UCL Institute of Health Equity
Reducing Health Inequities Through Action
on the Social Determinants of Health

An Equal Start

Improving Outcomes in Children's Centres

An Evidence Review

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Forward

In 2010, when we published *Fair Society, Healthy Lives*, we identified the importance of giving every child the best start in life. What was evident then was that inequalities in outcomes in the early years were highly predictive of inequalities in health and other outcomes in later years. I am deeply concerned that only 59 per cent of children reach a good level of development at age five and that this is partly related to family socioeconomic status. We should and can do more to improve outcomes for children. We advocated for action to reduce inequalities in physical and emotional health, cognitive, linguistic and social skills. We also called for high quality maternity services, parenting programmes, childcare and early-years education to meet the need across the social gradient. Since then government has placed greater emphasis on the early years; and the need to focus on this area was further highlighted by Frank Field and Graham Allen in two major independent reviews for government.

Encouragingly, I now find myself surrounded with activity trying to make this happen. This is a great opportunity to ensure that we get it right.

It is into this context that we were asked, by 4Children, to develop an outcomes framework for Children's Centres to help inform their activities and priorities. This would enable Children's Centres to prioritise those outcomes that would matter most to later life outcomes, and would enable them to judge whether or not they were making a difference. Our proposed priority outcomes are based on the best available evidence, and we were assisted by a steering group of highly skilled academics, government representatives, practitioners and commissioners.

The outcomes are described in the executive summary and the main report. They fall into three categories: outcomes targeted at improving children's abilities, outcomes based on parenting, and outcomes based on improving the lives of parents. We are encouraged by the work of government in this area, specifically on identifying the most important outcomes for children through the focus on school readiness at age five, and for acknowledging the importance of parenting. We identify the most important of these outcomes and link, where relevant, to existing frameworks. We add more detail on those aspects of parenting that have been shown to be particularly effective, and place importance on the parenting context, for instance housing quality, levels of debt, and physical and emotional health.

Our focus here, therefore, is not just on determinants of health, but on the determinants of a wider range of later life outcomes. In *Fair Society, Healthy Lives* we argued that focusing only on obesity and smoking, for example, could not reduce the gradient in health: rather, we needed to focus on the causes of the causes (the circumstances in which people are born, grow, live, work and age – the Social Determinants of Health). We do need to reduce obesity and smoking, but we also need to look at income levels and stress. Similarly, here we argue that we need to improve children's attention and skills, but we also need to

increase positive engagement with children, and to look at promoting the conditions that best support parents to be good parents. Juggling two jobs, while living in an overcrowded house, will limit the time and space available for good parenting. Insufficient income or poor quality work will increase parental stress and limit parents' capacity to be positive parents with high levels of attachment to their children. I am aware that the new approach by government reflects a belief that it is not who parents are that matters, but what they do. This is true, but what is also important is that parents' lives impact on what they do. Supporting parents to have good mental wellbeing, improved skills and knowledge, and financial security are important to ensuring that they do not have levels of stress that interfere with good parenting. Children's Centres can only support some of this, for instance through facilitating access to advice, support services and skills training.

It is clear from our work that focusing just on a small group of children who are most at risk, for instance children from 'troubled families', will miss many children with problems. More children have good development in the richest, highest social groups, while each step down the social scale is associated with more children not reaching their full potential.

Children's Centres can be at the heart of local area activity working to improve outcomes for young people. Our work in this area will continue, with added focus on the measurement of these outcomes.

Professor Sir Michael Marmot

Director of the UCL Institute of Health Equity

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We are grateful for the insight, challenge and expertise of our Advisory Group:
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Executive Summary

This work identifies the most important outcomes Children's Centres should be striving for in order to give all children positive early-years experiences. We draw together the best academic evidence, the views of practitioners and parents, and the work that government continues to take forward around the early years. We recognise the value of many of the existing national and local frameworks. Our project adds to the debate by drawing those together and emphasises the need to focus on supporting good parenting and the environment in which parents live and work.

The early years

What happens in pregnancy and the early years of a child's life has a profound impact on the rest of his or her life. Experiences in the early years influence children as they grow, through primary school, secondary school and into adulthood. For example, one study suggests that children born with very low birth weight are less likely to enter post-secondary education than their peers (30 per cent versus 53 per cent) (Hack *et al* 2002). More children are born with low birth weight in poorer communities than in those that are wealthier. Feinstein (2003) explored the success of children from the 1970 British Cohort Study on a development index derived from tests that children in this cohort underwent. His research found that 26 per cent of children in the lowest quartile at 42 months went on to gain no or 'miscellaneous' qualifications by 26 years old while the comparative figure for children in the highest quartile was 7 per cent. Only 17 per cent of lowest quartile children achieved A level or above compared to 53 per cent of highest quartile children.

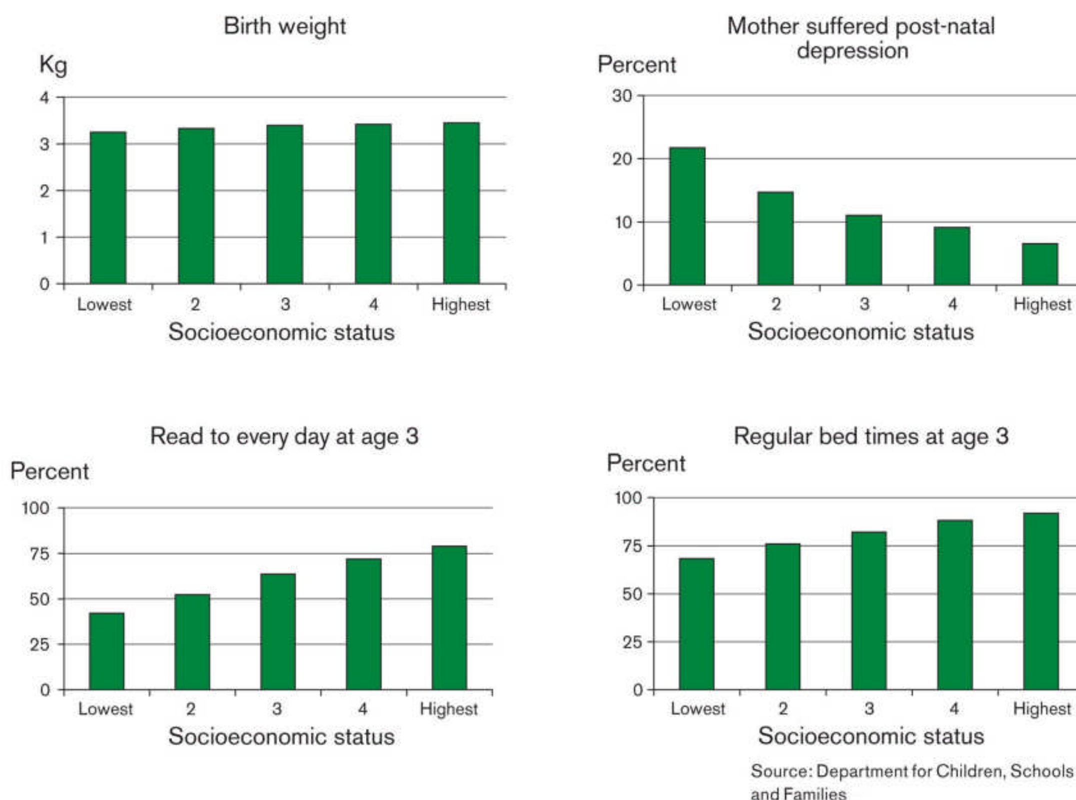
Parenting is critical to children's experience of early years and their life chances. The biggest influence on children's outcomes is from primary care-givers; most often these are mothers, frequently they are fathers, and sometimes others such as guardians, siblings or extended family members. Throughout this report we use the word 'parent' to recognise all primary care-givers.

The early years are not only critical for life chances: inequalities at this age perpetuate throughout life. Improving experiences in the early years is central to reducing inequalities in childhood and later life. Children from the lowest income households have an average percentile score on school readiness that is more than 30 points below their peers in the first quartile, and their vocabulary at age three is more than 20 points below their peers.

The link between inequalities of experiences in early years and inequalities in later-life outcomes is well established. So persistent is this inequity across the generations that our earlier work, *Fair Societies, Healthy Lives,* the review of health inequalities led by Professor Sir Michael Marmot, made improving experiences in the early years its priority objective for reducing health and other inequalities.

As we showed then, inequalities are not concentrated at the bottom of the socioeconomic spectrum in a specific group of poor or problematic families. Children's outcomes improve progressively the further up the socioeconomic spectrum, and worsen progressively the further down. There are inequalities in outcomes between the top socioeconomic status and everyone else, and the gap between those groups is growing relatively wider and more entrenched.

Outcomes by socioeconomic quintile as discussed in *Fair Society, Healthy Lives*



Source: Marmot M (2010) Fair Society, Healthy Lives, *quoting evidence from the Department for Children Schools and Families*

Policies that are universal and proportionate to increasing need are critical to reducing these inequalities.

The ambition to reduce inequalities and improve outcomes for all children is a central feature of Children's Centres, a universal service that tailors its responses to all families with children from pregnancy through to starting school, rather than just to those deemed most at risk. And Children's Centres can – and do – have an impact.

When Sure Start was first introduced, it had ambitions to sever the link between childhood disadvantage and poverty in later life. Twelve years on, Children's Centres still inspire that level of ambition among many.

Our work

The document *Core Purpose of Children's Centres,* co-produced in 2012 by the Department for Education, local authorities and early years professionals, articulated a vision for Children's Centres. They would: "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."

This built on years of attention and investigation from government into the factors that drive outcomes for children, and how to redress the inequalities that exist. Reports such as Professor

Cathy Nutbrown's *Foundations for Quality,* Professor Eileen Munro's *Better Frontline Services to Protect Children*, Dame Clare Tickell's *The Early Years: Foundations for life, health and learning,* Frank Field's *The Foundation Years: Preventing Poor Children Becoming Poor Adults,* and Graham Allen's *Early Intervention: Next Steps* all contribute to how we support families most effectively in the earliest years.

Questions remain over how best to achieve the Core Purpose. Practitioners and policy colleagues often seek to distil the most important aspects of children's early years into a manageable set of priorities. Choosing the right priorities becomes even more important in times of declining resources both in and around early years services for families.

We asked:

> *Where should Children's Centres focus their efforts to improve the early years for children, and in particular reduce inequalities in health and other outcomes?*
>
> *What are the essential outcomes that need to – and can – be improved?*

The identification of *essential* outcomes sits at the heart of our work. We provide policy colleagues, strategic leaders and Children's Centre managers with areas for focus and associated 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 are outcomes that the evidence suggests Centres can influence.

We describe the evidence and prioritise the following three areas. Once children are safe and their basic health needs are met, Children's Centres should focus on:

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 Centres 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. Children's Centres 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. Children's Centres can support parents to improve a number of these even if not all are within their remit.

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 Children's Centres already prioritise parenting, the measures of success now need to do the same, placing parenting and parenting circumstances on equal footing with influencing children directly.

Developing the evidence base

The areas chosen for focus stem from the research and have been rigorously debated by experts. The evidence we have assessed and on which our priority areas are based includes:

Evidence review

We have considered the existing evidence about why the early years are so important, the links between early-years experiences and outcomes and inequalities throughout life. We have explored evidence about ingredients of successful interventions and services and how Children's Centres can make a difference to parenting and to the family's context through services to children.

Field visits

We discussed this research with parents and professionals in local contexts, on visits to Warwick, Birmingham, Knowsley, Tower Hamlets and Gateshead. During these visits we gathered qualitative evidence about what parents and professionals think is important and how they assess impact, change and improved outcomes for children.

Advisory group

Our advisory group of practitioners, academics and policy officials has challenged our work, giving their expert input and advice throughout.

Together, these four inputs have shaped a detailed analysis of *why* the early years are so important, *what* impacts on these outcomes and on persistent inequality, and *how* Children's Centres can respond.

Outcomes

Against each of the areas of focus we suggest a small number of outcomes that should be measured at an individual and population level.

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. In *An equal start: the evidence base* we point to measures of these outcomes included in the current Ofsted Inspection Framework for Children's Centres, Early Years Foundation Stage (EYFS) Framework, and Healthy Child Programme, and to where there are outcomes to be developed further.

In some areas, particularly parenting and the parent context, we point to existing approaches drawn primarily from academic research. These may form the foundation for future development of measures that are both robust and practical.

