.

We also know that the effect of external factors do not stop at birth. Recently published data (DoH, 2013) identifies the prevalence of adverse childhood events in England. This builds on work from the USA that has identified a key set of events which, when they occur, have profound effects on the life course of the child. Events include growing up in a household with a family member who is depressed or who suffers from mental health problems, or exposure to domestic violence. Long-term studies have associated these events with poorer outcomes, such as poorer educational attainment, increased risk of imprisonment, more substance abuse, increased mental health problems, higher levels of obesity, heart disease, cancer and unemployment, and increased involvement in violence. Of particular note, the presence of adverse childhood events is cumulative, i.e. the greater the number of adverse events experienced, the higher the likelihood of experiencing more adverse outcomes.

**Early Educational Inequality**

Waldfogel and Washbrook (2008, 2012) trace early education inequalities for the current generation of children and identify the factors underpinning these gaps in different countries. The magnitude of early childhood inequality in the UK is well-documented; some estimates suggest that half the attainment gaps for pupils are already present at the start of primary school. Using Millenium Cohort study data, this research shows that the size of the emerging gaps in the test scores of children from different income groups reflects the spread of income in the UK. Large gaps exist in the UK for vocabulary tests between children aged 4 and 5 from families with middle incomes and those from families with lowest fifth of incomes (figure 3).
The data also shows that there are gaps in what is termed ‘school readiness’ associated with race and ethnicity and place of birth. In the UK, Pakistani and Bangladeshi children lag far behind white children in school readiness and vocabulary. Black children (a category that combines Black British children, children from the Caribbean and children from Africa) also score lower than white children, particularly in vocabulary. In contrast, Indian children, while lagging in vocabulary at age 3, demonstrate a good deal of catch up by age 5 and also score comparably to white children on school readiness at age 3.

The evidence also shows immigrant-native gaps for the UK. Although immigrant children lag in vocabulary at age 3, and to a lesser extent at age 5, their school readiness at age 3 is comparable to that of native-born children. Immigrant children have if anything fewer behaviour problems than native-born children although the differences are very slight. These comparisons suggest that income related gaps are not the same as racial/ethnic or immigrant/native gaps. In general, racial/ethnic minority or immigrant groups do not lag as far behind in cognitive measures of school readiness as the bottom income quartile does. This pattern of results reinforces the importance of looking at income related gaps and strategies which might address these.

The developmental delay in boys relative to girls is also significant in school readiness and in their ability to cope with a formal curriculum. The longitudinal EPPE study (Sylva et al 2004) suggested that in terms of their relative impact on educational achievement, poverty, gender and ethnicity
Early Years Literature Review

could be ranked in that order, so working class boys regardless of ethnicity would likely be one of the more disadvantaged groups.

One of the key challenges for schools is that substantial gaps in school readiness for these under-achieving groups of children are embedded in the earliest years of life. The presence of such large gaps even before children start school has prompted a great deal of interest in the role that early education (preschool), health and parenting policy might play in narrowing these gaps. If schools are to promote equality of educational achievement, it would clearly help if children were able to start school on a more equal footing and this means that action has to begin much earlier.

1.3 The potential for action in the early years

The interest in the early years as a focus for action in countering socio-economic disadvantage is supported by emerging research in neuroscience, developmental psychology and economics. The National Academy of Sciences Report ‘From Neurons to Neighbourhoods’ (Shonkoff and Phillips, 2000), highlighted research on early brain development, and linked this to the importance of quality experiences in the early years for child health and developmental outcomes. At the same time, Heckman and Lochner (2000) emphasised the importance of early years for human capital formation, arguing that investments made in the early years would lay a foundation for learning not only in those early years, but also in the future. Heckman has also joined with developmental psychologists in emphasising that both cognitive and non-cognitive aspects of development are consequential for later life chances (Carneiro and Heckman, 2003). Heckman’s work has particularly shown the long term importance to attainment of secure development of:

- Motivation;
- Sociability (the ability to work with others);
- Attention;
- Self regulation;
- Self esteem;
- Time preference;
- Health and mental health.

In evaluating educational policies, Heckman argues that ‘soft skills’ involving personality traits, such as conscientiousness, openness and diligence are often neglected, even though they are valued in school and work environments, and in many other domains. This is in part because so much value is placed on standardised test scores and ‘soft’ skills are considered too difficult to quantify. Such skills can, however, predict success in life and programs that enhance soft skills have an important place in the writing of public policies (Heckman and Kautz 2012). He argues that social policy should be directed towards the ‘malleable’ early years if we want to address the gaps in attainment. Heckman’s work has also pointed to the economic return of investing in high quality early education programmes, especially for disadvantaged children and particularly when compared with investments in higher age groups (See fig 4). This belief is supported by the work of Rolnick and Grunewald (2003) whose report considered several studies of model programmes and, when considering the Perry Preschool program in the USA, found a return on investment of 16 percent, with 80 percent of the benefits going to the general public.
A further impetus for early intervention, well documented in the Field and Allen Reviews (2010, 2011) is the growing evidence that high quality interventions can advance child development in the early years. Random assignment studies of programmes such as Perry Preschool, Abecedarian, Infant Health and Development and Nurse-Family Partnerships, and the EPPE research in the UK, have found that high quality early years programmes do have the capacity to significantly improve child health and educational outcomes for disadvantaged children, in both cognitive and non-cognitive domains (Karoly, Kilburn and Cannon, 2005; Sylva et al, 2004, 2008). These results provide grounds for optimism that well crafted early childhood policies can and should play a key role in narrowing the gaps in school readiness, and in the longer term, countering the effects of socio-economic disadvantage.

The evidence in these reports shows convincingly that there are both short- and long-term economic benefits to taxpayers and the community if high quality early education, coupled with early health and family support strategies are available to all children, starting with those who are most disadvantaged. In particular it shows that universally available early education of a high standard would benefit everyone and be the most cost-effective economic investment. In summary the evidence reveals that:

- **High-quality early childhood education helps prepare young children to succeed in school and become better citizens; they earn more, pay more taxes, and commit fewer crimes.**
- **Every £1 invested in quality early care and education saves taxpayers up to £13.00 in future costs.**
Early Years Literature Review

- The early care and education industry is economically important—often much large in terms of employees and revenues than other industries that receive considerable government attention and investment.
- Failing to invest sufficiently in quality early care and education shortchanges taxpayers because the return on investment is greater than many other economic development options.
- Access to available and affordable choices of early childhood learning programs helps working parents fulfill their responsibilities.
- Quality early education is as essential for a productive 21st century workforce as roads or the internet; investing in it grows the economy.

(Calman and Tarr-Whelan 2005, p2)

Whilst being optimistic, we should acknowledge that there are clearly some limits to what early years’ programmes in themselves can accomplish. Some aspects of the differences that emerge in the early years will be due to factors that are not readily altered by policy. A further challenge is that not all early years programmes are equally effective. High quality programmes are expensive and even the most promising model programmes might not work when delivered on a large scale. Yet analysis by economists (Barnett, 2011) and neuroscientists (Diamond, 2012) suggest that early childhood intervention has a disproportionate impact; a little of the highest quality goes a long way.

A UK report by the Daycare Trust (2009) which looked at the costs of paying for high quality early education and care revealed that staff qualifications and wages in nursery schools and nursery classes are already almost at the level described in their high quality model, so the difference for those settings to achieve high quality would be minimal compared to those in other settings: only around 15 per cent increase in costs for nursery schools. Cost increases in nursery classes within primary schools are slightly higher, at 27 per cent. The report also indicates that nursery schools and classes are actually the most cost-effective type of provision in the high quality model, followed by full daycare in children’s centres. Therefore, the high quality cost model represents only a relatively small cost increase (between 10 and 27 per cent) for maintained settings, but a very significant increase (up to 200 per cent) for PVI settings.

The Allen Report (2011) also presents some useful examples of the returns that have been reported from a selection of well-regarded studies. For example, an evaluation by the RAND Corporation of the Nurse Family Partnership (a programme targeted to support ‘at-risk’ families by supporting parental behaviour to foster emotional attunement and confident, non-violent parenting) estimated that the programme provided savings for high-risk families by the time children were aged 15. These savings (over five times greater than the cost of the programme) came in the form of reduced welfare and criminal justice expenditures and higher tax revenues, and improved physical and mental health.

An independent review (Aos et al 2004) placed the average economic benefits of early education programmes for low-income 3- and 4-year-olds at close to two to two and a half times the initial investment: these benefits take the form of improved educational attainment, reduced crime and fewer instances of child abuse and neglect. Within this overall figure, there is substantial variation, and reviews of individual early education programmes have noted benefit-to-cost ratios as high as 17:1 (Lynch 2009). Some of the largest returns have been seen in improving children’s ability to communicate, something central to any child’s social development. It has been estimated that the
Early Years Literature Review

benefits associated with the introduction of the literacy hour in the UK, even after controlling for a range of other factors, outstrip the costs by a ratio of between 27:1 and 70:1 (Allen 2011).

There are still thorny issues to be addressed, for example, whether such programmes are best delivered universally or targeted; however, the evidence for the significance of quality early childhood intervention and its cost effectiveness over nearly 40 years of research is now overwhelming. This review therefore sets out to identify what aspects of early interventions seem to be most promising in enhancing educational attainment and health outcomes for the less advantaged and how existing early years programmes might more effectively incorporate these features into practice and service delivery.
Early Years Literature Review

2. How far and in what ways can early years education and care, social care and health programmes counter socio-economic disadvantage?

As set out previously, we have to acknowledge that any early intervention strategy can make only a contribution to countering deep, social and economic inequalities in society. However, this section of our report reviews current evidence which identifies the most fertile areas for action in the early years, highlighting key factors which are associated with educational underachievement and poor health outcomes during this period of life and need to be addressed if any progress is to be made in countering socio-economic disadvantage.

There is a clear case made in all the recent reviews for an increase in the proportion of overall expenditure allocated to early intervention programmes, starting in pregnancy. UNICEF (2012) recommends that the minimum ‘level of public spending on early childhood education and care (for children aged 0 to 6 years) should not be less than 1 per cent of GDP’. The UK currently meets this target but is also trying to reverse its investment choices towards prevention and earlier intervention rather than remediation during the early years of a child’s life, as is evident throughout the OECD countries and beyond (Economist Intelligence Unit, 2012; Pascal and Bertram, 2012). The steady stream of reports and studies on the importance of early intervention over the last 18 months is testimony to the continued political awareness of the need to sustain investment in this area of policy. We should also note that the OECD (2009) reports that spending on young children is more likely to generate more positive changes than spending on older ones and, indeed, is likely to be fairer to more disadvantaged children. However it notes that, in the UK, for every £100 spent on early childhood (0–5 years), £135 is spent on middle childhood (6–11 years) and £148 is spent on late childhood (12–17 years).

Waldfogel and Washbrook (2008, 2012) use detailed cohort study data to explain the gaps in school readiness between children from the bottom fifth and children from the middle fifth of the income distribution in the US and the UK. They explore the relative importance of the factors that account for the poorer scores of low income children and the better scores of high income children to help identify policies that can play a role in closing gaps. They found that no one factor drives these results. Rather they highlight a host of differences - in factors such as parenting style and the home environment, maternal and child health, early childhood care and education, maternal education and other demographic factors - which together help explain why low income children come to school less ready to learn and why high income children come to school with an advantage.

A recent study by Bowers et al (2014) has more sharply identified from the evidence the most fruitful areas to focus on to improve the early years for children, and in particular reduce inequalities in health and other outcomes. Their work provides policy colleagues, strategic leaders and children’s service managers with areas for focus and clear outcomes based on what the evidence says matters most in the early years for improving early experience for all young children and their families. These areas and outcomes are also those that the evidence suggests services can influence. Once children are safe and their basic health needs are met, they prioritise the following three areas:
Early Years Literature Review

Children’s health and development
Cognition, communication and language, social and emotional development, and physical health are all critical for children to thrive as they grow up. While debate continues about which of these four aspects is the most important, there is agreement that they are all critical and interrelated. All children’s services should support children in these areas.

Parenting
The dynamic interaction between parent and child, and in particular the type of home communication and learning environment that parents establish and nurture for their children from birth, is critical. Parenting must also generate attachment between parents and their children. Early years services can offer a range of interventions and opportunities to support parents to improve their own approaches and skills based on an understanding of what is most important.

Parents’ lives
There are particular factors that sit outside the immediate parent–child relationship but exert powerful influence over parenting. Parents’ health, social networks, financial resources and knowledge about parenting collectively act as enablers or barriers to nurturing their children’s development. Early years services can support parents to improve a number of these even if not all are within their remit.

The literature suggests that the latter two focuses – parenting and parents’ lives – are particularly important in improving early years experiences and later-life chances. Evidence shows that parenting, shaped by the parent’s own context, drives much of what happens in the early years. Parenting and the context in which it takes place is associated with the inequalities that exist between families and across the social gradient, and with the inter-generational persistence of inequality. While many early years services already prioritise parenting, the measures of success now need to do the same, placing parenting and parenting circumstances on an equal footing with influencing children directly.

In summary, all of the evidence we considered have consistent conclusions which pinpoint three core areas for action in the early years. These areas are discussed in more detail below and include:

- Maternal Health, Health Related Behaviours and Child Health;
- Parenting;
- Early Education and Care.

We have included the evidence on each of these areas in this review as it is clear that the most effective early years programmes in countering socio-economic disadvantage are multi-pronged and include action in more than one of these areas. Whilst the central role of early education and care in addressing inequalities in child outcomes is acknowledged in this review, it is important that consideration should be given to its ability to work in partnership with wider early intervention initiatives in the other areas, and in particular health and social care services. The evidence also reveals that the potential impact of action in each of these areas is not equal, and that the primacy might shift as the child moves through the foundation years. For example, in the first months of life maternal and child health are pivotal, and later (from about 2 years), early education can make a
Early Years Literature Review

more significant contribution. What is clear, however, is that parenting and the home learning environment are the prime and most powerful contributory factors throughout.

2.1 Maternal Health, Health Related Behaviours and Child Health

There is evidence of income related differences in maternal health and health related behaviours such as smoking, breastfeeding, pre-natal care, depression, obesity and overall health, which play a role in explaining developmental delay and underachievement in young children, particularly from pregnancy to around 2 years of age. However, these factors appear to have much less of an impact on school readiness as the child gets older (4-7% of gap in cognitive outcomes between low and middle income families). Disparities in child health are also a well documented source of disparities in school achievement but are seen to account for only about 4% of the gap in school readiness (this may be an underestimate) again suggesting that child health does not seem to be a major factor in explaining the gaps in school readiness which increase as the child matures.

2.2 Parenting

Parenting differences between high and low income families are well documented and they are associated with sizable differences in cognitive and non-cognitive development, and in long term educational achievement. This evidence is definitively reflected in the EPPE study (Sylva et al, 2004, 2010,2012), as well as in Waldfogel and Washbrook’s (2008, 2012) analysis of the factors associated with educational underachievement.

Parenting style: This factor emerges in recent research as the single largest domain explaining the poorer cognitive performance of low income children relative to middle income children, accounting for 19% of the gap in mathematics, 21% of the gap in literacy and 33% of the gap in language (Waldfogel and Washbrook, 2012). A particularly important factor included in the parenting style domain is maternal sensitivity and responsiveness (sometimes called nurturance). Other factors include knowledge of infant development, discipline and rules. Developmental psychologists have long emphasised the importance of sensitive and responsive parenting for child development and this analysis shows that this one aspect of parenting style accounts for 11% of the gaps in literacy and maths between low and middle income children and 21% of gap in language skills between these two groups.

Home Learning Environment: Aspects of the home learning environment are the second most important set of factors, together accounting for between 16 and 21% of the gap in cognitive school readiness between low income children and their middle income peers. The EPPE research also found that for all children, the quality of the home learning environment is more important for intellectual and social development than parental occupation, education or income; as the report states, “what parents do is more important than who they are.” The Home Learning Environment includes parents’ teaching behaviours as well as their provision of learning materials and activities, including books and CDs, computer access, TV watching, library visits and classes. What particular factor matters most in this domain appears to depend on the specific outcome. For example, the
Early Years Literature Review

research shows that computer access explains 9% of the gap in literacy and maths, but is less important for language.

2.3 Early Education and Care

Recent international evidence (Corak et al. 2012) reveals that in many countries, including the UK, children from low income families continue to be less likely to attend high quality early education and care programmes, even though we know that they benefit more than their more advantaged peers. This review estimates that if all low income children were to be enrolled in high quality early education programmes, such reforms could close the gap in achievement by as much as 20-50%, revealing what a powerful driver early education can be in countering socio-economic disadvantage. This evidence is reinforced by EPPE study (2004, 2008, 2010, 2012) which demonstrates the positive effects of high quality preschool on children’s intellectual and social behavioural development up to end of KS1 (7 years) and beyond and also shows its particular benefit for less advantaged children. The current evidence provides an unequivocal argument for the pivotal role of early education programmes in countering educational underachievement, especially if targeted differentially towards lower socio-economic children and accessed from an earlier age.

The EPPE evidence also makes clear that both the quality of the early education experience as well as the quantity, (more months, not more hours a day), are influential in determining outcomes for children. The study also reveals that many of the UK early education programmes currently accessed are of variable quality, and as low income children more often attend these lower quality settings, it follows that if quality improvements were implemented in all early education programmes the reductions in the gap could be higher. In summary, the EPPE longitudinal evaluation of children’s early preschool experiences revealed:

- **Preschool attendance, compared to none, enhances children’s all round development, leads to better cognitive and non-cognitive outcomes;**
- **Duration of attendance (in months) is important: an earlier start (under three years) is related to better intellectual development;**
- **Full time attendance leads to no better gains than part-time provision;**
- **Disadvantaged children benefit significantly from good quality preschool experiences, especially where they are with a mix of children from different social backgrounds;**
- **Overall, disadvantaged children tend to attend preschool for shorter periods of time than those from more advantaged groups (around 4-6 months less);**
- **There are significant differences between individual preschools and their impact on children: some settings are more effective than others in promoting positive child outcomes;**
- **Good quality can be found across all types of preschool but quality is higher overall in settings integrating care and education and in nursery schools.**
  (Sylva et al 2004)

The next two sections explore further evidence from this important and detailed study, and also other research, which identifies those characteristics of early years programmes which are associated with enhanced educational and health outcomes, particularly for disadvantaged children.
Early Years Literature Review

What recent evaluative evidence is there on what has worked, including the impact of co-production in service design?

Over the last 10 years the UK has implemented a menu of different programmes and initiatives which aim to combat social inequality and educational underachievement through early intervention. The Allen Report (2011, Appendix D, p138-142) provides a useful table of such initiatives, giving programme characteristics, targeted age range, and measured examples of impact, outcomes and cost effectiveness and this is reproduced in Appendix 1. Parenting support and family health initiatives are increasingly offered in conjunction with early education programmes and viewed as a two generational approach in which professionals work with parents and children to support children's early development and learning. Early education is offered as a key element in this package of support as an educational intervention specifically to help 3-4 year olds (and now disadvantaged 2 year olds) to gain skills for school entry (school readiness). It also is seen to provide a place where children can form wider friendships, learn to get along with other children and regulate their behaviour so as to develop appropriate socio-emotional and dispositional behaviours that will facilitate later learning.

Examination of the evaluation evidence of these programmes reveals that there are different models of content and delivery mode adopted in successful programmes. For example, parenting support and maternal health programmes can use professionally trained nurses and a uniform delivery method or use para-professionals and other lay staff to deliver a mix of services tailored to a specific community. Early education can be public or private, centre or school based, targeted or universal at different ages. Also, each of the programmes can be implemented as stand alone or part of a multifaceted programme. Variations in models include:

- Focus on different child and / or adult outcomes eg school readiness – cognitive, socio-emotional, behavioural, health, economic success, childrearing skills, pregnancy, parent education, parenting skills;
- Different target person eg child, family, parent;
- Different targeting criteria eg single parent, ethnicity, mothers age, low income, low SES, high risk children, behavioural problems, substance abuse, relationship or social problems, universal;
- Different age of focal child eg prenatal to 5, shorter or longer spans;
- Different location of services eg home, centre, school, medical setting;
- Different services offered eg educational, preschool, parenting education, family supports, health or nutrition, job related, therapeutic;
- Different intensity of intervention eg starting age to ending age, hours per week, weeks per year;
- Differential approach to individualised attention eg individuals, small or large group;
- Different programme reach eg national, citywide, single setting.

The research considered in this review identifies a number of promising programmes that have shown the potential to counter socio-economic disadvantage by improving maternal and child health, parenting and early educational attainment, or all of these. Judged by the evidence, the core
characteristics and delivery features programmes that have successfully boosted the learning and development of disadvantaged children are set out below, grouped into five types of programme:

1. Programmes that provide support to parents during pregnancy and early childhood;
2. Early health programmes for children from 0-5 years.
3. Programmes that combine parent support and early education and care for children 0-2 years;
4. Early education and care programmes for children 0-2 years;
5. Early education programmes for children 3-4 years

A point of caution should be inserted here. While the value of evidence-based programmes is clearly promoted in recent reviews, such as the Allen Review (2011) we should note that to concentrate solely on those programmes which meet a narrow set of success criteria which focus on a set of ‘hard’ and proven outcomes may exclude some very valuable programmes with broader notions of social justice and reducing inequality which have key resonance in this review. We would recommend that alternative methods of evidencing value and impact should be considered as well as the Randomised Control Test, experimental style evaluation approach when evaluating a wider range of early childhood programmes. The following programmes have been identified within one or more of the core review documents as offering particular capacity and impact on outcomes for disadvantaged children.

3.1 Programmes that provide support to parents during pregnancy and early childhood

The Nurse-Family Partnership Programme
The Nurse-Family Partnership Programme has been shown to be successful in improving prenatal health, reducing dysfunctional care of children in early life, and improving family functioning and economic self sufficiency. This programme provides nurse home visiting to low income, first time mothers, delivering about one visit a month during pregnancy and the first two years of a child’s life. It has been shown to improve nutrition, reduce maternal smoking during pregnancy, reduce pre-term births, promote heavier birth weight and also reduce child abuse and neglect. It has also been shown to improve parenting by increasing responsive and sensitive parenting and by the quality of the child’s Home Learning Environment and parents’ literacy activities; these measures have led to small improvements in behavioural and cognitive outcomes for children, with larger effects for at risk children. It also improves family functioning, delaying subsequent births and increasing maternal employment. The success of this programme has been attributed to the fact that it has developed a highly manualised intervention and that it uses highly trained nurses to deliver it.

The Incredible Years Programme
The Incredible Years Programme provides parent training for families with severely behaviourally disordered children. It uses video clips to teach parents how to manage difficult behaviour and has been found to improve parents’ ability to manage their children’s behaviour and to lead to improvements in children’s conduct disorder and attention.
Early Years Literature Review

The Triple P-Positive Parenting Programme
The Triple P-Positive Parenting Programme is a manualised programme, led by trained professionals and has been shown to help parents better manage children’s behaviour.

The Play and Learning Strategies (PALS) Programme
The Play and Learning Strategies (PALS) Programme provides in home training to parents of infants and toddlers focused on improving parent’s responsiveness and sensitivity. The Infant Programme has well defined, manualised activities offered in 10 sessions; with the Toddler Programme having 12 sessions and parents with both ages using video clips as a training tool. The evidence shows it improves parents’ responsiveness and sensitivity and their ability to support children’s learning and development. It also shows impact on children’s attention, use of language and vocabulary scores.

The PEEP (Peers Early Education Partnership) Programme
The PEEP (Peers Early Education Partnership) Programme aims to foster reading readiness by providing parents with age appropriate materials and supporting them in using the materials either through group sessions or home visits. This programme is well specified and uses well trained professionals in its implementation. Results show gains in several measures of cognitive development between age 2 and 4-5 years. This programme is experimenting with additional models of delivery to reach parents who may not participate in formal programmes eg drop in sessions in shopping centre.

The Special Supplement Programme for Women, Infants and Children
The Special Supplement Programme for Women, Infants and Children is a health and nutrition focused programme, based in locality based centres, which provides nutritional advice and help in purchasing healthy foods to low income pregnant parent in US which shows reductions in low birth weight and improved child nutrition in disadvantaged families.

3.2 Early health programmes for children from 0-5 years

The Healthy Child Programme
The Healthy Child Programme (HCP), launched in 2009, includes a range of evidence-based interventions that are aimed at building resilience in early childhood across all developmental domains and underpins the public health efforts directed towards children and young people, seeking to include both universal and targeted approaches. The Healthy Child Programme is an evidence-based approach to ensure that children have the best start in life, underpinned by key health professionals, particularly health visitors. The delivery of the programme is based on a proportionate universal approach that involves adapting interventions according to risk factors present in the community, with the aim of achieving equitable outcomes for all children. It is a universal public health programme for all children and families. The Programme consists of a schedule of reviews, immunisations, health promotion, parenting support and screening tests that promote and protect the health and wellbeing of children from pregnancy through to adulthood. These are all services that children and families need to receive if they are to achieve their optimum health and wellbeing. There is strong evidence supporting the effectiveness of the whole of the HCP, which is based on Health for All Children, the recommendations of the National Screening
Early Years Literature Review

Committee, guidance from the National Institute for Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick. These reviews also reveal that the success of the whole programme depends on attaining equity of outcomes for all groups in our community.