Summary of the evidence

An equal start: the evidence base describes and assesses existing documents and measures. It details

the research and evidence behind the recommended areas for focus and priority outcomes proposed here.

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. This persists through life-long learning, leading to higher levels of qualifications, higher wages and better health, among other desirable outcomes. Poor communication and ineffective acquisition of early language are associated with behavioural problems, in turn linked to worse outcomes, including worse health, throughout life. Children with particularly poor communication skills often struggle to develop friendships, even from the youngest ages.

Cooperation, sociability, openness and self-regulation all help children flourish. Social adjustment is associated with improved employment, higher wages and reduced likelihood of criminal behaviour. 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 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. We welcome the introduction of a review of these Prime Areas at two years of age.

Our work builds on these and adds greater emphasis onto the role of parenting and parents. We reiterate that these areas are critical from birth – and in many cases prenatally. Parents need to know how they can support development throughout their child's life.

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. This happens for a range of reasons, some of which can be prevented and others Children's Centres are not able to change.

Of course, parents and children all have different temperaments – and parents in particular possess different levels of resilience. Families' living circumstances, such as their housing, income, community environment and many other social and economic factors, influence and affect parenting.

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.

Parents from anywhere on the socioeconomic spectrum may need support. However, the distribution of poor outcomes remains stubbornly unequal. Many outcomes such as academic achievement, behaviour and employment outcomes are worse further down the socioeconomic gradient. These disparities are often sustained through the generations.

The Core Purpose of Children's Centres recognises the persistent and complex relationships between family status and outcomes. The core purpose of Sure Start Children's Centres is to improve outcomes for young children and their families, with a particular focus on the most disadvantaged, so children are equipped for life and ready for school, no matter what their background or family circumstances. We emphasise that attention is needed across the social gradient, not simply for the most disadvantaged, although this is where most intensive support may be required. 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 still proves elusive.

We identify where further investment should be focused to fill the measurement gaps around the most important aspects of parenting. When taken together, the specific measures we propose give a robust analysis of parenting quality and children's development.

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.

There are, of course, aspects of family life that Children's Centres are limited in shaping, for example the quality of housing. Children's Centres should focus on supporting families within these environments while advocating for improvements in them across the social spectrum. Children's Centres can support parents in contacting services, and getting the best advice and support – for instance by facilitating access to housing services.

Existing measurement processes, including the current Ofsted Inspection Framework for Children's Centres, EYFS Framework and the Healthy Child Programme, recognise the importance of Children's Centres 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. We add 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. Identifying and responding to post-natal depression is key, and the prevalence of that condition is again disproportionately spread across the social gradient, with a greater concentration among more disadvantaged mothers.

An Outcomes Framework focused on what matters most

We start from the principle that we need to be measuring what is important: not to be guided by what we can measure.

Our Outcomes Framework echoes some of what Children's Centres already measure through the Ofsted Inspection Framework for Children's Centres (current and forthcoming), the EYFS profile and locally defined measurement regimes. We reframe and suggest additional outcomes, based on our recent review of the evidence. Each outcome stems from evidence about what is important and what can be influenced and improved. Where possible we align what is most important with what is most practical for Children's Centres. Where measures do not currently exist, in the main document we recommend actions to develop these.

All of these outcomes are important to achieve throughout children's early years. For example, talking to a child is not just something that happens when the child can talk back. Talking to a pre-verbal child is critical for his or her development. We highlight in the main report where evidence points to age-related impact.

Characteristics of Children's Centres: the features that best enable positive contributions to outcomes

Children's Centres play a fundamental role in protecting and safeguarding the children in their community. Beyond this it is appropriate that Children's Centres vary in their delivery. Some make use of formal programmes in their work while others bring together ingredients for success into less rigorously reviewed approaches. All provide interventions not codified in specific programmes through outreach, group work and individual interactions.

Children's Centres provide a universal service that helps those who are most at risk. Local-level conversations, including detailed discussions with commissioners, translate this into reality. We reinforce the focus on services that are proportionate to need across the socioeconomic spectrum, providing universal access coupled with targeted support.

The evidence suggests that there are key features of Centres themselves that enable success, particularly with some family groups. The Core Purpose of Children's Centres sets out many of these, reflecting the statutory duties of Centres.

The Ofsted Inspection Framework for Children's Centres assesses many of these areas, and *Development Matters* provides guidance to Children's Centres on how to translate the EYFS into practice. Our review of the evidence suggests that the following two areas are particularly important:

Well-trained, highly qualified staff

Professionals with a good grasp of early-years pedagogy supported by knowledgeable and stable leaders are critical. Research into play suggests staff should possess the following essential, specific attributes: they need to provide clarity of what is expected, positively encourage children to cooperate and engage, and to consistently model good behaviour (although perfection is not needed). There is evidence that collaboration between staff is powerful: workers with a wide range of skills and professional backgrounds can work together to deliver a high-quality family support service. This evidence is backed up by views from parents who consistently cite the staff – and often individual staff members – as *the* reason that their parenting skills and confidence have improved. We welcome the tenor of Professor Nutbrown's review into early education and childcare and in particular the call to ensure that professionals have the skills and understanding needed to give babies and young children the best start in life.

Outreach and engagement

Evidence shows that engaging with families is critical: many families would not naturally consider entering a Centre and while Children's Centres provide outreach services in the community, a significant proportion of their offer remains within the Centre building itself. Evidence and practice suggest a number of features for successful engagement, including peer support and peer referral.

Successful approaches to increasing engagement have included the development of trusting personal relationships between providers and service users; resolving practical issues (such as whether the parent had previous experience of being turned down when asking for help, opening times, availability of childcare and cost of services); providing a 'service culture'; and being responsive to the expressed wishes of parents.

Characteristics of interventions

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).

An equal start: the evidence base provides further detail on interventions that support particular groups of parents, and what the evidence suggests does not work as well.

What next?

The proposed framework is practical and aligned sufficiently with the required measurement regimes to give Children's Centres a simple approach to identifying what their focus should be, and if

their services are making a meaningful difference to children's lives.

The framework will support policy colleagues in early years, health, housing and employment to think about the network of services and social context that supports families and children in the first few years of life. We welcome the opportunity to work with colleagues at a national level to inform work underway to revise the current Ofsted Inspection Framework for Children's Centres and enduring activities to reduce inequalities for children as early as possible.

Ensuring every child has the best start in life is a priority for the Institute of Health Equity and we will continue to advocate for and participate in the development of measures where there are gaps. We will continue to call for high-quality services for children and families – and for the wider social determinants of health to be addressed to support parents in their unique and unparalleled role in raising their children.

The Outcomes Framework

Areas for focus		Proposed outcomes
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 birth-weight 8. Reduction in the number of children with high or low Body Mass Index
Parenting promotes 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
Parent context enables good parenting	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
	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
	Be financially self-supporting	21. Parents are accessing good work or developing the skills needed for employment, particularly those parents furthest away from the labour market

1 Introduction

Fair Society, Healthy Lives, the review of health inequalities led by Professor Sir Michael Marmot, highlighted the centrality of early-years experiences in shaping individuals' life chances. A positive start during a child's early development will shape the foundations for individuals to thrive in later childhood and onto adulthood. Positive early experiences are associated with a range of social outcomes including: better performance at school, better social and emotional development, improved work outcomes, and improved health.

The way children are born and develop is shaped by their environment: their primary care-givers, their wider families and communities and the contact they receive from others. It is therefore important that everyone involved with children's lives has the support and information they need to make children's experiences in the early years as positive as they can be.

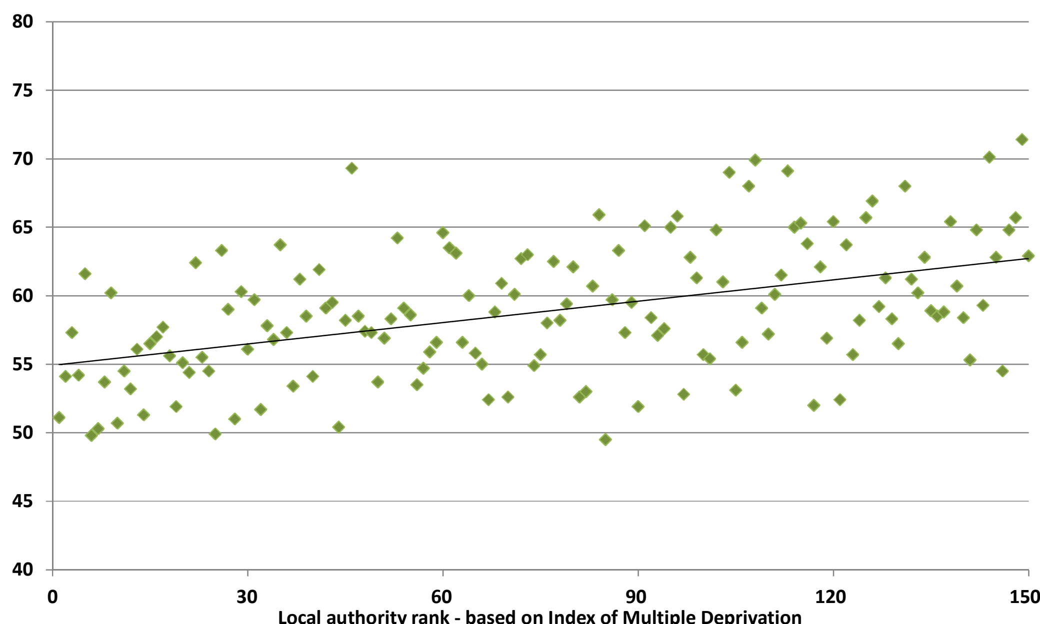
The Marmot Review called for a "second revolution" in early-years provision, to emphasise the importance that should be attached to this period in life and the ability of society to make a collective contribution to improve it and reduce persistent inequalities.

The aim of this work has been to develop an Outcomes Framework for Children's Centres. Its goal has been to identify those outcomes that matter most to children's lives and future life chances.

1.1 Inequalities in children's outcomes

The Institute of Health Equity's 2012 publication of annual indicators for health inequalities showed large disparities in early-years abilities across England with only 59 per cent of children reaching a good level of development at age five.[1] Wealthier areas have better outcomes while outcomes worsen progressively with increasing deprivation.

Figure 1 Percentage of children achieving a good level of development at age five by local authority (Early Years Foundation Stage profile)



Source: London Health Observatory (2012)

These figures are of concern. They mean that 41 per cent of children are not reaching a good level of development. These 41 per cent of children do not come only from the most deprived households. There are children across the whole socio-economic gradient not reaching their full potential.

However, we know there are many things that can be done to improve children's development. For example, in a study of the Millennium Cohort[1], Kelly *et al* found that if parents engaged in a number of activities, including reading to their children, having a positive home learning environment and setting firm boundaries and bedtimes, then whatever the socioeconomic group, outcomes improved and the socioeconomic gradient flattened.[2]

1.2 An emerging consensus

This view of the importance of early years to later life is shared across the political spectrum and internationally. As Graham Allen, a Labour MP, and Iain Duncan Smith, a Conservative Minister, note in their book *Early Intervention: Good Parents, Great Kids, Better Citizens:*

> *More and more eminent thinkers, policy makers and practitioners are acknowledging the importance of Early Intervention in children's lives. Teachers, health workers, police officers and parents tell the same story.*[3]

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[1] The Millennium Cohort Study is a longitudinal study following the lives of approximately 19,000 children born in 2000-1.

The need to address the early years is also gaining ground internationally. For example, UNICEF has argued:

> *Today's rising generation is the first in which a majority are spending a large part of early childhood in some form of out-of-home child care. At the same time, neuroscientific research is demonstrating that loving, stable, secure, and stimulating relationships with caregivers in the earliest months and years of life are critical for every aspect of a child's development. Taken together, these two developments confront public and policymakers in OECD countries with urgent questions.*[4]

1.3 Preventing future costs to society

The early years matter because they are the foundation stone; of course people have opportunities to develop throughout childhood and later life, but very often the trajectory gets set early on. As James Heckman, Nobel Prize-winning economist, has argued:

> *Skill begets skill…. Skill formation is a life cycle process. It starts in the womb and goes on throughout life. Families play a role in this process that is far more important than the role of schools. There are multiple skills and multiple abilities that are important for adult success…. Skill attainment at one stage of the life cycle raises skill attainment at later stages of the life cycle (self-productivity). Early investment facilitates the productivity of later investment (complementarity). The returns to investing early in the life cycle are high. Remediation of inadequate early investments is difficult and very costly.*[5]

One implication of this is that early investment, when the most significant changes can be made to people's long-term paths, reaps both social and economic dividends.