The Health Visitor Implementation Plan

This more recent Government initiative is a key element of the Healthy Child Programme, and aims to add extra capacity to ensure the ability of local teams to improve public health outcomes, providing personalised care, with health visitors having the time to provide parents with critical health and development advice, and to connect families to the array of health and wider community resources that help them to give their children the best start in life. As part of the preparation for the changes in health, public health and social care commissioning, a series of six briefings have been developed to demonstrate the impact that health visitors and the delivery of the universal Healthy Child Programme have in improving outcomes for children and families. The six areas are:

- Transition to parenthood and the early weeks including early attachment
- Maternal mental health (PND)
- Breastfeeding (initiation and duration)
- Obesity to include nutrition and physical activity
- Health and wellbeing at 2 (development of the child two year old review (integrated review) and support to be ‘ready for school’)
- Managing minor illness and reducing accidents (reducing hospital attendance/admissions)

The expanded health visiting service is intended to deliver the full Healthy Child Programme (HCP) 0-5 years with a focus on working across services for 0-5s and their families to improve public health outcomes.

A recent review of the Health Visitor Implementation Plan (Cowley et al, 2013) set out the evidence on how health visitors help build community strengths and found some evidence about how health visitor services are organised and fit with the wider community provision, including traditional approaches and some documented changes. Improvements in uptake and access to services were reported from health visitors working with a traditional caseload, extending their remit through community/public health activities, as well as from those who prefer to focus on community development activities without retaining responsibility for traditional one-to-one/family work. This literature includes a number of small project descriptions, which report the ways in which health visitors can contribute to the wider services, and various suggestions for organising services to build community strengths.

Some other studies explored the impact of multi-agency work and team composition and culture on service users, and identified some positive examples, but little evidence that the studies had engaged with wider research about organisational culture. Factors determining the fit of health visiting services with other community and children’s services include the way in which the teams are organised and supported by the employing organisation, but there was little evidence about how service innovations and change affected client outcomes.
Early Years Literature Review

The study also identified that an improved fit between provision and uptake of the service may be achieved through a health visiting orientation to practice that guides delivery of health visiting across the whole service spectrum, which:

1. Is salutogenic (health-creating), which involves being proactive, identifying and building strengths and resources (personal and situational) and being solution-focused.
2. Demonstrates a positive regard for others (human valuing), through keeping the person in mind and shifting (the health visitors’) focus to align with client needs, recognising the potential for unmet need, actively seeking out potential strengths, maintaining hope.
3. Recognises the person-in-situation (human ecology), through assessing and acting as a continuing process, always taking account of the individual and their personal and situational circumstances, whether acting in the client’s space, the community or the workplace.

In turn, the review suggests that these concepts and ways of working can - potentially - be instrumental in enhancing uptake and use by understanding more about a ‘service journey’ followed by service users. The unsolicited, proactive and health promoting focus of health visiting means that services need, particularly in the early phases of pregnancy and having a new baby, to reach out to parents who have not initially requested a service. To get to know the parent, the health visitor needs to first gain access to family, by attuning, listening and observing the situation, which in turn allows the parent to get to know the health visitor. Ideally, then, a range of activities including assessing and intervening, ongoing availability, reciprocal exchange and collaborative interaction leads to a situation in which the parent understands and has confidence in the service, is able to express needs and accept referrals or initiate further contact as required. However, these studies while providing good information about processes, were qualitative and descriptive, without a link to child and family outcomes. The evidence which highlighted service approaches and practice that failed to achieve the ideals is summarised below.

**Universal**

The Universal service for all families involves working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families, as well as leading the HCP for families with children under the age of 5. Here, the core question is: What are the key components of health visiting practice and how are they reflected in implementing the ‘new service vision’ and HCP?

The ‘health visiting orientation to practice’ (described above) appears to influence the way health visitors work in any situation, but is particularly evident in delivery of the Universal service, which then operates as a gateway to other levels of provision. Three core practices appear to operate together in delivering the Universal service:

1. the health visitor-client relationship,
2. health visitor home visiting and
3. health visitor needs assessment.

Research about these three components of practice describes similar skills and attributes, and cross
references the other two, indicating that they operate as a single process. Health visitor-client relationships are mentioned in much of the research as a mechanism or key way of working, which is considered especially important in enabling uptake by families who sometimes find services hard to access. Key processes involved in relationship-formation often proceed in tandem with home visiting and there is evidence in several trials to suggest that these approaches may help to promote more relaxed mothering and better use of services. Data also reveals that approaches to health visitor needs assessment should be a continuing process, rather than occurring as a single event and that it is also intimately bound up with home visiting and the professional-client relationship. The main skills and knowledge required for making these assessments and professional judgments are identified in the research, and include highly developed interpersonal skills, empathy, application of knowledge and observation.

The review also identified two key approaches that support the integrated approach to health visiting work, each acknowledged in the HCP. The Family Partnership Model (FPM) (Davis & Day 2010) (see previous section) has proven effectiveness and beneficial outcomes, particularly when used with promotional interviewing techniques (Puura, Davis, Mantymaa et al. 2005a). The Solihull Approach offers benefits as well, having positive pilot study evaluations and a strong theoretical base that is helpful and compatible with health visiting, (Douglas & Brennan 2004; Bateson, Delaney et al 2008).

There is also interest in improving the extent to which health visitors engage and work with fathers. The review found various resources designed to enhance practice including a pilot questionnaire that aimed to improve communication with fathers in practice, but limited evidence about the effect of health visitors’ work in this field. Similarly, there is wide acknowledgement that health visitors have an important role in supporting breastfeeding, particularly its continuation and in this field there is somewhat more research. Specifically training health visitors in breast-feeding support has been shown to be effective in improving breast feeding rates. Both technical knowledge and emotional support are required, and there is some suggestion that, when combined with knowledge of the ‘person-in-situation’ and non-judgmental approaches, these can be effective in enabling mothers who start (usually with support from midwives) to continue breastfeeding. The research about preventing unintentional injuries is somewhat mixed, again drawing attention to the need for additional training for health visitors in this area and barriers to promoting safety. The evidence suggests health visitors tend to focus on a micro/individual level, rather than on the broader public health level, although the latter may be more effective in the long term. One trial of safety consultations or free safety equipment showed some changes in families’ safety practices, but not to the recorded number of accidents. Peer educators seemed to be more acceptable and effective to mothers, and they were also welcomed by the health visitors who trained and supervised them.

Most health visitors appear to adopt a ‘parent-centred’ approach in informing and supporting decisions about immunisations, in order to achieve a balance between their public health role (to promote uptake and herd immunity) and that of providing (non-judgmental) support to parents. Again, the need for additional training was raised by the research, as were barriers to successful practice. As with breast feeding, health visitors were aware of a tension between an expectation that they would promote the ‘approved line,’ yet were anxious that this might undermine the trust and relationship upon which acceptance of health advice seems to depend.
Early Years Literature Review

Universal Plus

Universal Plus services are offered to any family that may need them, including packages of care that the health visitor may provide, or arrange through delegation or referral, intervening early to prevent problems developing or worsening. The core question is: What is the health visiting contribution to leading and delivering services where families need support or help with specific issues?

The evidence about how health visitors deal with post-natal depression (PND), as a key mental health issue with known effects on infants as well as mothers. This was one of the most widely researched areas, although the Cowley review reflected the findings of an earlier review in suggesting that the evidence of effectiveness of health visitor interventions for post-natal depression was limited, with many studies having methodological or reporting limitations. More recent evidence shows achievement of positive health outcomes through training health visitors to identify depressive symptoms in mothers and provide psychologically oriented support through home visiting (Morrell, Slade, Warner et al 2009). This resulted in statistically significant improvements for women with all levels of risk as predicted at 6 weeks post-partum including, in a later analysis of data, improved prevention amongst women who initially appeared to be low-risk. The ability to reach all women and form a health visitor-client relationship, combined with the additional sensitivity and knowledge gained from the PND-specific training, was the presumed reason for this universal prevention (Brugha, Morrell, Slade & Walters 2011).

There were surprisingly few studies about the health visiting role in nutrition and obesity prevention, particularly in the first year of life, despite parents reporting that they turn to health visitors more frequently than other professionals for advice on weaning. Studies focused on the need for a clear knowledge base and careful communication, particularly because of the strong cultural and family impact on weaning, and sensitivity about obesity, where health visitors may feel inhibited in raising issues of risk. This draws attention once more to the need for health visitor-client relationships along with awareness and use of an ecological approach and the non-judgmental orientation implicit in ‘human valuing.’

There is more evidence on support for parents and parenting support, but overall they offered limited insight into health visiting practice, being a collection of disparate studies that vary in methodology and quality with little conclusive evidence of service outcomes. There was some evidence that programmes helped parents of children with behavioural disorders, and there were promising outcomes from additionally-trained health visitors providing focused help for early identified sleep and behaviour difficulties. Additional training also helped when parents were able to access health visitors working within a specialist field and team (Attention Deficit Hyperactivity Disorder), which reduced childrens’ problematic symptoms and improve maternal well-being (Sonuga-Barke et al 2001) although that success was not carried forward when health visitors tried to implement the same approach whilst holding a generic caseload.

As well as specialist health visiting, we found evidence that health visitors enabled timely access to other services, through initial case-finding (for example, of pervasive developmental disorder, and young children with mental health needs), then referring them to appropriate services. Other
Early Years Literature Review

literature documented the way health visitors enabled parents to access Sure Start Local Programmes and general or specialist parenting programmes.

The Cowley et al (2013) review also identified that skillmix teams appear to have been widely implemented within health visitor services. Some project descriptions identified reduced stress where staff shortages had been relieved by the introduction of junior staff, including community nursery nurses or staff nurses who were then enabled to access health visitor education themselves, an approach that minimised tension in the team. There were very few studies that identified the process of planned delegation to a junior team member because she or he had appropriate skills and could relieve the health visitors’ time. Lines of accountability appeared clearest when they had been carefully considered ahead of time, but the most frequently reported approach to delegation involved pragmatically using team members interchangeably, which led to concerns about missed opportunities for health promotion and potentially reduced service quality. Indeed some papers challenged the idea that dilute skillmix reduced stress, because of the additional supervisory load and difficulty in maintaining quality of services. There was also concern about vulnerability, where local women were employed as support workers. 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 team (Russell 2008). However, reported studies focused mainly on implementation and change processes rather than child and family outcomes.

Universal Partnership Plus

Universal Partnership Plus provides additional services for vulnerable families requiring ongoing additional support for a range of special needs arising from social disadvantage or disability. The core question is: What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?

The 2013 Cowley review looked at evidence about how health visitors work with seldom heard populations, identifying a small number of publications about insecurely housed and travelling communities, asylum seekers and refugees. They state that these studies do not form a coherent whole but rather mirror the fragmented nature of the literature on health visiting. Descriptive studies identified the complexity and skill required to work successfully with families, such as asylum-seeking families who have no recourse to public funds or rights to receive health, housing or social care. This leaves the health visitor as the sole provider of care to very vulnerable children and families who may ‘go underground’ at any time, to avoid identification by immigration officials.

The review found very little research about health visitors’ work with people with learning difficulties or with insecurely housed families. However, survey evidence gathered from hostel-dwelling families identified that they knew their health visitor and how the provision and using it to avoid inappropriate use of emergency services. Whilst limited in amount, the evidence about health visitors’ work with this very disadvantaged population underlined the level of knowledge and skill needed. Cultural sensitivity and awareness of the complex nature of their lives is a fundamental requirement for all families facing disadvantage or with complex needs, and research emphasised the importance of such understanding, before families feel able to trust services. Most of the evidence about cultural competence was elicited from research concerning health visitors’ work with black and minority ethnic (BME) groups. There was evidence that some health visitors felt ill-
Early Years Literature Review

equipped to practice in a culturally-competent way. Also, one study about implementation of a Trust-wide policy espousing equity identified that the plans did not translate into practice, because of lack of clarity and education for staff. Other studies mirror the concerns of many health visitors (e.g. finding it difficult to manage limited resources in balancing attention to the baby with attention to the mother) and policymakers (e.g. developing cost-effective culturally sensitive systems of support), but found that BME mothers were particularly affected.

The literature on domestic violence provides examples of how health visitors can enable families to express their needs, in particular, in relation to disclosure and the subsequent referral of families to appropriate services (Baccus, Bewley & Mezey 2003). Reasons for underreporting include women being fearful of losing their children or feeling that they have nothing to gain from their disclosure, often linked to a lack of trust for health visitors or others. Evidence of enhanced disclosure came from one area that included routine questions about domestic violence, with other studies emphasising the importance of privacy and trust gained through home visiting and established relationships (Peckover 2003a, Hester & Westmarland 2005).

The HCP and Implementation Plan both emphasise the importance of evidence-based home-visiting programmes for vulnerable families. The Family Nurse Partnership programme is implemented separately but alongside the health visiting service for first-time teenage mothers. However, other home visiting programmes were identified, which provide evidence that health visitors are able to implement such programmes with fidelity. The type and quality of the studies varied, with two external evaluations, one non-randomised longitudinal comparison study, one cluster randomised trial and two RCTs (Emond, Pollock, Deave et al 2002, Austerberry, Wiggins, Turner & Oakley 2004, Puura, Davis, Cox et al 2005, Shute and Judge 2005, Barlow, Davies et al 2007a, Kemp, Harris, McMahon et al 2011). Each of the programmes achieved some significant benefits in key areas, along with other beneficial changes that were not statistically significant or identified only in qualitative work. These include mothers having a more relaxed experience of parenting, being able to use health services appropriately (with reduced use of emergency or GP care), more sensitive mother-child interactions and improvements to the home environment.

Child Protection

The contribution to child protection is about ensuring that appropriate health visiting services form part of the high intensity multi-agency services for families where there are safeguarding and child protection concerns. The core question is: What is the role and contribution of health visitors to child protection and safeguarding?

Most of the preventive work carried out by health visitors includes an element of safeguarding, which is a broad concept encompassing emotional and physical safety as well as protection from harm. Their key role in terms of child protection lies in identifying (or ‘case-finding’) children who are, or who are at risk of, experiencing significant harm and initiating formal safeguarding procedures by involving colleagues from social care or the criminal justice system, as necessary. Once other services are engaged, health visitors maintain contact and a relationship with the children and family, to continue their preventive health role. The evidence about how health visitors assess risk in families, including identification of high risk and low protective situations reveals that identifying future significant harm to children cannot reliably be predicted in advance, and attempts
at identifying suitable screening instruments have failed to achieve the required levels of specificity or sensitivity. Longitudinal research showed that health visitor screening for risk factors in a single post-natal assessment did not help to accurately identify those families who would go on to maltreat a child (Browne, 1995b; Dixon, Browne, Hamilton-Giachritsis et al 2009), so repeated contacts, preferably through home visiting as part of the Universal service, is required. This is particularly because Serious Case Reviews identify that very young children are most vulnerable to significant maltreatment, including death.

Studies about health visitors’ professional judgments showed that they tend to prioritise families on their caseload according to key risk factors, but also took into account family strengths and context. This is a dynamic and multi-factorial process, which requires repeated reassessments and awareness of the whole context ('person-in-situation') taking into account information and knowledge of individual families, factual knowledge of child health, as well as about theories of child development, attachment and family functioning (Appleton and Cowley 2008a,b). Some studies identified that Trusts have often implemented some form of structured assessment protocols or guidance in an attempt to standardise this process, but by and large these are unhelpful, in that they do not improve identification of risk, but inhibit relationship-formation and trust, thereby reducing access by the families who need services the most.

Much of the evidence about health visitors’ work to modify risks to children and families comes from the home visiting programmes detailed under the ‘Universal Partnership Plus’ service level, supporting maternal sensitivity and engagement with services. There is also evidence about universal education programmes that highlight the risk to infants of brain damage from shaking and head injury, although this was cited in a narrative review of ways that health visitors could help, and no outcomes are reported (Coles and Collins 2007).

Reports about health visitors’ work where there is a child protection plan tend to emphasise the amount of time taken, proportionate to that for the rest of the families, with some qualitative work noting that the interface between health visitors and social workers changes according to thresholds operated to manage workloads. This may lead to health visitors being the sole worker involved with high-risk families, which is reported to be the cause of high levels of anxiety and concern, about both the child at risk (who is not in receipt of appropriate social care) and of other families for whom the health visitor is responsible, who receive a correspondingly lower share of time. Continuing to provide a non-stigmatising universal service in cases where families are involved with multi agency child protection plans requires both a supportive relationship and a surveillance component, which can be a difficult professional and ethical balancing act, requiring a high level of knowledge and skill.

3.3 Programmes that combine parent support and ECEC for children 0-2 years (and above)

**Sure Start Children’s Centres**
For more than a decade Children’s Centres have been the cornerstone of attempts in England to invest in the early years in order to transform children’s lives. Starting as Sure Start Local Programmes in the most deprived areas of the country, the role of Children’s Centres has evolved.
Early Years Literature Review

Today they are a universal service with a tailored approach to supporting disadvantaged children. There are approximately 3,500 centres across the country, one in every community, available to every family. Children’s Centres build on a long tradition of nurseries, early education, health services family centres and other services. However, Children’s Centres are unique in the breadth of their remit and responsibilities. Children’s Centres also have a community responsibility as a “hub for the local community, building social capital and cohesion”. Children’s Centres now sit within a policy framework of Families in the Foundation Years, focusing on families with children from pre-birth to five years old. This framework identifies five critical areas as determinants of future chances: children’s health in early life, good maternal mental health, quality of parenting and parent–child relationships, learning activities and high-quality early education. In 2012 the Coalition Government set out its vision for Children’s Centres and the role they would play in securing foundation-years outcomes. The Core Purpose of Sure Start Children’s Centres charges Children’s Centres to:

*Improve outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in child development and school readiness supported by improved parenting aspirations, self-esteem and parenting skills and child and family health and life chances.*

Sure Start is essentially a community based programme, supported by a network of locality based Children’s Centres, where anyone residing in the reach area is able to receive services. The local communities have increasing influence on what services they offer, although all offer some core services such as outreach and home visiting. Some local programmes have a strong health focus, others are led by social services or education or the voluntary and community sector. Increasingly, it is a mix of these approaches which is being employed, with the sectors working together in locality partnerships. The Coalition Government have recognised the importance of Children’s Centres as critical to the wider programme for children and families across government. However, they have more recently signalled a radical, new approach, with a power shift between central and local government, ensuring local communities have a greater say in the issues that affect them. They argue there is enough money in the Early Intervention Grant to maintain the existing network of centres accessible to all but focussed on identifying and supporting the most disadvantaged and vulnerable families. They also point to the new investment through the DoH budgets to provide 4,200 extra health visitors, working alongside outreach and family support workers, will enable stronger links with local health services.

The Coalition Government has retained the statutory duty under the Childcare Act 2006 for local authorities to provide enough Children’s Centres to meet need. However, ring-fencing for Sure Start Children’s Centre funding was abolished following the 2010 Comprehensive Spending Review, with resources absorbed into the wider Early Intervention Grant (EIG), which itself ceased to exist in April 2013. Funding for early intervention and family services is now part of the new local government funding scheme (the Business Rates Retention Scheme). By 2014/15, the available budget from which local authorities provide Children’s Centres will have fallen by more than a third (down 36 per cent or £0.9 billion), since 20108. Children’s Centres are anticipating further cuts and are being counted on to do more for less.
Funding reductions have meant that some services are either being cut or scaled back. For example, there is evidence that local authorities and Children’s Centres are attempting to manage these cutbacks by reducing their universal offer and wider family-centred in-house provision to focus instead on delivering a more targeted, focused approach. In the 2013 return of 4Children’s Sure Start Children’s Centre survey, just under a third of Children’s Centres anticipated providing fewer services to parents next year. Children’s Centres have also reported limited provision of English for speakers of other languages (ESOL) courses, job skills courses and Jobcentre Plus advice. Ofsted inspection reports published since the latest Ofsted framework for inspecting Children’s Centres was introduced have similarly highlighted insufficient adult employment and training opportunities. During field visits they found that many family-centred services to address the context in which parenting takes place, such as partnership working with Jobcentre Plus, are either being cut or the roles absorbed by Children’s Centre staff as part of the reorganisation of Children’s Centres and their delivery of services. Professionals within one case study area spoke of not feeling qualified to provide employment or debt advice, although this was now expected of them.

Ofsted (2014) have also reported that many local authorities are redesigning their Children’s Centres so that they operate in clusters, leading to a reduction in administration and back office costs and increased opportunities to share specialisms. In addition, an increasing number of centres are being brought together to operate under shared leadership, management and governance arrangements. In response, Ofsted has revised “its framework so that it is flexible enough to take account of the wide range of organisational structures that are emerging across and within local authorities”. This means inspecting groups of centres across localities. Research by the NFER (2013) found that “leaders and local authority staff were more positive about cluster models (where several Children’s Centres work together on strategic goals) than ‘hub and spoke’ models (whereby a leader of a hub Centre is responsible for the work of satellite centres)”. The leaders felt that they were unable to get to know the families using satellite centres and reported inefficiencies in managing split sites (such as travelling time). A few leaders also complained of increased accountability without the autonomy to remodel their Centres to meet local needs.

Recent evidence (Bower et al 2014) shows that in response to austerity, Children’s Centres are reshaping their services to deliver more for less and in some cases to deliver fewer services. While each local area will take its own unique approach to this, some Centres are reducing their management and oversight, expanding the scope of responsibility for experienced leaders. Others are shifting towards more group programmes and away from more resource-intensive one-to-one support. Other Centres are re-profiling their staff mix to rely more heavily on more junior and less qualified staff and a greater use of volunteers. These changes are having a significant impact on what Centres might be able to deliver to support children and families. According to the DfE (2013), the services most commonly provided by Children’s Centres currently include “stay and play”, home-based family services, parenting classes and breast-feeding support. Recent research indicates that centres are continuing to offer a surprising variety of services, despite recent cuts and changes in focus, but the 2013 4Children census shows clearly that the services being expanded by centres are parenting, rather than child-related.

Early evaluations of Sure Start did not shown consistent evidence of impact for the programme but more recent evaluations indicate that multi-professional and multi-agency programmes are
Early Years Literature Review

associated with improvements in parenting and Home Learning Environments and have shown some improvements in some aspects of child behaviour, child development and health (National Evaluation of Sure Start, 2008) The wider Children’s Centre programme which now operates nationally in every local community is currently being evaluated (Children’s Centre Evaluation 2012). Early indications have shown that the leadership of the multi-agency partnerships required for effective delivery of the range of services is critical. Key characteristics of this programme are its multi-agency emphasis, the locality and needs-led focus, the use of well qualified, multi-professional staff teams with qualified leadership and the adoption of evidence based practices.

Research also identifies characteristics of programmes that suggest a greater likelihood of achieving improvements. The evidence of what works in parenting programmes continues to develop. Caveats remain, particularly around effect size and whether or not the families who are assessed are representative. There are concerns that high attrition rates from particular programmes have meant that the evidence of success stems from self-selected participants. However, there is growing agreement over the aspects of parenting programmes that work, including highly qualified staff, regular and consistent engagement with children and their families, opportunities to practise new approaches and behaviours that may be discussed or ‘taught’ in particular programmes, and providing support before a crisis occurs. Programmes that support children directly need to be high-quality, regular and long-term (dosage and intensity are both important).

It should also be noted that the recent Select committee Report (2013) recognised that Nursery Schools continue to provide the highest quality early education and—when combined with Children’s Centres—offer the most effective model for achieving the child outcomes that Children’s Centres were set up to achieve. In the absence of a clear strategy to secure their future, they point out that many maintained nursery schools have closed in the last decade, with the result that the opportunity to build on them to create a seamless integrated approach for parents and children has been lost.

The recent Select Committee’s Report on Children’s Centres (2013) analysis of the evidence also led them to emphasise the importance of qualified and skilled staff, qualified leadership and, where centres are providing early education and care recommending that it should be led by a qualified Teacher or Early Years Professional and the need to use evidence based intervention programmes, but evidence is that this best practice is not yet common practice in all Children’s Centres. The importance of outreach and family support is also emphasised as critical in reaching the most vulnerable and disadvantaged families in greatest need, and it acknowledges that when these workers work alongside health visitors, social workers and other early years professionals, they are most effective. Establishing multidisciplinary teams in local areas which offer good integrated approaches, clear supervision, good information sharing and professional development for outreach and other support workers is seen as effective practice. They also recommend best practice reaches up into the primary and secondary schools, extending their family support work beyond the early years. Currently the report stresses that the focus should be on quality and improvement.

Ongoing research into the impact and effectiveness of Sure Start is provided by the Evaluation of Children’s Centres in England (ECCE) project. This is a six year study commissioned by the DfE in 2011 and undertaken by NatCen Social Research, the University of Oxford and Frontier Economics. The
aim of ECCE is to provide an in-depth understanding of children’s centre services, including their effectiveness in relation to different management and delivery approaches and the cost of delivering different types of services.