Estimating the cost of inaction in the early years is complex: poor early-years experiences increase the demands made on budgets that deal with health, education, crime, and social security, and reduce tax revenue from employment. Despite this difficulty, it is clear that the savings to be made from early intervention could be substantial. For example, some estimates suggest that youth unemployment costs £10 million per day in lost productivity, and that a person who spends his or her lifetime on benefits costs society £430,000. The cost of youth crime in the UK is £8.5–£11 billion per year and the cost of children in care is an estimated £3 billion per year.[6] Estimates in *Fair Society, Healthy Lives* suggest that health inequalities cost the UK £31–33 billion a year in lost productivity and £20–32 billion a year in lost tax revenue and higher benefit payments.[7] Investing in children early in life should bring down these costs over the long term.

1.4 Children's Centres

For more than a decade the Children's Centre has been the cornerstone of attempts in England to invest in the early years in order to transform children's lives.

In her book *Providing a Sure Start: How Government Discovered Early Childhood*, Naomi Eisenstadt wrote:

> *There are ongoing debates about what kind of early years services the nation needs but no longer arguments about whether the nation needs these services at all.*[8]

Starting as Sure Start Local Programmes in the most deprived areas of the country, the role of Children's Centres has evolved. 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".[9] Our review focuses on what Children's Centres can do to meet their primary objective: to improve outcomes for young children and their families and in particular the responsibility to support those who are at most risk.[10]

1.4.1 Current context

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.[11] 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.*[12]

Measuring effectiveness against this vision currently takes place through the Ofsted Inspection Framework for Children's Centres, 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 a Children's Centre, these EYFS measures are still used to understand a local area's effectiveness.

This national assessment architecture continues to evolve: at the time of publication the

Ofsted framework is under review and the Payment by Results trials are ongoing, challenging local authorities across the country to identify robust yet practical measures of success. The public health sector is 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 policy priorities 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. 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 capture early-years factors,[2] there will be young children in some of these families who will be impacted by any new interventions and Children's Centres may play a role in supporting those families.

Like all services, Children's Centres face a changing economic and social context which impacts on their levels of resources, the extent of need and the demand for their services. Growing levels of poverty across the UK, 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.[13]As a recent report published by the Institute for Health Equity argued:

> *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.*[14]

At the same time we know from our visits that in response to austerity, Children's Centres are reshaping their services to deliver more for less and in some cases to deliver fewer

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[2] *Guidance on identifying troubled families instructs councils to begin by identifying families who are involved in crime and anti-social behaviour and/or have children of school age who are not in school. Councils are then told to identify families within these groups who also have an adult receiving out-of-work benefits. Families who meet all three criteria are immediately considered troubled and local authorities make up the balance of their 'allocation'. www.communities.gov.uk/documents/communities/pdf/2117840.pdf, accessed 6 July 2012.*

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.

1.4.2 Evidencing the value of Children's Centres

Children's Centres are dealing with many and rapid changes and there is a need to demonstrate with sound evidence the contribution made by Children's Centres 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 Children Centre 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.

Making the 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 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.*[15]

Despite the paucity of strong evidence about the impact of individual interventions, there is a strong case for Children's Centres, not least the abundant evidence about the importance of intervening early and offering early support for families. Children's Centres are very popular among practitioners and families but there is a need to demonstrate more than popularity: we need to assess *impact*. Only by being explicit about goals, and transparent in the way we measure outcomes against those goals, can we improve quality on a consistent basis. We need 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.[16]

1.5 Project aims

The focus of this project is an Outcomes Framework. It makes explicit where Children's Centres should prioritise their efforts to support all children to thrive. The list of outcomes is in the executive summary, above, and in section 8.1.

This document is the evidence base behind this Outcomes Framework. It provides the information and the analysis that supports the outcomes we have identified.

Several influential reviews over the past five years have focused on various aspects of the early years. Most recently Professor Cathy Nutbrown's *Foundations for Quality* has looked at the training and pedagogy requirements across the early-years sector, Professor Eileen Munro gave recommendations for *Better Frontline Services to Protect Children.* Dame Clare Tickell's *The Early Years: Foundations for Life, Health and Learning,* Frank Field's *The Foundation Years: Preventing Poor Children Becoming Poor Adults* and Graham Allen's *Early Intervention: The Next Steps* all focused in particular on how to reduce the inequalities that start and then persist from the early years. The Institute of Health Equity's report *Fair Society, Healthy Lives* similarly advocated for every child to have the best start in life – arguing that, "giving every child the best start in life is crucial for reducing health inequalities across the life course".[17]

This project builds from these foundations. We have looked at how best to respond to the challenge set by the Core Purpose document: how can Children's Centres most effectively enable all families and children to thrive, but in particular help those most at risk of not achieving what they can and should? We have focused our work on reviewing evidence to respond to the following questions:

> *Where should Children's Centres focus their efforts to improve the early years for children, and in particular reduce inequalities in health and other outcomes?*
>
> *What are the essential outcomes that need to – and can be – improved?*

We explicitly chose the word 'essential'; we want to provide policymakers, strategic leaders and Children's Centre managers with specific areas for focus. We then identified outcomes that Children's Centres should focus on. These outcomes fit three criteria: evidence says the outcomes are important in the early years, there is evidence that these outcomes are distributed unequally across the social gradient, and to the extent to which it is possible there is evidence that Children's Centres can make a difference.

Of course, the evidence varies from outcome to outcome and across these three criteria. Evidence about what matters is particularly robust, as is the evidence about the social gradient. The evidence about *why* outcomes are unequal and what we can do to redress this inequality is less clear.

1.6 This document

An overview of our methodology is provided in Section 2. In Section 3 we present the conceptual approach which forms the basis of our focus on children's health and development, parenting and parents' lives. In Sections 4 to 6 we present the evidence that underpins the outcomes that we propose. In Section 7 we discuss ensuring engagement and access for all parents; in Section 8 we present the outcomes framework, and in Section 9 we identify our next steps in this work. The appendices provide useful information such as a table that maps our outcomes against the current statutory frameworks.

2 Methodology

Our aim was to propose a set of early-years outcomes strongly rooted in the evidence base. These are outcomes that have significant impacts on children's lives and their later lives and would be sensitive to intervention by Children's Centres. However, we also wanted to ensure that the outcomes made sense to practitioners and were applicable in a local context.

Our approach therefore focused on three strands of activity: a literature review, visits to Children's Centres, and setting up an advisory group of policymakers, academics and practitioners.

2.1 Literature review

We reviewed the literature on the relationship between early-childhood outcomes and later-life chances, and the drivers of these outcomes. We structured our literature review around five strands of the evidence:

- the early years of children's lives as determinants of health and wellbeing in later life,
- the influence of parenting on children's early lives,
- the influence of the parents' skills and capabilities and the context in which they parent,
- the inequalities that exists across the outcomes,
- and the role of Children's Centres in addressing these factors.

Our literature review was wide-ranging. We drew on recently completed reviews and original research from the UK and abroad. We worked with experts from our advisory group to identify key research themes to incorporate. We also drew on research conducted for the Department for Education.

We have considered the existing evidence about why the early years are so important, and the links between early-years experiences and outcomes and inequalities throughout life. We have explored evidence about ingredients of successful interventions and services and how Children's Centres can make a difference to parenting and to the family context through services to children and families.

We have not considered the full range of services with which children interact in their earliest years, such as health visiting and immunization. They are critical partners for Children's Centres but the complete makeup of the early-years system is for another review.

2.2 Field visits

We visited five areas across England – Warwickshire, Birmingham, Knowsley, Tower Hamlets and Gateshead – aiming to see a wide range of types of Children's Centre and different

localities. We sought to include areas that reflected a mix of delivery contexts including urban, suburban and rural areas, more or less diverse areas, areas with wide-spread levels of deprivation and areas where deprivation primarily exists in pockets.

During our visits we asked professionals and parents to give us their views on what they thought was most important for children and families in the early years, what worked to support those outcomes, what Children's Centres could do and how they would know if interventions and activities were having an impact. We used a set of 'outcomes cards' with professionals, and a facilitated 'mind-mapping' process with parents.

Most of the visits were two-days long, giving us the opportunity to engage with parents (mothers, fathers and grandparents), front-line staff from a range of agencies, senior management, local politicians and other partners.

We tested what was emerging from the literature review, held discussions, and ran workshops with parents and professionals. Together we undertook exercises to identify what participants felt was 'most important' in the early years, what impact Children's Centres could have and how we would know that this impact was occurring.

Parents told us: "I just know she's getting something out of it. I can tell", and "I can feel that I am getting something out of it." The visits ensured that in considering how to apply the evidence base we remained grounded to the challenges and constraints experienced at a local level. A challenge in all frameworks will be to find a way to capture and turn into evidence these types of observations and 'feelings' from parents and professionals as a legitimate part of any assessment of outcomes.

Example output of discussions with parents as part of the research visits

2.3 An advisory group of experts

We assembled an advisory group that brought together practitioners, senior managers, leading academics and policy officials to respond to our work. They acted as 'critical friends' and helped to synthesise the academic evidence and practice based understanding. They provided challenge through four meetings and numerous interactions in the interim. In particular they worked with our team to ensure that we balanced academic rigour with practical applicability and relevance. The list of advisory group members can be found on page 4.

2.4 Reflections on the evidence base

These three activities formed the evidence base for the outcomes framework. We are confident that the outcomes that we propose are supported robustly by the evidence. However, there are gaps in the evidence and some areas where it is stronger and others where it is weaker.

For example, there is an increasingly rich evidence base about the importance of the home learning environment and its independent contribution to children's outcomes.

This level of specificity and certainty does not exist for all of the outcomes we propose. We know that knowledge about parenting is important – professionals told us this and parents wanted to develop their own parenting skills. However, the evidence base linking parenting knowledge, as distinct from parenting style or particular parenting behaviours, to children's outcomes is limited and the complexity of unpicking it is beyond the scope of this report.

Evidencing causality is also a challenge. The association of outcomes in early life with outcomes in later life does not necessarily mean the first caused the second. Even when utilising sophisticated statistical analyses, where multiple variables are controlled for, we can only demonstrate significant and strong associations between two outcomes. There is strong association between parenting behaviours and the outcomes for their children but again these associations alone do not demonstrate a causal relationship. A range of biases can occur. For example, our initial measures could be proxies for something else, closely correlated with another factor, but it is the other unmeasured factor that is the critical ingredient. Indeed many of the outcomes we focus on in early life are highly correlated with each other and this has important implications for the statistical reliability of any one individual measure.

With the maturation of many longitudinal datasets both in the UK and elsewhere, including those with a specific focus on the early years such as the Millennium Cohort Study, we are building up a stronger picture of what outcomes appear to matter. Where there is a wealth of evidence about a particular outcome we have taken this as a strong suggestion of the importance of this attribute in the early years.

There are still gaps in joining up evidence from various disciplines around early-years

development. Where this is particularly important is in the links between neurobiological development – what is happening to a child's brain from conception to age five – and observable development of speech, dexterity, confidence and so on. While discussion between education/early-years experts and brain scientists are taking place, this represents an emerging area of knowledge, which will in the future inform developments of policy and practice.[18]

2.5 Children in special circumstances

Some children have diagnosed developmental delays, speech and language impairments, physical disabilities and other characteristics which mean that they and their families may need additional support.

Other families are deeply affected by issues such as alcohol and substance misuse, violence and crime. These family lives can be particularly hard and chaotic. There is a separate area of children's services dedicated to reducing harm for children in such circumstances.

Children's Centres should play a core role in local systems that identify and respond to children who have particular needs. The detailed evidence about the impacts of these special circumstances and the most effective responses are the purview of other work.

3 An ecological approach to the early years

I know that what I do makes a difference to her – and I want to be a good role model.

Mother, speaking during parent workshop

We started by identifying the areas of children's development from pregnancy to age five that are most important for later-life outcomes. These largely mirror those already identified by government and in particular the prime areas of the Early Years Foundation Stage.[19] *Development Matters* provides detailed guidance about how development should manifest over ages and stages and what Children's Centres can do to promote it.

From there we focus on parenting and the parent. All of the existing frameworks talk about the need to support parents but there is less detail about what might work. We highlight what the evidence suggests is most important in both parenting and the parent context and what we do know about what Children's Centres can do.

Drawing on Bronfenbrenner's Ecological Model[20], the domains of influence that we propose recognise that children are primarily influenced by their parents, whose behaviours and resources are shaped by a myriad of influences on their own lives:

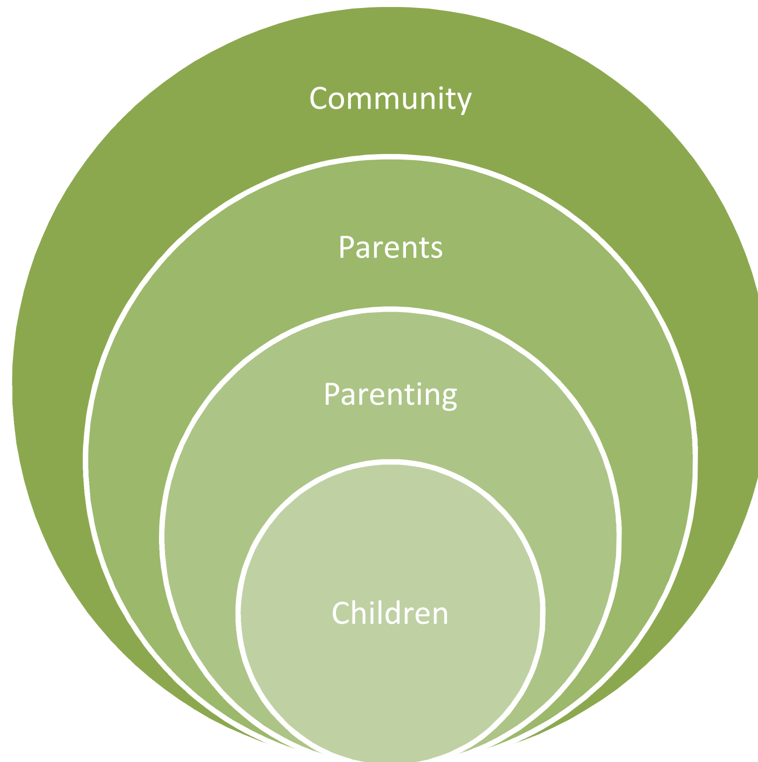
- **Children's health and development:** Cognition, communication and language, social and emotional skills, and physical health are all critical for children to thrive as they grow up and prosper when they are adults. While debate continues about which of these four aspects is the most important, there is agreement that they are all critical and interrelated. All Children's Centres 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. Children's Centres 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.
- **Parent's 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. Children's Centres can support parents to improve a number of these, even if not all are within their scope.

We know that these all sit within a wider context of neighbourhood and community, including quality of housing, green spaces, safety, crime and so on. Children's Centres are not in a position to make radical changes in these areas. They support parents to be resilient in the face of challenging contexts and work with local partners to showcase the long-term

harmful impacts that these have.

These domains of influence are represented in Figure 2, the conceptual model.

Figure 2 Domains of Influence in the early years



The rest of the document provides the evidence base. In each section we set out the evidence about why the chosen outcomes are important and in particular how they contribute to the areas of focus that we have prioritised. We consider the evidence on inequalities in these areas and what we know about the impact that Children's Centres can have. We then highlight measurement approaches used elsewhere and make recommendations for responding to gaps in the evidence base.

4 Children are developing well

We focus on four domains of outcomes for children: their cognitive development, how well they are learning to communicate and use language, the emergence of social and emotional skills and their physical health. These are all vital aspects of early child development. These domains are helpful for understanding and discussing different aspects of child development. There is, however, fluidity in the underlying relationship and an interaction between development in each of these domains.[21]

As David *et al* write:

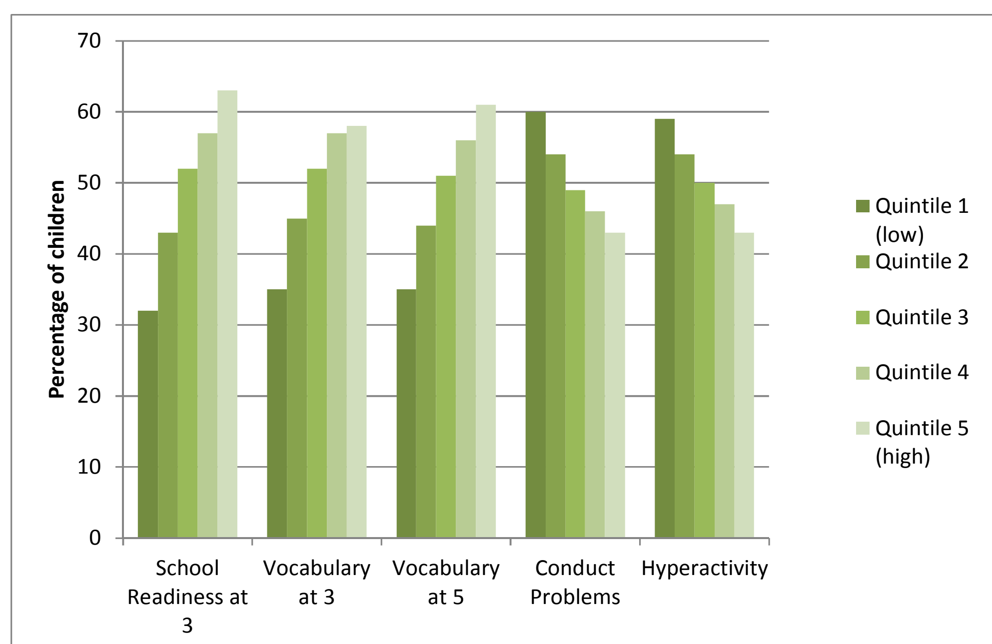
> *In real life, children's development and learning is not compartmentalised but is holistic, with many inter-connections across different areas of experience.*[22]

For example, communication and language skills are closely correlated with experiences in childhood, with the other domains we discuss, and with later life.

Across all these domains there are differences in outcomes, differences which can in part be explained by wider social inequalities. For example as Figure 3 shows, children from less well-off backgrounds perform less well in achieving 'school readiness', specifically regarding verbal, spatial and non-verbal abilities and socio-emotional difficulties.[23]

Parents and parenting are the biggest influences on children's development across all four domains (see Sections 5 and 6). However, where Children's Centres provide nurseries they can make an impact through the delivery and/or promotion of high-quality, affordable preschool and nursery provision as well as targeted inputs.

Figure 3 Indicators of school readiness by parental income group



Source: Washbrook E and Waldfogel J (2008)[24]

4.1 Cognitive development

Outcome 1: All children are developing age-appropriate skills in drawing and copying

Outcome 2: Children are increasing the level to which they pay attention during the activities and to the people around them

Children develop their cognitive skills more in the early years than at any other time in their lives. Those skills are the foundation on which learning builds.

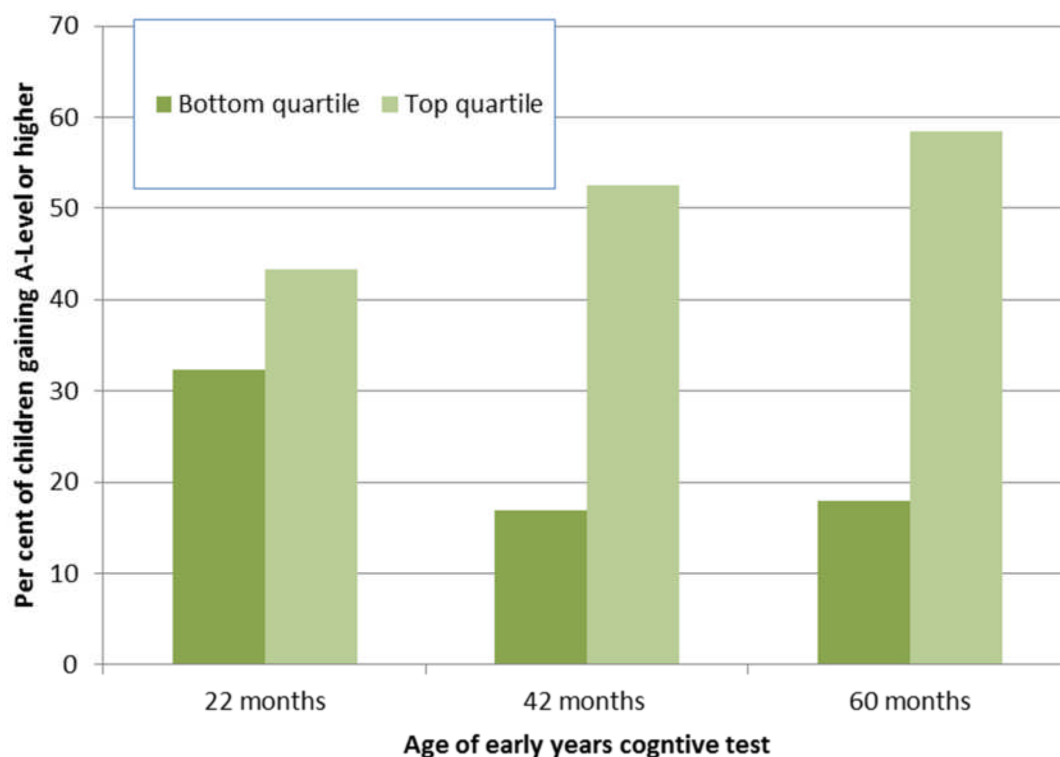
Attention to cognitive development in the early years is particularly important, as these skills seem more fixed after the early years than the other domains.[25] Children's academic achievement from primary through to adulthood is closely linked to their cognitive skills.[26] Children's earliest cognitive development is also associated with their adult experience of the labour market, including quality of jobs and the level of wages.[27]

Gaps in cognitive test scores widen through childhood and adolescence. Feinstein created a development index using a range of variables shown to predict maths and reading skills during primary school. Using the 1970 British Cohort Study he looked at children's position on this development index aged 22 months, 42 months and 60 months and compared it to their qualifications at age 26.

As Figure 4 shows, differences in cognitive scores at age 22 months were already linked to education outcomes at the end of schooling life. By 42 and 60 months respectively, these links were very strong.

There are a various reasons for this. Firstly, those factors that influence different levels of development in the earliest years such as parenting, home learning environment and children's own temperament will continue to impact on children as they get older. But there is a cumulative effect as well. Children who start school with good cognitive skills are able to thrive in the school environment. Those who lack basic foundation skills may struggle and continue to fall behind.[28]

Figure 4 Percentage of children attaining A-Level or higher by age 26 by quartile position in early development scores



Source: Feinstein L (2003)[29]

Two particularly strong markers of children's cognitive development are their copying skills and the level of attention they pay to other children and adults while involved in tasks and activities. Copying skill tests are regularly used to measure cognitive development and consistently show strong predictive power for later outcomes. Feinstein and Duckworth write that, "the long-term explanatory power of the copying designs test is striking".[30] The same research found that children whose copying ability improved between 42 months and five years old showed gains in reading and mathematics at 10 years old. These improvements were strongly associated with higher qualifications and incomes at 30 years old.[31]

The ability to sustain attention – such as a focus on one person, one toy, one activity – is part of a child's cognitive development.[32] As they grow, children's ability to retain this focus improves.[33] Children who pay attention are more likely to perform well in school and to engage well in activities.[34] They are shown to have high levels of social competence and low levels of behaviour problems throughout life.[35] Preschool skills around attention and self-control are also correlated with the transition into school which itself links to later educational successes.[36] Mother-reported inattention at age five showed a strong association with reading scores at age 10.[37] Good levels of early attention skills are associated with higher academic achievement and wages at age 30. Poor levels of attention in the early years have been linked to conduct and behavioural disorders later in life.[38]

4.1.1 Inequality in cognitive outcomes

Evidence shows that children from poorer backgrounds tend to have lower levels, on average, of cognitive development even in the earliest years.[39] They have lower IQ scores than other children in a range of tests. Most of this is based on vocabulary tests, discussed in Section 4.2. However, composite measures of cognitive development are linked to socioeconomic status. Feinstein's analysis of the 1970 British Cohort Survey showed a 13 percentage point difference in average rank of development between children at the bottom and top of the social gradient. By age 10 this gap had widened and the difference was 28 percentage points between children from the most disadvantaged and the most affluent backgrounds.[40] The Effective Preschool and Primary Education project shows that there is an association between parents' income and their children's cognitive ability. As income increases, so do cognitive ability scores.[41]

The relationship between position on the social gradient and cognitive outcomes is complex.[42] Much of the research has focused on the relationship between parental education and cognitive development while other evidence has shown a relationship between the type of work that mothers do (e.g. level of variation in tasks, level of problem solving) and their children's outcomes.[43]

Guo and Harris tested the protective nature of these in response to poverty in childhood. They found that the influence of family poverty on children's intellectual development can be explained by cognitive stimulation in the home, to a lesser extent parenting style and to an even lesser extent the physical environment of the home.[44]

A child growing up in a family with a strong home learning environment and positive parenting, even if the family is poor, has every chance of succeeding in life.[45] Conversely, where children's care is neglectful, inadequately stimulating, overly harsh or punitive, or unpredictable and inconsistent, they can be harmed permanently.[46]

4.1.2 Improving children's cognitive development

Children's cognitive development is strongly influenced by their experiences of parenting, particularly the learning environment at home (see Section 5.2). Improving the home learning environment will have the biggest impact on children's cognitive ability. While copying is a valuable marker of cognitive development, Feinstein and Duckworth suggest that direct attention to copying itself may not be the most effective way to improve cognitive outcomes. Attention to the skills underlying copying – and then review through the use of copying tests – may be a powerful approach to improving outcomes.[47]

Children's ability to pay attention and cooperate effectively seems to be relatively static from the age of three with little change in their performance on various tests for attention between three and five years old.[48] It is not clear why some children have stronger levels of attention than others, although some of the rich evidence base around attachment and early nurturing can help our understanding.