### 3.4 Early education and care programmes for children 0-2 years

**Part time, early education to disadvantaged 2 year olds**

A programme for the expansion of high quality, part time, early education to disadvantaged 2 year olds is currently being rolled out in the UK, to allow access for 40% of the most disadvantaged children. Programmes which focus primarily on delivering early education and care to infants and toddlers have received less attention in the literature, and are less commonly found. However, the EPPE research showed clearly high quality early education for toddlers is particularly effective for raising cognitive achievement for disadvantaged children. A key aspect of this programme is that it is offered in conjunction with parenting support, and also accompanied by strategies to improve the access children from low income families and measures to improve the quality of early education experiences offered in the providing settings. This programme would appear to build on the evidence base we have but its impact on countering socio-economic disadvantage is yet to be evaluated. The programme is building on existing provision in the private, voluntary and maintained sector, using professionally trained educators working with trained family support staff, and implementing a defined EYFS curriculum, with a focus on communication and language; personal social and emotional development; and physical development. This programme is about to be evaluated on behalf of the DfE and further evidence of its impact will be available in due course.

There has also been a recent directive from Government to engage the school sector more actively in the delivery of the 2 year old offer but the capacity and willingness of this sector to take this on is yet to be revealed. Some worries have been raised about the training and appropriateness of the school environment for these young children, but there is capacity for development in this sector which might be effectively utilised. As Michael Wilshaw argues (Ofsted 2014),

"What children facing serious disadvantage need is high-quality, early education from the age of two delivered by skilled practitioners with degrees in a setting that parents can recognise and access easily. These already exist. They are called schools."

According to Ofsted, only a third of children from low income backgrounds reach what is considered a good level of development at the early-years stage. "If we are to boost social mobility there is little point of expanding childcare without much more action to improve its quality," A Department for Education spokesman said high-quality school nurseries enabled children who are behind to catch up with their peers before starting school.

A recent study on the quality of early education and care programmes for under threes by Mathers et al (2014) considers international research on the dimensions of quality in early years education and care that facilitate the learning and development of children from birth to three and provides some useful evidence on best practice. This review identified four key dimensions of good quality pedagogy for all children under three:

- Stable relationships and interactions with sensitive and responsive adults
Early Years Literature Review

- A focus on play-based activities and routines which allow children to take the lead in their own learning
- Support for communication and language
- Opportunities to move and be physically active.

It concluded that in order to deliver high quality pedagogy, practitioners need to be skilled and knowledgeable and to work within environments which support them in their practice. The review of the research evidence suggests five ‘key conditions’ for quality:

- Knowledgeable and capable practitioners, supported by strong leaders
- A stable staff team with a low turnover
- Effective staff deployment (e.g. favourable ratios, staff continuity)
- Secure yet stimulating physical environments
- Engaged and involved families.

3.5 Early education programmes for children 3-4 years

Free entitlement to part time early education programmes

The expansion of free entitlement to part time early education programmes which deliver early education to all children from 3-5 has been in place in the UK since 2006. There is strong evidence from US Head Start evaluations and UK EPPE studies to support the expansion of high quality, part time early education programmes which have been shown to improve school readiness, cognitive development, health and behaviour improvements, and longer term improvements to school achievement and life success. The evidence on which this programme is based favours universal provision for 3-4 year olds. There is a compelling case that high quality programmes promote school readiness with larger effects for disadvantaged children.

In the UK there is work underway to improve quality, availability and access to provision as quality remains very variable and low income children still appear to access it less. Also the flexibility of the offer is being worked on to support parents’ work commitments. Policy responses are setting higher quality standards, expanding wraparound care, developing new models for parents who work irregular hours and increasing childcare subsidies for lowest income families to allow the integration of early education and childcare more effectively. There are also moves to achieve a tighter link between nursery provision and primary schools where alignment of curricula and raising the standards of teachers would reap benefits. Also, it is argued that this might free up voluntary and community services to focus on younger children. This programme is led by professionally trained educators (teachers in most cases), working with trained support staff, and implementing a defined EYFS curriculum, with a prime focus on communication and language; personal social and emotional development; and physical development.

Quality is clearly a factor in enhancing outcomes for the less advantaged but generally the quality of services is poorer in deprived areas except “The only early education provision that is at least as strong, or even stronger, in deprived areas compared with wealthier areas is nursery schools...these schools are disproportionately located in deprived areas...however these schools form a very small
Early Years Literature Review

part of the sector.” (Ofsted, 2014). The difficulty is that there are not enough nursery schools for all children, and although some 3-4 year olds in deprived areas will have access to nursery provision in a local primary school there is a gap in the proportion of good or outstanding schools in wealthier areas and the most deprived.
Early Years Literature Review

4. What particular aspects of best practice across early years social care, health and early education and care does research evidence show are critical in improving outcomes for the disadvantaged?

Our analysis of recent research and evaluative evidence provides strong and convincing evidence of the qualities and features of successful early intervention programmes. This evidence provides useful guidance for the further development of early years programmes to enhance their capacity to boost early achievement and health outcomes for less advantaged children. We have divided these factors into three, interrelated aspects of early years’ policy and provision which demand continued attention:

- Systemic factors: factors which are shaped by the wider system in which early education is placed;
- Structural factors: factors which shape the nature, scope and capacity of early years programmes;
- Process factors: factors which determine how early years services are experienced by those involved.

For each factor we provide a clear rationale drawn from the evidence to support further action to enhance the quality of early years’ provision and practice in all settings so that the current investment in early years programmes might have greater impact in countering social, health and educational inequality. Each set of factors generates a set of recommendations which collectively provide an agenda for further reflection and action.

4.1 Systemic Factors

Differential funding and investment

The evidence we have reviewed in the core documents supports the thrust of advice given in the Marmot Review ‘Fair Societies, Health Lives’ (2010), calling for a ‘second revolution in the early years’ to increase the proportion of overall expenditure allocated, starting in pregnancy. “What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being—from obesity, heart disease and mental health, to educational achievement and economic status….Later interventions, although important, are considerably less effective where good early foundations are lacking” (Marmot 2010 p.16)

The cost benefit analysis of investment in high quality early years programmes (Heckman et al 2006) demonstrates that the highest per child benefits stem from programmes that focus on economically disadvantaged children. Indeed, studies have shown that these children make significant gains in cognition, social-emotional development, and educational performance when they participate in high-quality early education programmes relative to children who don't participate. The economic benefits of these gains include increased earnings of the participants and public savings due to reduced crime and reduced need for rehabilitation and treatment. According to Heckman et al (2006), “Cost-benefit analysis also shows that these benefits are higher than those from public investments like sports stadiums or office towers”.

44
Early Years Literature Review

A study by Lynch (2007) documents the returns on investment made by high-quality pre-kindergarten programmes for three and four-year-olds and provides an indication of the cost-benefit savings that investment in targeted and universal early education programmes can achieve. These findings are based upon an extensive review of the economic literature, and data extrapolated from various past investments in Early Years programmes in the US such as the Head Start program, the Perry Preschool Project and the Chicago Child-Parent Centers program. Lynch argues that reallocation from later to early years investment will improve the academic performance and quality of life of millions of our nation’s children, reduce crime, make the workforce of the future more productive, and strengthen our nation’s economy. He demonstrates that a US nationwide investment in universal high-quality early childhood education would cost roughly $50 billion annually, (approximately one-third of 1% of US GDP) but that benefits would be far reaching and would include increased lifetime earnings, reduced social costs from crime, and increased tax revenue. In all, Lynch estimates that the annual benefits-to-cost ratio in 2050 of universal early years services would be roughly 8-to-1. For investment targeted on the most disadvantaged children this rate of return increases to more than 12-to-1 (See Figure 5).

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<th>Government budget benefits in 2050 (billions of 2006 dollars)</th>
<th>Increased compensation in 2050 (billions of 2006 dollars)</th>
<th>Savings to individuals from reduced crime and child abuse in 2050 (billions of 2006 dollars)</th>
<th>Total budget, compensation, and crime benefits in 2050 (billions of 2006 dollars)</th>
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* Targeted to lower-income families

Reproduced from Lynch (2007, Table 1)

A report from the House of Commons Education Select Committee (2010) recommended that there is compelling evidence that a child’s experience in the early years is key to its future development and that any increase in funding for early years might be met by a corresponding decrease in funding for primary or secondary education, although stated that this is largely a matter for local
Early Years Literature Review
determination. They also recommended that LAs should make use of the quality supplement to differentiate funding to different providers.

**Multi-agency and intergenerational action**

It is clear from the evidence that breaking cycles of disadvantage requires systemic action which brings together a range of health, education, social care and economic strategies which together work to create an early intervention approach at every stage in the life cycle. This means a wider and integrated programme of early intervention strategies are needed which are active from birth to adulthood, with a focus on children, parents and the wider family and community. The most effective early intervention schemes often improve more than one set of factors, with some of the most effective programmes working in conjunction with adult and child education, parenting programmes, child health and maternal health programmes. A recent report from the Home Office (2013) on multi-agency working and information sharing has drawn attention to the key features of effective multi-agency working. Local areas mentioned a number of factors they believed played a pivotal role in their multiagency working and information sharing approaches. These included:

- **Co-location** was cited as a welcome approach for good information gathering and decision making. Where these arrangements were in place, local areas reported that these approaches had yielded benefits for speedier information exchange, information sharing, greater area engagement and facilitating the culture of joint working as working together in the same place fosters mutual respect among different agencies and builds trust.
- **Good engagement from health** is very important as their information/perspective is often crucial to effective decision making on risk assessments. Health care professionals are often more comfortable sharing information with other health care professionals.
- **A good link and joint working with the Troubled Families agenda** helps with early identification and prevention work, i.e. housing problems.
- **Need buy in from the strategic leadership team and good leadership within the MASH.** A lack of good leadership can lead to drift on performance. Having an operational/business manager who was seen as independent acted like a glue to bind all the agencies together. They could push forward towards a shared culture more easily than any individual agency.
- **Having staff within a rotating team** keeps the balance between triage, risk assessment and frontline work and evolves the team’s competence. It also transfers knowledge back to the donor organisation when staff members return from their secondment.
- **An analyst or someone with the capacity to examine monitoring data to identify trends or hotspots within the MASH can enable early identification of potential harm and can reduce the risk of cases escalating unnecessarily.** It can also provide the evidence behind repeat referrals.
- **Listening and capturing service users’ voices.**
- **Strong accountability and leadership: governance and oversight through the Local Safeguarding Children’s Board (LSCB) and other local partnership accountability structures.**

Local areas also mentioned a number of barriers that they had experienced in the setting up of their multi-agency working and information sharing approaches. These included:
Early Years Literature Review

- All areas highlighted issues around information sharing when talking about barriers for establishing effective multi-agency models and mentioned key themes such as IT systems and confidentiality of information.
- They found that multiple IT systems could hamper attempts to join agencies together to share information for risk assessments.
- Many areas were using a secure email system but not all organisations had access to this.
- There was some misunderstanding among professionals about what client information can be shared, for example around confidentially (which is not limited to those engaged in these models), especially among health professionals. This could result in low confidence and uncertainty about what information can be shared.
- Many areas also thought that high staff turnover and corporate memory loss impacted upon operational outcomes. This was particularly salient at management level.
- Shared ownership among agencies was deemed important. Sometimes a lack of understanding about safeguarding resulted in a reliance on social services taking the lead. Several areas mentioned a lack of engagement from housing.

Continuity in Primary School

The evidence indicates that while early years schemes show promise in narrowing early achievement gaps, these gains will be lost unless the interventions continue during the schooling years. The core challenge for schools during the still formative years for children from 5 to 11 years, is to continue the focused attention on raising attainment to the highest levels among all children from poor and prosperous backgrounds alike. Evidence presented at the House of Commons Select Committee into Sure Start Children’s Centres (2010) showed that the best and most sustained impact in countering the effects of disadvantage occurred where the development of ‘community’, ‘broad based’ or ‘full service’ primary schools were combined in one building and under one management team. On this basis the select committee supported the extension of continuing wider child and family focused intervention strategies for disadvantaged children throughout the birth to 19 age phases and recommended that this finding should be followed through.

Regulation and Accountability

There is emerging evidence that reform to bring in better regulation and accountability in the early years sector can foster changes in behaviour and improve outcomes for disadvantaged children (although we must note that it can also lead to unintended consequences eg cutting corners, focusing on certain students, inflating test scores, narrowing the curriculum). The development of enhanced statutory standards, a comprehensive regulatory framework and more efficient systems to manage data, measure quality and evidence the impact of practice on children and family outcomes is associated with better quality, more effective targeting, the efficient deployment of resources at all levels and improved outcomes for the less advantaged.

Workforce Labour Markets

There is some evidence that manipulating the workforce mix of staff working with disadvantaged children, to give them access to more effective and highly trained practitioners, can lead to improved educational and health outcomes. Pay for performance, incentives to teach the disadvantaged and closer monitoring of poor performance are factors which, according to evidence
Early Years Literature Review

presented at the recent Social Mobility Summit (Corak et al 2012), can enhance the quality of services available in some of our most disadvantaged communities.