Many Children's Centres provide nursery and preschool services for parents. The Effective Preschool and Primary Education (EPPE) study has provided an unprecedented wealth of evidence about the potential impact of preschool on children in the UK. The research found that attending preschool, particularly high quality preschool, for more than two years had an impact on children's outcomes.[49]

Making a difference across the social gradient

The Effective Preschool and Primary Education study shows that preschool can improve the cognitive outcomes for children who are at risk (defined through a range of socioeconomic background factors). One third of the at-risk children studied had low cognitive attainment at age three (when they entered preschool) and by age five this number had dropped to one fifth. These children were also seen as at risk for Special Educational Needs (SEN). Twenty-one per cent of the cohort showed some form of SEN but this was compared with 51 per cent of children who stayed home, who are also more likely to be from at-risk backgrounds than not.[50]

EPPE found that the use of preschool varies across the social gradient as well. Children from lower socioeconomic groups attend preschool for four to six months less time than their better-off peers. The greatest proportion of children in private day nurseries (shown to be particularly effective) had mothers with degree-level or higher qualifications while the majority of the 'stay home' children had mothers with less than GCSE qualifications. Notably, more than 50 per cent of children attending integrated centres (also shown to be particularly effective) were from families where mothers had no more than GCSE education levels.[51]

At the same time the study showed that disadvantaged children had the potential to benefit the most from good quality preschool. They benefited from attendance at centres with children from a mix of social backgrounds, from attending for a longer duration, and from early entry.[52]

4.2 Communication and language[3]

Outcome 4: Children are developing age-appropriate comprehension of spoken and written language

Outcome 5: Children are developing age-appropriate use of spoken and written language

Children's language skills develop particularly quickly in the first three years of their lives.[53] These skills are critical to how a child engages with his or her environment. Communication and language have two aspects: comprehension or understanding of how the language is

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[3] *Children's communication language skills are often discussed as a subset of cognitive development. We have chosen to treat the two separately as the understanding of the interplay between communication and language skills and social and emotional skills continues to develop.*

spoken, heard or read; and use of language – that is, speaking and in some cases, in the early years, their own writing.

Communication begins with the crying of very new babies, the cooing noises as they grow a bit older, the sounds that become words and the words that become sentences.[54] Infants begin to develop an understanding of sounds and associate them with voices they hear regularly.

Language development and in particular multiple –word sentences at age two are a strong predictor of children's performance on entry to primary school.[55]

Vocabulary is a predictor of later-life outcomes, including, but not only, their success in learning to read.[56] Children's phonological skills at age five are strong predictors of reading at age seven and their vocabulary skills at age five are similarly useful in anticipating complex tasks of reading at age 11.[57] Marchman and Fernald in the US have demonstrated powerful links between vocabulary use at 25 months and a range of cognitive abilities including language use at age eight.[58] Feinstein showed that vocabulary use at five years old was one of the two most powerful predictors of reading at 10 years old and a particularly powerful predictor of maths at that age.[59] Vocabulary tests at age five are highly predictive of later life outcomes including income at age 30. Children who are shown to have language problems at age five (based on scores on the English Picture Vocabulary Test) have been shown to have comparatively low levels of language skills at age 34.[60] Persistence of poor language and communication skills into adulthood has been linked to a higher rate of unemployment, low earnings, and ill health.[61]

Children with poor language and communication also have more behavioural difficulties, and problems with social communication.[62] Research on children with diagnosed Speech and Language Impairments (SLI) suggests that they struggle to develop friendships at the same rate and level as other children, even from preschool days. Poor language skills can leave a child less sensitive to others' starting interactions, more likely to have inappropriate verbal responses and achieve fewer agreements.[63] While these children have specific impairments, the relationship between strong verbal skills and peer relationships is likely to exist with other children.

Poor language skills in adulthood are also closely associated with ill-health and with poor self-management of chronic conditions.[64]

4.2.1 Inequality in communication and language

Socioeconomic adversity is negatively associated with children's language and communication development.[65] Compared with children with good language ability, those with very limited or poor language skills are more likely to grow up in relatively disadvantaged circumstances in socioeconomic terms as well as in terms of their early literacy environment. One study of children growing up in poverty found that more than 50

per cent of the children were language-delayed, although girls' receptive language abilities were significantly better than boys'.[66]

Children from high socioeconomic groups have been shown to use more types of words than children from middle socioeconomic groups. A study by Hoff (see Table 1) showed children from higher socioeconomic backgrounds have a greater variety of words than other children.[67]

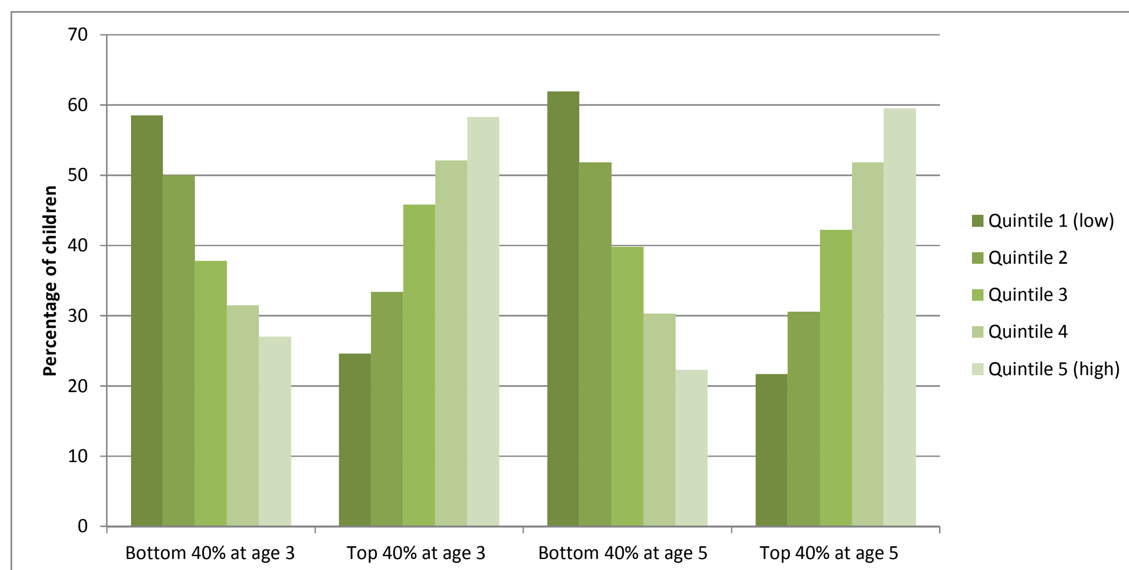
Table 1: Average number of types of words used in two observations of children's language

	Number of word types in 90 utterances of children's spontaneous speech	
	Time 1	Time 2
Mid socioeconomic status	35	46
High socioeconomic status	37	51

Source: Hoff E (2003) The specificity of environmental influence: socioeconomic status affects early vocabulary development via maternal speech (numbers in table rounded)

Analysis of the Millennium Cohort Study also suggests that poorer children have worse vocabulary. Using the British Ability Skills (BAS) Early Years Version Naming Vocabulary tests, Dearden *et al* found a gap between children from the highest socioeconomic quintile and those from the lowest quintile at age three and this gap widened by age five.

Figure 5 Language Ability age 3 and 5 by socioeconomic position quintile, (measured using British Ability Scales)

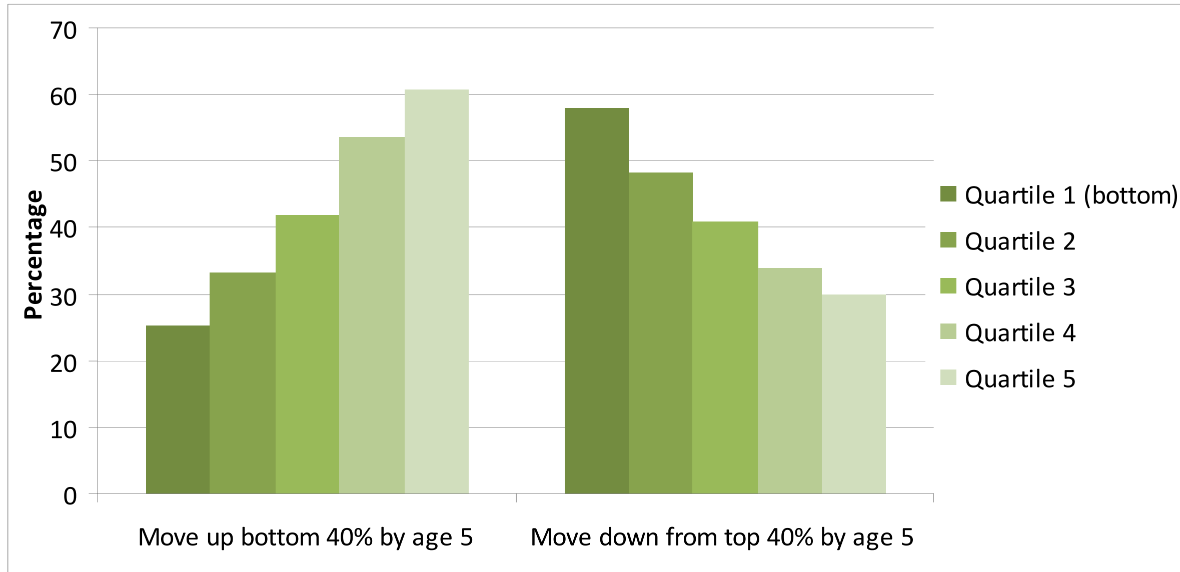


Source: Dearden L, Sibieta L and Sylva K (2011)[68]

Moreover the same research showed that children from lower socio-economic groups who were performing well on vocabulary tests at age 3 were more likely to be performing less well by age 5 than children with the same ability at age 3 from higher socio-economic groups. Similarly among those who were performing relatively poorly at age three, children

from higher socio-economic groups were more likely to be performing relatively better at age 5.

Figure 6 Children's change in position on a vocabulary test between age three and five by parents' socioeconomic position (measured using British Ability Scales)



Source: Dearden L, Sibieta L and Sylva K (2011)[69]

A number of studies have tried to explain why poor children lag behind their better-off peers in the development of their language. Dearden *et al*'s work with the Millennium Cohort Study showed that parenting skills and the quality of the home learning environment explain a large percentage of the difference. But other family characteristics such as mother's age, parental education and number of siblings also seem to matter and are not entirely explained by differences in the parenting variables.

In their 2003 study of vocabulary in the United States, Hart and Risely echo this focus on children's experience at home. Children of poorer parents (classified as parents on welfare in the US context) heard half as many words per hour as their working-class peers and less than a third of the words of their peers from professional families.

Figure 7 Average number of words heard by children per hour by socioeconomic group

Source: Hart B and Risely T R (2003)[70]

The impact is cumulative so that by the age of four a child of a poorer family has on average heard 13 million fewer words than a child from a middle-income family.

4.2.2 Improving communication and language skills

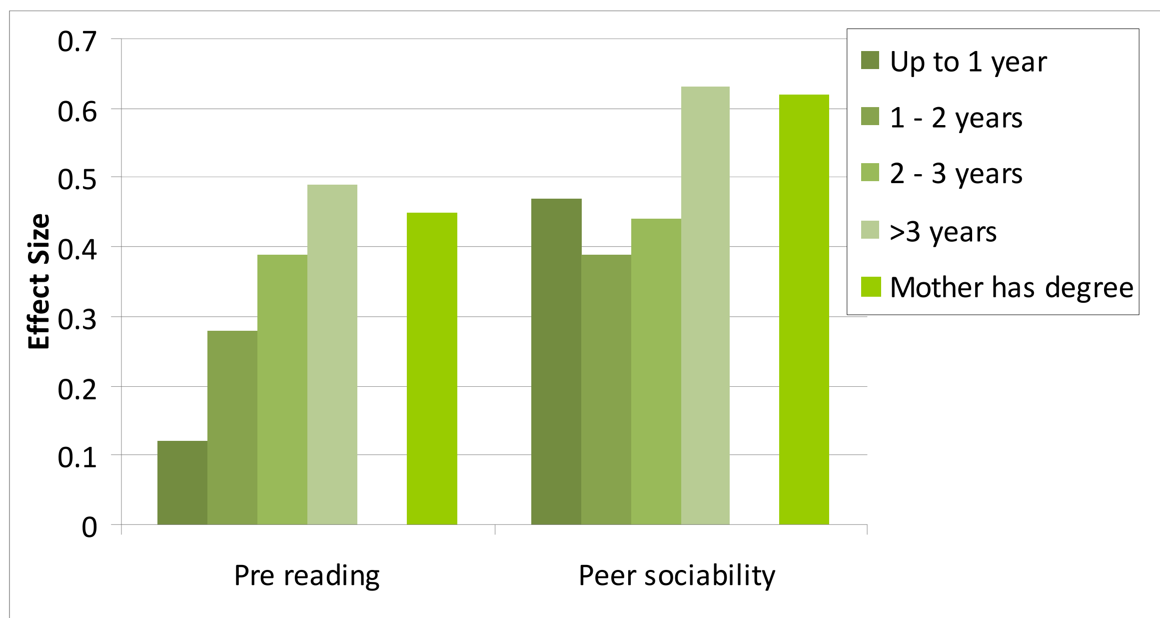
The evidence suggests that parents are the strongest drivers and enablers of children's communication and language development.[71]

Direct intervention to build children's language and breadth of vocabulary may have limited impact. In the US study discussed above, children retained new words that they were directly taught but there was no impact on the pace at which they developed their own vocabulary outside of the sessions. As Hart and Risely write:

> *However many new words we taught the children in the preschool, it was clear a year later, when the children were in kindergarten that the effects of the boost in vocabulary resources would have washed out.*[72]

The EPPE study suggests that preschool can have a significant impact on children's language development with the effect size growing as children spend more time in preschool. The work points to teaching songs and nursery rhymes as particularly linked to improved language. The evidence suggests that attendance for more than one year is particularly important for pre-reading. EPPE also looked at the impact of a mother having a degree versus no qualification. Only attendance for three years at preschool had greater effect than a mother having a degree.

Figure 8 Impact of years spent in preschool and mother having a degree on early childhood pre-reading and peer sociability



Source: Sylva K, Melhuish E,et al(2010) [73]

Those Children's Centres not providing preschool need to be aware of how their communication can help or hinder children's development. In the main, Children's Centres should focus their efforts on supporting parents to provide a high-quality home learning environment, increasing their own range of vocabulary and conversation, and should encourage parents to take advantage of free, high-quality preschool provision, or paid provision where it can be afforded.[4]

4.3 Social and emotional development

Outcome 5: Children are engaging in age-appropriate play

Outcome 6: Children have age-appropriate self-management and self-control

From the first smile to the sophisticated social person that can express empathy, feel guilt and describe their emotional state in nuanced terms, early childhood is a period of rapid social and emotional development. Young infants are, from an early age, able to respond to signals of others and begin to internalise emotional responses.[74] Behaviour – and good behaviour – is a core part of being ready for school.[75] Children need to develop purposeful control of their own behaviours, allowing them to internalise social rules.[76]

[4] *All three- and four-year-olds are entitled to free childcare provision. Central and local government have been rolling out a targeted programme of free childcare for the most disadvantaged two-year-olds.*

The evidence base linking social and emotional development to later life outcomes is not as developed as the evidence linking cognition and communication and language. In large part, as Carneiro and Heckmann argue, this is because these skills are harder to measure.[77] Many of the tools used are parent-reporting and observational tools rather than specific tests. The approaches to measurement are also often focused on assessing problematic behaviour and observing children with unusual behaviour.[78] In addition, much of what we know about improvement to social-emotional skills looks at experiences of children who have been severely neglected or maltreated and then placed in new family environments.[79]

However, there is a growing evidence base to suggest the importance of social and emotional skills. Early-years practitioners believe these to be very important; primary school teachers and senior leaders say that children's confidence, resilience and self-reliance are critical to their success; and parents place these skills high on their list of priorities.[80] A core part of the EYFS framework is recognising the role that social skills play in learning and school readiness.[81]

In the EPPE study children whose parents reported child development problems before the age of three showed lower attainment in mathematics and English at age 11; children who had one behavioural problem had lower skills in self-regulation and fewer positive behaviours.[82] Poor social and emotional skills have also been linked to truancy. In addition, post-16 staying-on rates at school are higher for children with stronger emotional skills, while teenage pregnancy and criminal activity rates are lower.[83] Social adjustment has also been shown to be associated with improved labour market participation and higher wages.[84]

The ways in which children behave, both in their play and in the general interactions with others, give important insights into the early development of their social and emotional skills. Play – spontaneous, creative and imaginative – gives children the chance to test the ways in which they might engage with the world.[85] Children get to practise the skills they need for later life – and in particular the social skills they need to interact with other people as they grow.[86]

As Bonel and Lindon write, play gives children:

> *...a way of dealing with – experimenting with – the surrounding world or parts of it. It is a way of exposing yourself, and your surrounding world, to chance, trial and error – and seeing what happens.*[87]

Play helps children build their social and emotional skills while navigating and testing new relationships.[88] Play also helps children build their cognitive skills – although the research in this area is still developing.[89]

A child's approach to play can reflect their sense of security or lack of attachment. Children who feel more secure are more likely to be outgoing and to engage in made-up games and complex play with other children.[90] Children who are under stress or anxiety are less likely to play.[91]

Self-regulation is also an important component of children's social and emotional development. Children begin life unable to control themselves – they cry when they are hungry, wet or in any other way uncomfortable or needing help. As they get older, however, they learn to understand their feelings and are better able to control their behaviours and their emotions.[92] This control over their behaviour is often referred to as self-regulation.

Summarising a number of international studies, Eisenberg *et al* identify three groups of children. Well-adjusted children (that is, those who were generally resilient and self-assured) remained so as they grew up. Uncontrolled children had low levels of behaviour regulation and were prone to externalised behavioural problems as teenagers and adults. Over-controlled children who were shy and inhibited were found to develop attention problems as early as three years old and had limited social capacity as adults.[93]

4.3.1 Inequality in social and emotional wellbeing

Marked differences exist across the social gradient in children's social and emotional development and adjustment. These gaps do not seem to narrow as children get older. In fact, as children get older there is evidence that the steepness of the gradient in social and emotional problems becomes greater.[94]

Children from poorer backgrounds are more likely to display more behaviour problems than children from more affluent families.[95] In one study at three years of age, two per cent of children from families in the highest income group had socio-emotional difficulties compared with 16 per cent of those from families in the lowest income group. This gap persists: at age five, only two per cent of children from higher income families struggle while 16 per cent from the lowest income families face challenges.[96]

There is growing evidence that children from lower socioeconomic backgrounds have higher rates of mental ill-health and diagnosed mental illness.[97] Based on Melzer's 2000 study of child mental health in Britain, Spencer argues that:

> *If all children had the same risk of mental disorder as the highest income groups, then there would be 40.6 per cent fewer mental disorders, 59.3 per cent fewer conduct disorders (anti-social behaviours), 53.7 per cent fewer hyperkinetic disorders (ADHD) and 34.4 per cent fewer emotional disorders.*[98]

4.3.2 Improving social and emotional wellbeing

Children's social and emotional skills are formed in large part by their attachments and their experience of attachment with their parents (and primarily with their mothers).[99] We discuss attachment in more detail in section 5.3. The attachments that children form with their parents have primacy in influencing how they will relate to others.[100] Children who experience poor treatment at home are more likely to behave aggressively to peers in nursery school, even if the setting is nurturing and supportive, and this can persist into adolescence.[101]

Children also learn their social and emotional skills by watching others, primarily their

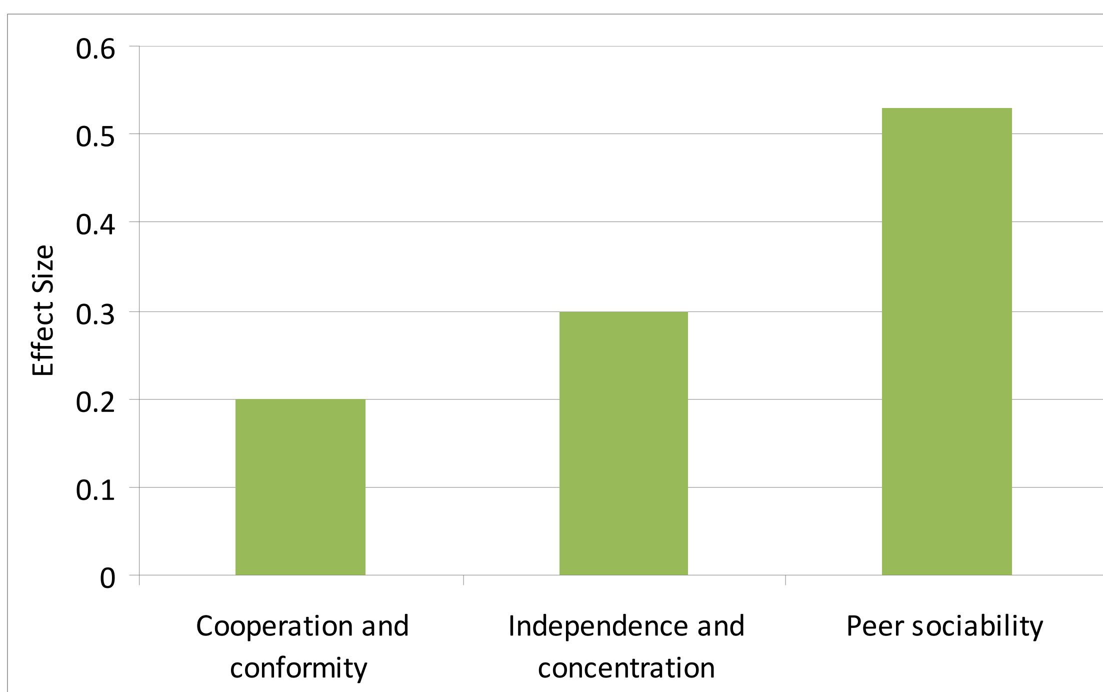
parents but also other significant and present adults. The use of 'circle time', stories, and collaborative games all support children to develop. These can be features of a nursery setting or individual stay-and-play sessions or other sessions with children and their parents.[102]

Children's Centres can also influence the complexity and impact of children's play. Research by Dockett found that supporting children to develop their play increased the complexity and therefore developmental benefits of play.[103] Children's Centres can also work with parents to increase the amount of joint play between mother and child, which is correlated with measurable improvements in conduct by age four.[104]

Many mothers and fathers we met on our visits said that they had learned new ways to play with their children from attending sessions at the Centre and from seeing how staff were engaging with the children. Many of these new ways of playing were cost-free – something that parents said was very important in order that they can translate them from the Centre to their homes.