4.2 Structural Factors

Staff: Child Ratios
There is some evidence that a favourable adult: child ratio in early years programmes, particularly those working with less advantaged children, is helpful in ensuring the quality of interactions between educators and children (Howes, Philips and Whitebrook 1992). Favourable ratios are seen to help to create a climate of emotional security, allow practitioners to be responsive to the needs of children and able to support them when they have needs or are in distress. There is yet to be definitive research which indicates optimal adult: child ratios at different ages, as work so far has been unable to disentangle the effects of staff qualification, group size and ratios. While the available literature on the effects of adult: child ratios cannot offer an exact ‘best’ ratio there is a general consensus with the UNICEF report (Bennett 2008) that an acceptable model for ECEC classes for four and five year olds would be a group of 22-24 children with two adults, assuming that both have qualifications related to working with young children in an ECEC setting. It should be noted that all the reports considered in this review continue to advocate that to support a pedagogy with more intensive educative dialogues which are beneficial to underachieving children, requires smaller group sizes with more favourable staff: child ratios.

Class/Group Size
There are clear indications that smaller class/group sizes are directly linked to overall effectiveness of early years provision; a reduction in class/group size enables teachers/practitioners to spend more time with individual children; tailor instruction to match children’s needs and monitor classroom behaviour more easily. Barnett et al stated in their NIEER report that “in sum, preschool research strongly indicates that smaller class sizes are associated with greater educational effectiveness and other benefits” and that “even within studies that focus only on pre-school children, the effects of class size have been found to be larger for younger children” (Barnett at al 2004). However other studies have shown that consistency of teacher quality is also an important factor: In California where the government introduced smaller class sizes but struggled to find space or qualified teachers to sustain the quality of teacher input, the same results were not found. Teacher quality and physical resources are key to the success of this strategy in combating disadvantage. Across Europe there is considerable variation in group size regulation, ranging from 10 to 20 children for under threes and from 20-26 or even higher for the 3 to 6 year old age group (Oberhuemer et al 2010). Barnet et al (2004) quoted two separate studies with differing conclusions; one reported that only those programs with small effective class sizes (15 or fewer) produced very large educational benefits. The second suggested that the major benefits could be seen with groups below 20 pupils. These levels of variation make it difficult to arrive at an ideal class size for maximum effectiveness.

Staff Training and Qualifications
There is strong evidence that a well trained early years’ workforce, with high levels of qualification and access to ongoing professional development, is vital to close the achievement gap between children from poorer homes and their peers. There is a consensus that working in early years should
Early Years Literature Review

not be seen as a less well paid, lower status and less skilled job than working with older children. Research from the UK, the US, Canada and Australia shows that well targeted investment in training those who work with disadvantaged young children is a crucial strategy in countering educational underachievement. The education of the workforce matters because practitioners can do a lot to improve vocabulary, and enhance the cognitive and social skills of young children, particularly when they are not gaining these skills at home. The EPPE study makes a powerful case that teachers should be involved as part of a well qualified team of wider professionals working with young children, and particularly those who come from less advantaged homes. The evidence indicates that qualified staff provide children with more curriculum-related activities (especially in language and mathematics) and encourage children to engage in challenging play. Less qualified staff have also been shown to be better at supporting learning when they work with qualified teachers. The presence of well educated, professional staff who use extended vocabulary and replicate what well educated mothers can do has been shown to be crucially important in improving school readiness. Montie et al. (2006) suggest that teachers with more education use more words and more complex language when communicating with children.

The EPPE study consistently found positive associations with levels of teacher education and higher levels of teacher education were associated with children’s reading and language progress in the first two years of schooling. These included the findings of Montie et al (2006) from the IEA Pre-primary Project in 10 countries that as the level of teacher education increased, the language performance of 7 year olds improved. In the recent EIU report ‘Starting Well’ which compared preschool provision across 42 countries, UK was ranked third in the category ‘Quality’ for which 2 of the 8 criteria were ‘average pre-school teacher wages’ and ‘preschool teacher training’. Only Finland and Sweden fared better, with Finland being held as an example of good practice in terms of early childhood teacher quality and training A case study in the report headed ‘Lessons from Finland’s preschool’ points out that through systematic development of preschool teaching as a professional career, early childhood educators are “accorded the same respect as other professionals, such as lawyers, with comparable working conditions” (EIU 2012)

Quality is clearly a factor in combating these problems but generally the quality of services is poorer in deprived areas except “The only early education provision that is at least as strong, or even stronger, in deprived areas compared with wealthier areas is nursery schools...these schools are disproportionately located in deprived areas...however these schools form a very small part of the sector.” (Ofsted, 2014,p22). In some areas 3-4 year olds in deprived areas will have access to nursery provision in a local primary school but there is a gap in the proportion of good or outstanding schools in wealthier areas and the most deprived.

Research in the UK (Ofsted 2014) shows that children from low income families make the strongest progress when settings have highly qualified staff, especially trained teachers but there is great variation in the number of early years settings with graduate staff and demand for these places overruns supply. Ofsted points out that responsibility for this lies with LAs who have a statutory responsibility to “improve the well being of children in their area and reduce inequalities between young children in their area.” The redefined core purpose of Children’s Centres also includes responsibility for reducing inequalities. The evidence seems to indicate that to achieve enhanced
Early Years Literature Review

access to qualified staff, the link to schools, especially nursery schools where they exist, within a local system is critical.

Research over the last 8 years has consistently strongly identified strong leadership as a key element of effective early childhood provision (Muijs et al, 2004; Rodd, 2005). Blatchford and Manni claim "there is no doubt that effective leadership and appropriate training for the leadership role is an increasingly important element in providing high quality provision for the early years, especially as we move to larger and sometimes more complex, multi-professional teams of staff across the early years sector” (2006 P 27)

Enhanced Practitioner Skill Base

The evidence indicates that the knowledge and skill base of an early years’ practitioner is central to their effectiveness as an educator. The EPPE study showed that the practitioner’s knowledge of the particular curriculum area that is being addressed is vital and argues that curriculum knowledge is just as important in the early years as it is at any later stage of education. In addition, an effective educator also needs to have knowledge about how young children learn and how this learning occurs and can be supported through improved parenting and a more stimulating home learning environment. This research revealed that knowledge of child development underpins sound practice but it often weak among early years staff, especially those coming from a social care and health background.

Early Years’ Pedagogy

The evidence indicates that certain pedagogical practices are more effective than others in improving attainment for less advantaged children. There has been a long debate about the extent to which preschool education should be formal or informal, often summarised by the extent to which the curriculum is ‘play’ based. The EPPE study concludes that in most effective centres ‘play’ environments were used to provide the basis of instructive learning. However, the most effective pedagogy combines both ‘teaching’ and providing freely chosen yet potentially instructive play activities. Effective pedagogy for young children is less formal than for primary school but its curricular aims can be academic as well as social and emotional (Sylva et al 2004).

Curriculum Coverage

Recent research has indicated that there are some areas of learning and development that are particularly vital to focus on in the foundation years of life. (Pascal and Bertram 2008; Tickell Review, 2011) However, as Heckman (2011) emphasises, any early education programme seeking to reduce social inequalities between children must focus on the crucial role of skill formation, but this requires more than basic intellectual skills. He states that just as important are ‘life skills’ such as conscientiousness, perseverance, motivation, sociability, attention, self regulation and anger management, self esteem, and the ability to defer gratification. He also notes that the critical period for such skills formation is in the pre-school years. Recent research from neuroscience (Diamond, 2010) affirms this approach to the early years curriculum and has identified a range of ‘executive functions’ which are needed for a child to make progress. Three of these core functions appear to be particularly associated with long term attainment and are vital for children to develop if the gap in achievement is to be narrowed:
Early Years Literature Review

1. Cognitive Flexibility i.e. switching perspectives;
2. Inhibitory Control: ability to stay focused despite distraction, have selective focused attention, stay on task;
3. Working Memory: holding information in mind and mentally working with it, making sense of what unfolds over time, relating events, ideas, learning from before to now, reasoning, cause and effect, remembering multiple instructions in sequence and following step by step in correct order.

The evidence indicates that these aspects of development are more important than IQ, entry level reading, or maths (Blair and Razza, 2007; Blair and Diamond 2008). Therefore to support a child to be ‘school ready’ and able to operate as an effective learner, the early years curriculum needs to focus on both cognitive and non-cognitive aspects of early learning and, importantly, give the child a sense of their own capacity to be a successful learner. This approach is supported by Moffit et al (2010 p.2) who state that “even small improvements....shift the entire distribution of outcomes”.

Parenting Programmes

The evidence shows that early education programmes that encouraged high levels of active parent engagement in their children’s learning, (through regular dialogue about children’s learning at home and in the setting), were more successful in closing the attainment gap for socially disadvantaged children. The most effective settings shared child-related information between children and staff, and more particularly, children did better where the centre shared its educational aims with parents. This enabled parents to support children at home with activities or materials that complemented those experiences in the Foundation Stage. EACEA states that “the ‘winning formula’ consists in combining care and education of the young child in a formal setting with support for parents. Research still needs to identify the precise nature and characteristics of the parental support which should be provided in European countries”. (2009 p 142)

4.3 Process factors

Child-Centred Services

The Munro Review (2011) of child protection set out proposals for system reform which, taken together, were intended to create the conditions that enable professionals to make the best judgments about the help to give to children, young people and families. This involved moving from a system that had become over-bureaucratised and focused on compliance to one that values and develops professional expertise and is focused on the safety and welfare of children and young people. It concluded that the forces in the existing system had come together to create a defensive system that put so much emphasis on procedures and recording that insufficient attention was given to developing and supporting the expertise to work effectively with children, young people and families. It concluded that instead of “doing things right” (i.e. following procedures) the system needed to be focused on doing the right thing (i.e. checking whether children and young people are being helped). The report set out the principles of a good child protection system that underpinned the review’s recommendations for reform. Its first statement was that the system should be child-centred: that everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation
Early Years Literature Review

in decisions about them in line with their age and maturity. The UN Convention on the Rights of
Children sets out a legal code of conduct for listening to children and giving them voice and power
within our services. The evidence is clear that best practice in service delivery includes an authentic
commitment to child centres services, with staff who are skilled at listening and responding to
children’s perspectives on their lives and experiences.

The Quality of Interactions

The quality of interactions between adults and children has been shown to be a vital element in the
effectiveness of an early years programme, and responsive, sensitive, nurturing relationships are
more effective in supporting an open attitude, learning and exploration. The EPPE study identified
effective pedagogic interactions and revealed that more ‘sustained shared thinking’ was observed in
settings where children made the most progress. This occurs when two or more individuals work
together in an intellectual way to solve a problem, clarify a concept, evaluate an activity, extend a
narrative etc. Both child and adult must contribute to the thinking and it must develop and extend
the understanding. It was more likely to occur when children were interacting 1:1 with an adult or
with a single peer partner and during focussed group work. In addition to sustained shared thinking,
staff engaged in open-ended questioning in the settings where children made the most progress and
provided formative feedback to children during the activities. Adult ‘modelling’ skills or appropriate
behaviour was often combined with sustained periods of shared thinking: open ended questioning
and modelling were also associated with better cognitive achievement.

Initiation of Activities

The opportunity for children to self manage, to take initiative and self direct their learning has been
shown to be a vital factor in effective early education programmes. In the EPPE study, the balance
between staff or child initiated activities was equal in the most effective settings. Similarly, in
effective settings the extent to which staff members extended child initiated interactions was
important. The study found that almost half the child initiated episodes that contained intellectual
challenge included interventions from a staff member to extend the child’s thinking. Freely chosen
play activities often provided the best opportunities for adults to extend the child’s thinking. It may
be that extending the child initiated play, coupled with the provision of teacher initiated group work,
are the most effective vehicles for learning. Children’s cognitive outcomes appear to be directly
related to the quantity and quality of the teacher/adult planned and initiated focused group work.
(Sylva et al 2004)

Behaviour Expectations and Discipline

Research has shown that the way in which behaviour is managed and discipline expectations are
enforced is key to effective learning support. The most effective settings in the EPPE study adopted
discipline/behaviour policies in which staff supported children in rationalising and talking through
their conflicts. In settings that were less effective in this respect, EPPE showed that there was often
no follow up on children’s misbehaviour and, on many occasions, children were simply distracted or
told to stop what they were doing.

Diversity

The evidence from the EPPE study shows that training and developing provision for diversity and
monitoring provision for diversity leads to better outcomes for less advantaged. Research showed
Early Years Literature Review

that quality practices related to diversity were associated with as many as 5 of the 9 cognitive and behavioural attainment outcomes, more than any other one factor, including literacy. Low attainment is associated with diversity in ethnic background, language, gender, special needs and SES at all levels of education. EPPE found that most early childhood settings provide a relatively low quality learning environment for children in terms of diversity. The quality of diversity was higher in combined centres and nursery schools. Yet, strong patterns of association were found between scores for diversity and children’s attainment in early number and non-verbal reasoning and positively linked to scores on pre-reading. Diversity quality was a very strong predictive factor in terms of children’s cognitive outcomes. It was also associated with social and behavioural outcomes such as independence, cooperation and conformity. The diversity rating included factors such as planning for individual learning needs, gender equity and awareness and race equality within the settings (Sylva et al 2008).
5. How might effectiveness and value for money be measured?