The EPPE study found that preschool had a particularly strong effect on children's ability to mix with their peers: those who had attended were more confident and comfortable in engaging with other children. The effect on cooperation and conformity was also positive. However, the study found no effect from preschool on anti-social behaviour or the degree to which children were worried or upset.[105]

Figure 9 Effect of attending preschool against not attending on child outcomes



Source: Sylva K, Melhuish E, et al(2010)

4.4 Physical development

Outcome 7: Reduction in the number of children born with low birth weight

Outcome 8: Reduction in the number of children with high or low Body Mass Index

Children's physical development underpins all the other domains: their cognitive, communication and socio-emotional development. From birth, children who struggle physically may also have difficulties in other areas. As children grow, their physical needs continue to underpin their capacity to experience and enjoy life.[106] As David *et al* write:

> *A child who is hungry, tired or uncomfortable will not enjoy the company of adults or other children. A child who is physically well will have the energy and enthusiasm to benefit from the range of activities on offer.*[107]

Low birth weight is strongly correlated with poor outcomes in early and later life.[108] An American study of very low-birth-weight children (children with a mean birth weight of 1,179g) showed:

- Significantly higher rates of chronic conditions compared with their peers (33 per cent compared with 21 per cent).
- Forty per cent of very low-birth-weight children had repeated a year in school, and 74 per cent had graduated from high school by 20 years of age. In comparison, 27 per cent of children born with normal birth weight had repeated a year and 83 per cent had graduated from high school.
- In later life only 16 per cent of men born with low birth weight had enrolled at a four-year college by the age of 20 compared with 44 per cent of their peers.[109]

The same study found that children's health was also impaired in the long term. A total of 23 per cent of the very low-birth-weight participants had one chronic condition compared with 17 per cent of their peers, 9 per cent had two chronic conditions (against 4 per cent), and 1 per cent had three or more chronic conditions.[110] Children who are born with low birth weight are found to have higher rates of cardiovascular diseases in middle age.[111] For each kilogram increase in birth weight, improvements can be seen in cognitive tasks and educational achievement.[112]

There is significant and growing attention to the increase in the number of children who are overweight and obese. High BMI at eight months and 18 months is a risk factor for later obesity, as is weight gain in infancy. In 2010 13 per cent of children were overweight at Reception and 9 per cent of children were obese.[113]

Obesity persists from a young age. Of obese six- to nine-year-olds, 69 per cent were obese as adults.[114] Obese children are more likely to face psychological or psychiatric problems in later life, with girls at greater risk than boys.[115] The risk increases with age and is primarily associated with low self-esteem and behaviour problems. These children are at greater risk of cardiovascular disease including high blood pressure, of diabetes, and of contracting

asthma.[116]

There is a weak negative association between obesity and educational attainment in children and young people (as the former rises, the latter falls). Much of this is explained by the association of obesity with socioeconomic status. When socioeconomic status is taken into consideration, the association between obesity and attainment often loses statistical significance. A systematic review by Caird *et al* suggested a range of factors that may connect obesity with educational attainment, including poor mental health, stigmatisation and discrimination, disordered sleep, decreased time spent in physical activity and socialising, and absenteeism. Caird *et al* argue that these remain hypotheses and this is an area where more research is required.[117]

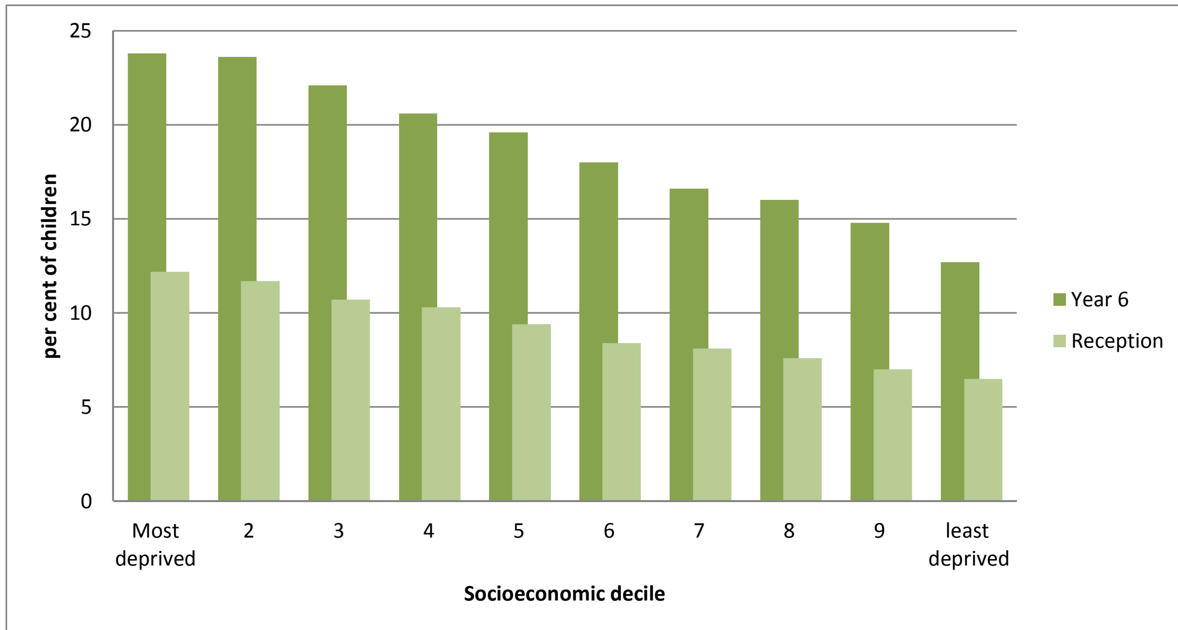
4.4.1 Inequality in physical development

There are differences in physical development across the social gradient. In general, poorer children are more likely to suffer from poor dental care and avoidable injuries, and they are more likely to die early in their lives.[118] Poorer children are less likely to have immunizations on time.[119]

Rates of low birth weight are higher in lower socioeconomic groups.[120] Spencer has calculated that, based on data from the Millennium Cohort Study, if all births in the UK followed the distribution of weight of the most well-off, there would be 34 per cent fewer low-birth-weight births in the UK.[121] Maternal neo-natal behaviours such as poor prenatal care, substance abuse, poor nutrition during pregnancy and smoking are all more prevalent in mothers lower down the social gradient and are associated with poor outcomes.[122]

Obesity also persists across the social gradient with the least deprived children being less likely to be obese than their peers lower down the social gradient – and this difference grows by age eleven. Evidence has emerged to show child obesity rates in the UK levelling off; however, this is not the case among the most deprived groups of children.[123]

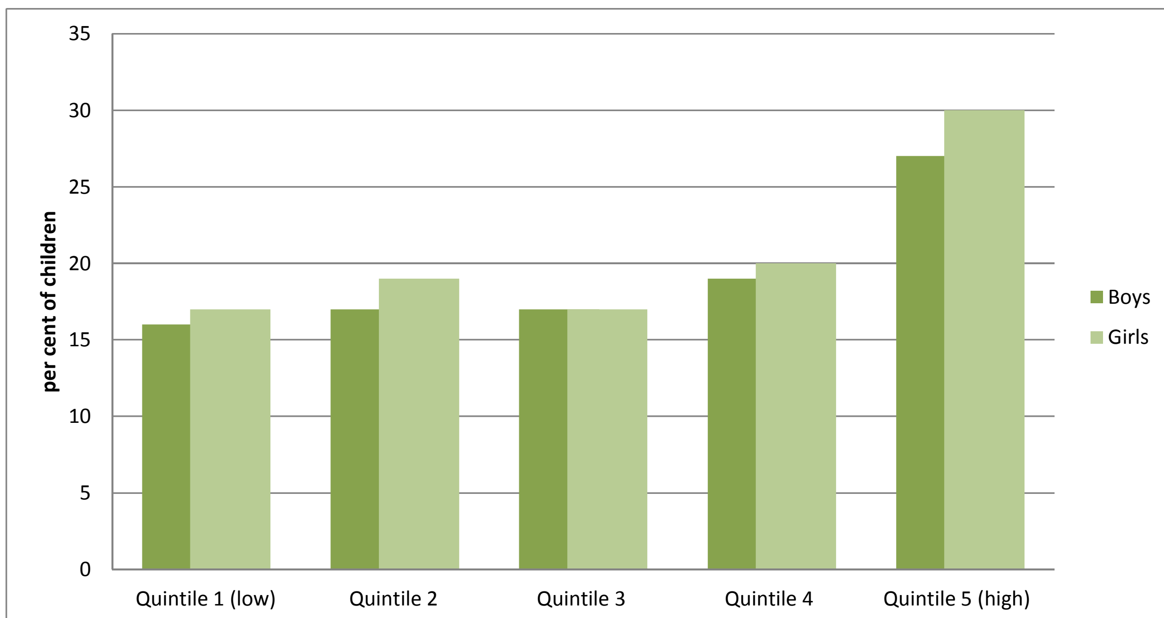
Figure 10 Obesity rates by deprivation decile at Reception and Year Six, 2010/11



Source: National Child Measurement Programme (2012)

Healthy eating also follows a social gradient, with children from higher socioeconomic groups more likely to eat five or more portions of fruit and vegetables in a day than their peers.[124]

Figure 11 Percentage of children (age five–15) eating five or more portions of fruit and vegetables per day by household equivalised incomes, 2008



Source: National Obesity Observatory (2012)

4.4.2 Improving physical development among young children

As well as working with many mothers, Children's Centres often work with midwives and GPs, which means they are well placed to target health promotion at pregnant women. There is evidence about the types of programmes that work to reduce the habits that create risks for causing low birth weight. Around one-fifth of women who smoke give up themselves before their first antenatal visit, which means that four-fifths do not.[125] While there are caveats around some of the evidence (many trials take place in managed-care settings rather than in the home and intensity of the programmes vary significantly), a review of targeted smoking cessation programmes for pregnant or new mothers found that programmes which included face-to-face support, self-help materials in print and telephone counselling were more successful than others. The review also found that programmes which take a family approach – that is, supporting partners to quit together and explaining the benefits for children – could have greater impact.[126] This was supported by research that suggests incorporating smoking cessation into discussion about social networks and routine health care can be effective.[127]

NICE guidance suggests that effective programmes are those that combine: brief interventions by a GP or other professionals working in a GP practice or the community (including advice, self-help materials and referral for more intensive support), individual counselling, group sessions, nicotine replacement approaches, self-help materials, and telephone helplines.[128]

Improving healthy eating behaviours is similarly difficult: a 1998 review by NICE of interventions that work in improving healthy eating found that while there is some evidence that programmes can improve 'nutritional knowledge', there was mixed evidence on improving healthy eating behaviour.[129]

5 Parenting promotes development

Parenting has the greatest influence on children's lives. From even before children are born, the way they are nourished, cared for, stimulated, and bonded with makes a big difference to how they develop across all of the domains of development.[130]

At both political level and among the public, arguments take place about what constitutes good parenting, who is to blame when good parenting is absent, and how to fix it. These discussions range from how we nurture and support 'good' parents to how quickly we should remove children from 'bad' parents. Our purpose is not to get involved in this level of discussion. Instead we focus on what the evidence suggests are the critical aspects of good parenting.

From birth, parents need to keep children healthy and safe, they need to create a stimulating and creative home environment and build strong attachments to them.[131] A literature review of positive parenting suggests that there are some characteristics that lead to better outcomes, including: parents expecting high levels of development, good supervision, appropriate disciplinary efforts, and sensitivity to and support for children's needs.[132] In the earliest days and months parents need to focus on creating secure and lasting attachment with their children through supportive and nurturing parenting. In the second and third years the needs become more complex and responding becomes more nuanced. In many cases at this time parents will need to be supportive and positive while also being instructive and directive.[133] Then change is needed again as between three and five, when nurturing and control seem most important.[134]

There are caveats around the evidence on parenting. Much of it takes a deficit approach, focusing on what has prevented positive outcomes or contributed to negative experiences for children, rather than seeking to understand the factors at play for children who thrive and succeed. Mothers have featured in most research as historically not only have they been the primary care-giver, but also fathers have not played much of a role (in terms of parenting: they have consistently played a part in mothers' support structures).[135] Research is starting to look at fathers although it appears that they still have less of an effect on children's outcomes than mothers.

5.1 Creating a safe and healthy environment

Outcome 9: Reduction in the number of mothers who smoke during pregnancy

Outcome 10: Increase in the number of mothers who breastfeed

One of the primary responsibilities of parents is protecting their children from harm. Young children – particularly babies – depend on their parents and care-givers. They need to be 'kept safe' by adults and their health needs must be met. Choices – particularly by mothers – will impact on long-term health and wellbeing.

There are many aspects to staying safe and healthy such as prenatal maternal nutrition,

drugs and alcohol use including in pregnancy, dental care and accident prevention. In section 6.2 we highlight parents' knowledge as a key enabling factor for parenting. Many Children's Centres offer programmes specifically to improve awareness in these areas.