5.1 The measurement challenge

Making the social and financial case for early years services is challenging. Linking specific interventions to specific outcomes – and therefore quantifiable savings or benefits – is very difficult. As Frank Field (2011) wrote in his review, The Foundation Years: Preventing Poor Children Becoming Poor Adults,

*The evidence is not as strong as we would like. The most quantitative data is often based on studies from the United States while a lot of British evidence is based on ‘softer’ indicators such as whether participants have said they found a course useful, rather than changes in behaviour or outcomes.*

A study by Roberts et al (2014) confirmed this and revealed that Children’s Centres currently attempt to overcome these measurement hurdles by demonstrating their success in terms of:

- Outputs, such as the number of families reached and engaged by services
- Case files that track and demonstrate the improvements made by individual families
- ‘Soft outcome’ data, such as whether a parent feels like they and/or their children have benefitted from a service.

This is important information that can help services to show the ‘distance travelled’ by families and the ‘stepping stones’ towards achieving impact. However, inspectors, investors, commissioners and managers, as well as the Government, need to see clear comparable data that demonstrates the ways in which services improve outcomes for young children and their families and reduce inequalities between families in greatest need. Failing to evidence the positive difference early years services make to families’ outcomes will make it difficult for them to improve their offer, and leaves them vulnerable to criticism, cuts and closures. Children’s Centres and other early years services are very popular among practitioners and families but there is a need to demonstrate more than popularity: they need to assess impact. Policy needs to act on evidence that shows that not only are poor outcomes later in life expensive but responding early in life can make a difference. Early years services face particular challenges in measurement, including finding approaches that are both rigorous and practical and in particular finding ways to measure changes in behaviours that take place in homes.

Measuring effectiveness and value for money for early years services currently takes place through the Ofsted Inspection Framework which evaluates progress towards a range of early education and health outcomes, including attainment measured by the summative assessment of pupil performance drawn from the statutory Early Years Foundation Stage (EYFS) Framework. Assessment also rests on the EYFS Profile (revised) at entry to primary school, in which children are assessed against three prime areas and four specific areas. While not all children will have attended similar early years services, these EYFS measures are still used to understand a local area’s effectiveness. This national assessment architecture continues to evolve: currently the Ofsted framework is under review and the Payment by Results trials are ongoing, challenging local authorities across the
Early Years Literature Review

country to identify robust yet practical measures of success. The public health sector is also exploring a new outcomes framework which includes a number of measures about children, including young children. At the same time the landscape of services for very young children and their families is also changing. For example, this includes the recent introduction of 15 hours of free early education for the most disadvantaged two-year-olds from 2014, and a significant increase in the number of health visitors. In addition the government is creating an assessment tool to measure the development of two year olds, as part of the Early Years Foundation Stage.

The literature suggests that evaluating service impact and value should start from the principle that we need to be measuring what is important: not to be guided by what we can measure. A recent review of the evidence on assessing outcomes by Bowers et al (2014) affirms this principle and puts forward an Outcomes Framework for early years services that echoes some of what services already measure. The outcomes are those that the evidence illustrates are the most important for improving children’s lives and futures, and for reducing inequalities in outcomes. Each outcome suggested stems from evidence about what is important and what can be influenced and improved. The review identifies a small number of outcomes that they believe should be measured at an individual and population level. It is suggested by Bowers et al (2014) that these outcomes should build on the child outcome measures which are included in the current Ofsted Inspection Framework for Children’s Centres, the Early Years Foundation Stage (EYFS) Framework, but suggests where there are other outcomes to be developed further, particularly with a greater emphasis onto the role of parenting and parents. In these areas, particularly parenting and the parent context, there are existing approaches drawn primarily from academic research which can be usefully used. These suggestions may form the foundation for the development of outcome measures that are both robust and practical for use.

5.2 Outcome Measures

The evidence reviewed points to three key areas in which outcome measures should be developed and implemented:

1. **Children are developing well: cognitive development, communication and language, social and emotional development and physical health**

Children develop across four interdependent and reinforcing domains: cognition, communication and language, social and emotional development and physical attributes. All of these are important and mutually reinforcing. Cognitive skills such as memory, reasoning, problem-solving and thinking shape later-life outcomes. Paying attention is strongly associated with later-life outcomes, including employment. While many frameworks suggest communication and language are a subset of cognitive development, the evidence suggests that progression in each area is so important that we choose to treat each independently. Strong communication and language skills in the early years are linked with success in education throughout life. Cooperation, sociability, openness and self-regulation all help children flourish. Mental wellbeing in early years protects against poor mental health in later life. At the earliest stages, low birth weight relates to adverse outcomes in later life. The relationship between physical health and development and outcomes persists. They both link strongly to engagement in education later in life. Cognition, communication and language, social and emotional skills and physical attributes are covered comprehensively by existing national
Early Years Literature Review

frameworks. Three (communication and language, social and emotional skills and physical health) directly mirror the revised EYFS Prime Areas, while cognition is recognised throughout the Specific Areas of the EYFS.

2. Parenting: the interaction between parent and child
Parenting is a dynamic, evolving relationship, informed by the parent and the child. Emerging evidence suggests that some children may require more attention and more active parenting than others. Children’s behaviours and mothers’ resilience both shape the nature of parenting. The reciprocal nature means that patterns are reinforced, whether they are positive or detrimental to a child’s development. In addition to ensuring their children are safe and healthy, there are two critical roles for parents:

- Being responsive and attentive: Attachment is crucial and comes through attention and interaction. This ranges from body language through to setting boundaries that keep children safe while allowing them to explore their world.
- Providing a nurturing and active learning environment: A rich and responsive language environment, a range of toys and books and in particular talking to and reading to children, are fundamental.

All the statutory frameworks refer to parenting, and there are some existing measures. For example, the Ofsted Inspection Framework for Children’s Centres looks at: “the extent to which all children and parents, including those from target groups, enjoy and achieve educationally and in their personal and social development”. Yet further detail is often absent. Finding individual measures that balance rigour with simplicity is challenging.

3. Parent’s lives: those elements of parent’s lives which exert powerful influence over parenting
Parenting is influenced by parents’ own childhoods and their current lives, including their own mental wellbeing, their income, and their networks of support. Existing measurement processes, including the current Ofsted Inspection Framework for Children’s Centres, EYFS Framework and the Healthy Child Programme, recognise the importance of services in supporting parents to thrive in their wider environment. Employment and the skills needed to secure work are regularly included in these regimes as measures. There is also a renewed focus on securing parental wellbeing. Parents’ mental wellbeing – particularly mothers’ – is critical. Mental wellbeing has both direct and indirect impacts on a child: directly through the impact on parenting itself and indirectly through the mother’s capacity to withstand stressors that can affect home and community environments.

The Institute of Health Equity (Bowers et al 2014, Roberts et al, 2014) have developed an outcomes framework with 21 indicators which flows from the priority areas set out above and provides a useful starting point in the consideration of what policy makers might use to measure effectiveness and value for money in its early years services. The Outcomes Framework attempts to balance what the evidence says makes a difference with what is practical; it makes allowances for where evidence may be weaker but is still strongly suggestive of what is important; it builds on what parents and practitioners say, and it aligns where possible to the existing frameworks.
Early Years Literature Review

Proposed outcomes measure

Focus 1: Children are developing well

Cognitive development
1. All children are developing age-appropriate skills in drawing and copying
2. Children increase the level to which they pay attention during activities and to the people around them

Communication and language development
3. Children are developing age-appropriate comprehension of spoken and written language
4. Children are building age-appropriate use of spoken and written language

Social and emotional development
5. Children are engaging in age-appropriate play
6. Children have age-appropriate self-management and self control

Physical development
7. Reduction in the numbers of children born with low birthweight
8. Reduction in the number of children with high or low Body Mass Index

Focus 2: Parenting development

Creating safe and healthy environment
9. Reduction in the numbers of mothers who smoke during pregnancy
10. Increase in the number of mothers who breastfeed

Promoting an active learning environment
11. Increased number and frequency of parents regularly talking to their child using a wide range of words and sentence structures
12. More parents are reading to their child every day

Positive parenting
13. More parents are regularly engaging positively with their children
14. More parents are actively listening to their children
15. More parents are setting and reinforcing boundaries

Focus 3: Parent context

Good mental wellbeing
16. More parents are experiencing lower levels of stress in their home and their lives
17. Increase in the number of parents with good mental wellbeing
18. More parents have greater levels of support from friends and/or family
Early Years Literature Review

Knowledge and skills

19. More parents are improving their basic skills, particularly literacy and numeracy
20. More parents are increasing their knowledge and application of good parenting
21. Parents are accessing good work or developing the skills needed for employment, particularly parents those furthest away from the labour market

This framework provides a starting point and the next steps are to look in depth about how easy this will be for early years services to follow and measure. The next stage of work will be to set out how to achieve this, working closely with children’s centres and other services and linking in with the existing measurement regimes that exist, wherever possible.

5.3 Benchmarking

The DfE (2014) has very recently developed and published a useful Early Years Benchmarking tool which might be used in evaluating the effectiveness and value for money within and between local authority areas. The tool contains information on the datasets used in the benchmarking and any calculations done by the Department to develop the instrument. It is divided into sections as follows:

- Funding
- Quality
- Take up of funded early education
- Staff Qualifications
- Child Development (EYFS Profile results)
- Contextual data

For each of the spreadsheets, users are able to compare authorities across the Children's Services Statistical Neighbours or with up to ten other authorities. This tool might form a useful part of early years service assessment strategy.
Early Years Literature Review

6. How might early years services and programmes better adopt these successful strategies? Recommendations for action and further innovation

“We seem to know as much in principle about how parental involvement and its impact on pupil achievement as Newton knew about the physics of motion in the seventeenth century. What we seem to lack is the ‘engineering science’ that helps us to put our knowledge into practice. By 1650 Newton knew in theory how to put a missile on the moon. It took more than 300 years to learn how to do this in practice. The scientists who did this used Newton’s physics with modern engineering knowledge. We must not wait three hundred years to promote stellar advances in pupil’s achievement. We need urgently to learn how to apply the knowledge we already have in the field.”

(Desforges and Abouchaar, 2003, cited in Field 2011)

This quote aptly captures the challenges in ensuring the growing evidence base we have about the early causes of educational under-achievement and how an integrated mix of early years services might be used more effectively to counter social-economic disadvantage. The last ten years have seen the creation of a significant international and national knowledge base about the factors that are associated with early disadvantage and poor health and how early years programmes might work more effectively, both systemically and structurally, to promote better quality early development and learning processes to close gaps in achievement and health outcomes, especially for the socially disadvantaged. According to EACEA,

“low intensive, low dose, late starting, mono-systemic approaches are less effective overall. A didactic or academic approach in a negative socio-emotional climate may do more harm than good. Early starting, intensive, multi-systemic approaches that include centre-based education and the involvement of trained professionals as a core activity are superior, with impressive long term results and very favourable cost benefit ratios. It is now clear that investing in accessible, high quality, early starting and intensive care and education provisions for young children is socially and economically very profitable.” (2009, p38)

The problem is that many targeted early years programmes still do not meet the criteria of quality and efficiency and many programmes are often temporary projects and vulnerable to economic trends. They can also reinforce social and ethnic segregation in the system which transfers to primary schools where we see a concentration of children with disadvantages in particular schools. The evidence is that mixed income populations are more effective (Schechter & Bye, 2007). As Ancheta (2012) succinctly explains

“The policy challenge is to rebuild the current systems so that they meet the crucial design features, that provide high early quality education and care for all children, that are integrated, attractive and affordable to all families regardless of social class or minority status, yet that are sensitive to differing educational needs, working in a child and family centred way and able to compensate for early educational disadvantages”.

The recent OfSTED (2014) annual report shines a light on the evidence base which might support the further development of the early years sector and raise the profile of the important work done by
Early Years Literature Review

practitioners in the early years. Ofsted’s 2013 report had emphasised the importance of early years for breaking cycles of disadvantage. Also, it powerfully demonstrated the importance of parenting – parenting style, parental involvement in education and quality of HLE are major factors explaining the difference between children from low income backgrounds and their wealthiest peers. The report argued that not enough is being done to support and encourage parents, and particularly those who need the most help, to secure for their children the benefit that the best early education and care can offer.

The current report more strongly makes the case to break down the barriers between schools that teach the youngest children and early years provision outside schools. It also argues that the best early years providers whoever they are, focus on helping children to learn. It provides evidence to show that the most successful Children’s Centres work to engage parents who don’t know how to support their children’s learning (teach) and give them the tools to be teachers too. It states that Children’s Centres can play a fundamental role in tackling disadvantage but acknowledges that realising this ambition will require greater clarity for this rapidly changing sector. It also argues that the contribution that schools and health colleagues can make, and the similarities between what schools do and what other early years providers do, should be clearer and better understood.

We have set out below three areas of early years policy and practice which the evidence shows would benefit from further development, listing fruitful actions in each area.

5.1 System Developments

- Continued and increasing investment in early childhood programmes, particularly those aiming to enhance parenting and healthy living skills and provide children with early access to high quality early education;

- More cohesion between the range of different early years services that children experience as they move from birth through infancy, to preschool and into schooling through the development of a common value base, vision, set of working principles and shared outcome measures which all providers and practitioners adhere to;

- Early education and care programmes working in closer alliance and partnership with wider early intervention programmes, especially those concerned with supporting parenting skills and maternal and child health enhancement;

- Greater and earlier engagement of health professionals and systems within the early years service delivery, to ensure information sharing and enhanced early intervention;

- More engagement and clearer articulation of the key role of health visitors and the potential of the Health Visitor Implementation Programme within the development of universal and targeted support services for vulnerable young children and families;
Early Years Literature Review

- The further development of locality systems which integrate all early years service providers systemically to ensure effective local coordination of multi-professional and multi-agency services to children and families;

- The development of LA supported but system led improvement strategy, building on a network or alliance of high performing early years settings, particularly outstanding Nursery Schools, and offering them capacity to extend their practice across the local authority to upskill the workforce and improve quality across all settings;

- Greater emphasis and involvement of the responsibility of the school sector in the delivery of early years services, and in particular, a clear strategic and operational linkage between nursery and primary schools and Children’s Centres;

- The development of ‘enhanced service’ primary schools, which work closely with Children’s Centres and other early years services on a locality basis to ensure continuity of support for the less advantaged;

- Maintenance of policies beyond the short term to track impact and insist on rigorous evaluation of outcomes;

- Rigorous implementation and monitoring of the new statutory framework for early years providers, including greater accountability and support to improve performance.

- The development and implementation of a system wide, and carefully focused, framework of agreed early years outcomes for children and families, which provides cohesion and focus for the delivery of all early years services and an agreed strategy for measuring performance against these outcomes;

- Tighter specifications and greater support around the nature of high quality early years provision and how to improve poorly performing settings;

- Exploration of strategies to attract, recruit and positively reward high calibre, well qualified professionals to work in disadvantaged communities;

- Improvement of training for the early years workforce, including up-skilling current employees, and supporting and deploying those with graduate qualifications, and especially qualified teachers, to operate effectively as leaders within the local system. In addition, the development and delivery of advanced training for local system leaders.

5.2 Structural Developments

- Investment in early years leadership at all levels, and across early education, social care and health services to champion and promote the importance of early years services and ensure the development and delivery of an integrated high quality system;
Early Years Literature Review

- Favourable staff: child ratios should be encouraged, especially in health and education programmes which work with disadvantaged children;

- Reductions in group/case load size should be encouraged, especially in programmes that work with disadvantaged children;

- Development of well trained and qualified staff teams, including trained teachers, to work in integrated early years programmes, offering them access to ongoing staff development opportunities;

- Development of early learning (cognitive and executive functioning development) knowledge amongst all staff who work with young children and families, as well as knowledge and understanding of child development and an improvement of the child development content of both initial and continuing professional development for all early years practitioners;

- An active, play based pedagogic approach with young children in early education and care programmes which encompasses a blend of formal and informal teaching and learning experiences should be encouraged;

- A focus in the early years curriculum on both cognitive and non-cognitive aspects of early learning and, importantly, give the child a sense of their own capacity to be a successful learner with the prioritisation and measurement of executive functioning (PSED) and language development in early years provision;

- A stronger emphasis in all health, social care and education programmes to encourage parents to support and engage more actively in their children’s learning.

5.3 Process Developments

- Adoption of more sensitive, responsive and nurturing staff: child relationships;

- Adoption of family focused relationships, with key workers that have consistency and deep knowledge of a family over time;

- Clarity about children’s right to be heard in all early years programme development and implementation, and the development of staff skills to listen more effectively to children’s voices at all times;

- Encouragement of ‘sustained shared thinking’ with the children which encourages dialogue, negotiation of meanings and co-construction of understandings;

- Work towards a more equal balance of child and adult initiated actions and encourage the development of self management, self regulation and critical thinking in children’s activities;
Early Years Literature Review

- Development of better training on diversity in all early childhood settings and for all early years staff;

- Encouragement of behaviour policies in which staff in health, social care and early education support children’s behaviour management through reasoning and talk.
7. What aspects of early years require more supporting evidence?

Research in early childhood has developed significantly over the last 10 years, with some major, longitudinal evaluations of young children’s progress through the Foundation Years revealing the impact of differential experiences on learning and development outcomes. This research is also being fed by a rapid development in practitioner research, the documentation of practice and the evidencing of outcomes within the early years sector. Knowledge creation and knowledge transfer in the early years is gaining maturity but still has some way to go.

Research into features of effective early years programmes has identified two key characteristics:

- Systemic and structural characteristics eg staff education, staff: child ratios;
- Process characteristics eg nature of care giver interaction, warmth, responsiveness, programme coverage and delivery.

Progress is evident but there are key aspects of early years policy and practice which need more detailed evidence which draws on qualitative as well as experimental and quasi experimental approaches. Areas which require further evidence are especially needed in the process areas of programme delivery and the following issues need to be explored:

- How to improve access for less advantaged to health, social care and early education and care services
- How the home environment shapes and influences early development and learning and what we can learn from higher achieving but disadvantaged children, especially boys;
- How staff: child ratios, staff qualifications and outcomes for children are linked in all services;
- How different staff qualifications and training opportunities impact on quality of service delivery;
- How robust outcomes data at a system level can be captured earlier;
- How leadership works across a locality delivery reach and across services;
- How early intervention partnerships operate;

There is also a need to provide and utilise:

- Evaluations which show which early years programmes are more effective than others and what factors are critical in effective programmes (would need alternative research approaches to Randomised Control Trials (RCTs) which are expensive and difficult to do for many very worthwhile programmes, including observational studies);
- Cost benefit analysis of various initiatives.
Early Years Literature Review

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Early Years Literature Review


Early Years Literature Review


Early Years Literature Review


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Early Years Literature Review


### Appendix 1 – Allen Report (Appendix D)

<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
<th>Age of children involved</th>
<th>Measured examples of impact, outcomes and cost-effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Family Partnership (NFP) / Family Nurse Partnership</td>
<td>Intensive home visiting programme administered by health professionals. It is delivered to first-time mothers.</td>
<td>0–2 years</td>
<td>NFP has consistently delivered positive economic returns over 30 years of rigorous research. Benefit-to-cost ratios of studies examined fall in the range of around 3:1 to 5:1. Some example impacts from the US evaluation include:</td>
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<td><strong>Age 2</strong> — nurse-visited children seen in emergency departments: 32% less often than the control group;</td>
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<td><strong>Age 4</strong> — this effect on emergency treatment endured (on average 1 visit per child to emergency room vs. 1.5 for the control group);</td>
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<td><strong>Age 15</strong> — greater effects on reports of child abuse than at age 4 (0.29 verified reports vs. 0.34 for the control group);</td>
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<td></td>
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<td>— fewer subsequent pregnancies (1.5 vs. 2.2 for the control group);</td>
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<td>— fewer months on welfare (average of 60 months per child vs. 90 months for the control group);</td>
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<td>— fewer arrests (average of 0.16 per child vs. 0.9 for the control group).</td>
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</thead>
<tbody>
<tr>
<td>Triple P</td>
<td>Multi-tiered parenting programme with universal and highly targeted elements.</td>
<td>0–16 years</td>
<td>One of two parenting interventions identified by the National Institute for Health and Clinical Excellence (NICE) as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £250,000 in extreme ones, suggest that even a low success rate would constitute good value for money. Measured outcomes from Triple P include:</td>
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<td>— significantly lower levels of conduct problems; and</td>
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<td></td>
<td>— noted clinical changes in behaviour (32% vs. 12% of children with problems).</td>
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<tr>
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</thead>
<tbody>
<tr>
<td>Incredible Years</td>
<td>Parenting programme for those with children at risk of conduct disorder.</td>
<td>0–12 years</td>
<td>One of two parenting interventions identified by NICE as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money. Evaluation outcomes include:</td>
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<td>— significantly reduced antisocial and hyperactive behaviour in children;</td>
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<td>— reduction in parenting stress and improvement in parenting competence; and</td>
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<td>— positive effects on child behaviour and parenting.</td>
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<tbody>
<tr>
<td>Parent-child</td>
<td>A parent-child interaction therapy designed to improving the quality of the parent-child relationship and change interaction patterns.</td>
<td>2–7 years</td>
<td>A review of parent-child interaction therapy found it to have a benefit-to-cost ratio of around 3.5:1. Improvements noted include:</td>
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<tr>
<td>interaction therapy</td>
<td></td>
<td></td>
<td>— improved child behaviour;</td>
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<td></td>
<td></td>
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<td>— reduced parental stress; and</td>
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<td></td>
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<td>— reduced abuse and neglect.</td>
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### Early Years Literature Review

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</table>
| Success for All                        | A range of programmes in the UK which foster school readiness and early literacy and numeracy development. | 3–11 years               | An economic evaluation found Success for All cost the same to deliver as the control group through reduced need for remedial schooling. For low-achieving students Success for All was found to be notably cheaper – $9,600 less per student – than the standard educational approach. Some example impacts include:  
- better attainment;  
- fewer special education placements; and  
- less frequent grade reiterations. |
| Multi-dimensional treatment foster care (MDTFC) | A fostering programme in which families are recruited, trained and closely supervised to provide adolescents with treatment and intensive supervision at home, in school, and in the community. | 3–16 years               | A US economic appraisal of MDTFC found a benefit-to-cost ratio of around 1:1. The potential savings from rolling out eight adolescent units of MDTFC for five years have been estimated at £213,300,000 after seven years, provided assumptions on take-up and other factors are met. The latest annual report on MDTFC in England found statistically significant differences for:  
- offending  
- self-harm  
- sexual behaviour problems  
- absconding  
- fire setting. |
| Promoting Alternative Thinking Strategies (PATHS) | A primary school curriculum designed to develop self-control, self-esteem, emotional awareness and interpersonal problem-solving skills. | 4–6 years                | PATHS is a relatively low-cost programme, estimated in the US at $1.5–4.6. Evaluations of PATHS have found positive impacts in terms of:  
- reducing sadness and depression  
- lower peer aggression and disruptive behaviour; and  
- improved classroom atmosphere. |
<table>
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<tbody>
<tr>
<td>Reading Recovery</td>
<td>A school-based, short-term intervention designed for children who are the lowest literacy achievers after their first year of school</td>
<td>5–6 years</td>
<td>The benefit-to-cost ratio of delivering Reading Recovery, as part of the Every Child a Reader campaign, has been estimated in the range of around 15:1 to 17:1 over the period 2006–39. This estimate is based on a range of outcomes, including special educational needs provision, crime and health costs.</td>
</tr>
<tr>
<td>Life Skills Training (LST)</td>
<td>A school-based intervention aimed at developing social skills in order to prevent alcohol and substance misuse, behavioural problems and risky sexual behaviour.</td>
<td>9–15 years</td>
<td>A US economic appraisal of LST estimated the benefit-to-cost ratio at 25:1. A review of alcohol interventions by NICE noted the impact of LST on long-term drinking behaviour. Noted outcomes include reductions in the use of tobacco, drugs and alcohol.</td>
</tr>
<tr>
<td>Functional Family Therapy (FFT)</td>
<td>A structured family-based intervention that works to enhance protective factors and reduce risk factors in the family. It is aimed at young people displaying antisocial behaviour and/or offending.</td>
<td>10–17 years</td>
<td>FFT has been estimated to have a benefit-to-cost ratio of around 7:5:1 to 12:1. Clinical trials have demonstrated impacts in terms of: treating adolescents with conduct disorder; oppositional defiant disorder or disruptive behaviour disorder; treating adolescents with alcohol and other drug misuse disorders, and who are displiant and/or violent; reducing crime and reducing likelihood of entry into the care system.</td>
</tr>
<tr>
<td>Multisystemic therapy (MST)</td>
<td>A youth intervention that focuses on improving the family's capacity to overcome the known causes of delinquency.</td>
<td>12–17 years</td>
<td>The benefit-to-cost ratio of MST has been estimated at around 3.5:1. Noted outcomes from evaluations include: reductions of 25–70% in long-term rates of re-arrest; reductions of 47–64% in out-of-home placements; improvements in family functioning; and decreased mental health problems for serious juvenile offenders.</td>
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Early Years Literature Review