Similarly, we include healthy weight among the desired child outcomes and this is hugely contingent on the parents creating a healthy environment and making healthy food choices.

Behaviours before and just after birth are particularly important for children's long-term health. In section 4 we discussed the impact of low birth weight and in particular the increased risks presented by prenatal smoking. Smoking during pregnancy is responsible for a significant proportion of foetal morbidity and infant mortality.[136] Smoking can cause low birth weight, significant reduction in growth of head circumference, abdominal circumference and femur length (a particularly strong indicator of healthy development). Prenatal smoking is associated with a 20–30 per cent higher likelihood of stillbirth, a 40 per cent increased risk of infant mortality and a 200 per cent increase in the incidence of Sudden Unexpected Death in infants.[137] Smoking in pregnancy is also related to increased risk of obesity in the early years (by age seven).[138]

Breastfeeding – and breastfeeding for at least six months – provides children with a healthy start.[139] Children who are breastfed are less likely to experience many of the infections and allergies of infancy and have lower risks of obesity in childhood.[140] Research suggests breastfeeding is particularly important for single and lower-income mothers, continuing to have a positive effect for these groups when their children were five years of age.[141]

5.1.1 Inequality in the safety of a child's environment

There is a social gradient in children's safety and health. Children born into poverty are more likely to die younger particularly from injury, to face a serious illness during childhood and to have a long-term disability.[142] Their early health impacts on their later life outcomes with increased risk of death even when taking into account the adult circumstances.[143]

Rates of prenatal smoking are higher in lower socioeconomic groups.[144] There is also a social gradient in breastfeeding. In one recent study 51 per cent of mothers from the poorest quintile attempted to breastfeed compared with 90 per cent of mothers from the most affluent quintile. Duration of breastfeeding also followed the gradient with poorer mothers spending less time breastfeeding (under 10 weeks in the lowest quintile compared with nearly 17 weeks in the most affluent). As

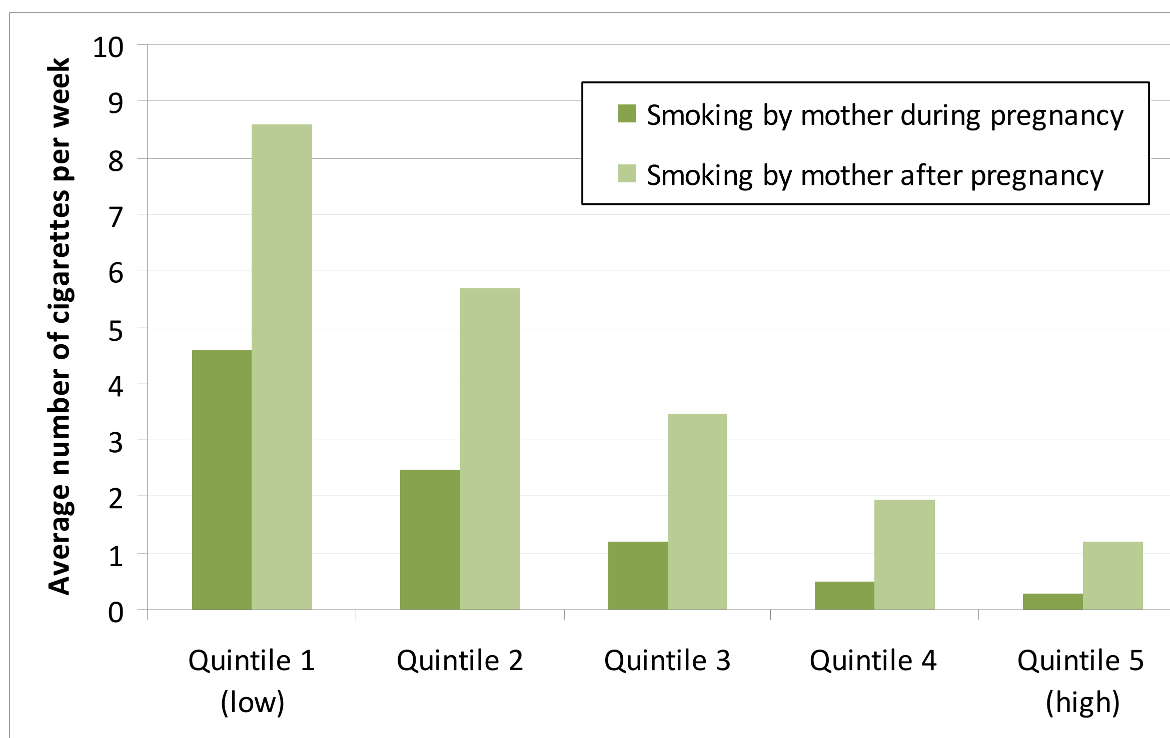
Figure 13 shows, the mothers in the highest quintile were also much more likely still to be breastfeeding when children were about nine months old.[145]

5.1.2 Reducing parental smoking in pregnancy

Elsewhere we show evidence that certain types of smoking cessation programmes are

particularly effective at curtailing smoking during pregnancy. Providing mothers with support, encouraging partners who smoke to also stop, and providing ongoing information as part of general health care all improve the efficacy of interventions.

Figure 12 Smoking among mothers during and after pregnancy by socioeconomic (SEP) quintile



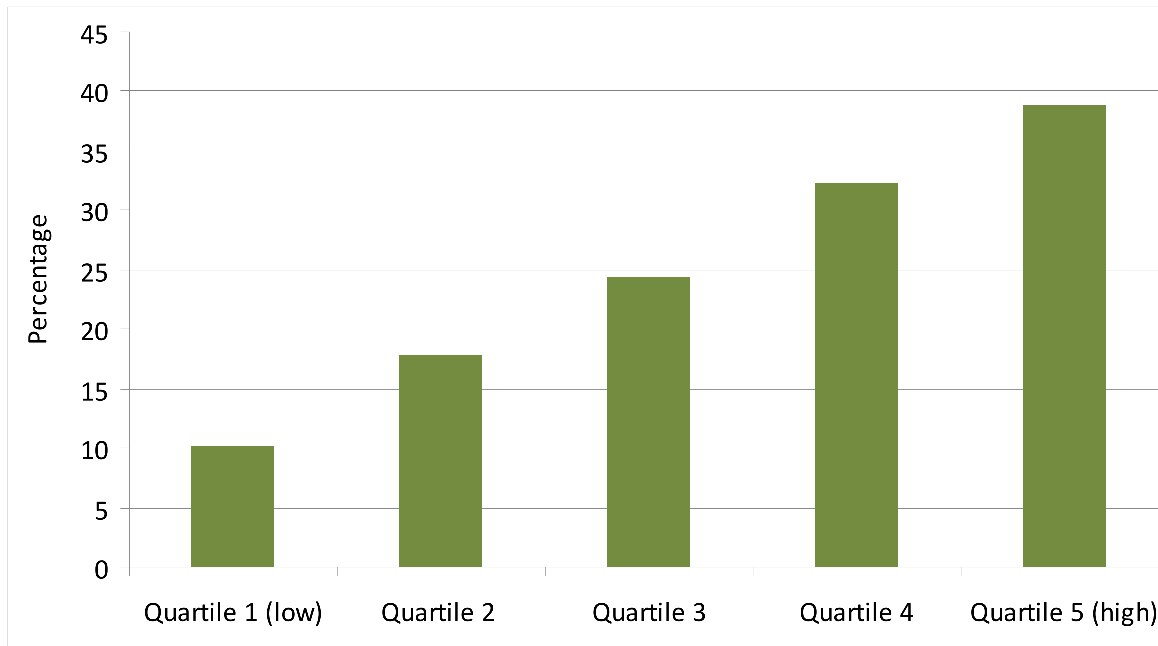
Source: Dearden L, Sibieta L and Sylva K (2011)[146]

5.1.3 Supporting mothers to breastfeed

During our visits we spoke to mothers attending a breastfeeding drop-in session. They told us that lack of knowledge and social stigma had made them nervous and unsure about breastfeeding their children. For many, they were the only mother they knew outside of the drop-in sessions who was breastfeeding and in particular felt uncomfortable breastfeeding in public. They found the drop-in sessions not only reassuring and comfortable – a place where they could breastfeed without concern – but also useful in building confidence and knowledge. NICE summarises evidence about what works to support mothers to breastfeed. Breastfeeding support and peer-to-peer support should be proactively offered to women in their communities and given to women immediately following birth, and this support should continue. Daily log-keeping by mothers and supportive reassurance for women who find breastfeeding challenging also shows promise.[147]

Most, if not all, Children's Centres offer breastfeeding support, including breastfeeding clinics and breastfeeding drop-in sessions.

Figure 13 Percentage of mothers still breastfeeding at nine months



Source: Dearden L, Sibieta L and Sylva K (2011)[148]

5.2 Promoting an active learning environment

Outcome 11: Increased number and frequency of parents regularly talking to their child

Outcome 12: More parents are reading to their child every day

Before they go to school, children's primary learning environment is their home. It is both a place to develop skills but also where children develop their interest and enthusiasm for learning. As Meluish writes,

> *Stimulating activities may help children with specific skills-enhancing development (e.g. linking letters to sounds) but also, and perhaps more importantly, by developing the child's ability and motivation concerned with learning in general.*[149]

The home learning environment (also sometimes called the communication environment) can be measured in a number of ways such as the presence and use of books and toys, the extent to which parents read to their children, trips to the library, use of letter, word and number games and so on. It is in effect where parents become what David *et al* call 'educarers' – intertwining development and care for their children.[150]

The EPPE study looked in detail at aspects of the home learning environment. Social activities (playing with friends, visiting relatives, shopping, watching television, eating meals together and regular bedtimes) were not found to be associated with children's attainment

in literacy and numeracy at age five. However other factors around 'clear learning opportunities', including frequency of being read to, going to the library, playing with numbers, painting and drawing, being taught letters and numbers and singing songs, poems and rhymes, were all found to have a significant effect on children's achievement.[151]

Owning books has also been shown to be associated with outcomes. Children in families that owned more books and were taken to the library more frequently at age two achieved higher scores on the school assessment when entering primary school than their peers.[152]

Conversation and reading are particularly important aspects of the home learning environment. Interactive conversation between children and their primary caregivers, someone they feel safe and secure with, supports longer-term outcomes.[153]

The complexity and breadth of vocabulary heard at home makes a significant difference to a child's language development by age three and their literacy development as they grow up.[154] It is not the amount that a mother speaks to her child but the number of word types that she uses when having a conversation.[155] Children's vocabulary is very strongly associated with their parents'. In one study, 86 to 98 per cent of the words in children's vocabulary were also found in their parents' vocabulary and by age three their vocabulary variation was similar to their parents'.[156]

The amount a parent reads to their child is repeatedly associated with outcomes much later in life such as employment and wages. The earlier the age that shared reading activities begin, the better the language outcomes at two years of age, particularly their receptive language. While no relation has been found between shared reading with children at four months of age and later language outcomes, shared reading at eight months has been shown to be strongly associated with children's expressive language at 12 and 18 months.[157]

In another study, 37 per cent of children whose parents did not read to them had 'very limited' language development at five years of age and only 18 per cent of children in this cohort had normal levels of language development. This is compared with children whose parents read to them every day, where only 21 per cent had very limited development and 40 per cent of children had normal language skills.[158]

Payne *et al* looked in detail at reading habits of 236 low-income families to identify associations with children's literacy development. They tested children's ability using the Peabody Picture Vocabulary Test-Revised and the Expressive One Word Picture Vocabulary Test, which both measure receptive and expressive vocabulary.[5] The results suggest that frequency of reading and number of books in the home are both very significantly associated with children's performance.

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[5] More detail on the PPVT-R can be found at www.michigan.gov/documents/mde/PPVT-IV_training_10-08_258864_7.pdf and more detail about the One Word test can be found in Gardner M F, *Expressive one-word picture vocabulary test,* Academy Therapy Publications, 2001.

5.2.1 Inequality in the home learning environment

The quality of home learning environment is associated with socioeconomic position.[159] The EPPE study found that eight per cent of the group of children who stayed at home came from families where mothers had achieved GCSEs at most.[160]

Meluish looked at a number of factors associated with differences in the home learning environment. He found that girls consistently had stronger home learning environments than boys. He also found differences between families from different ethnic groups which may reflect different approaches to the home learning environment.[161]

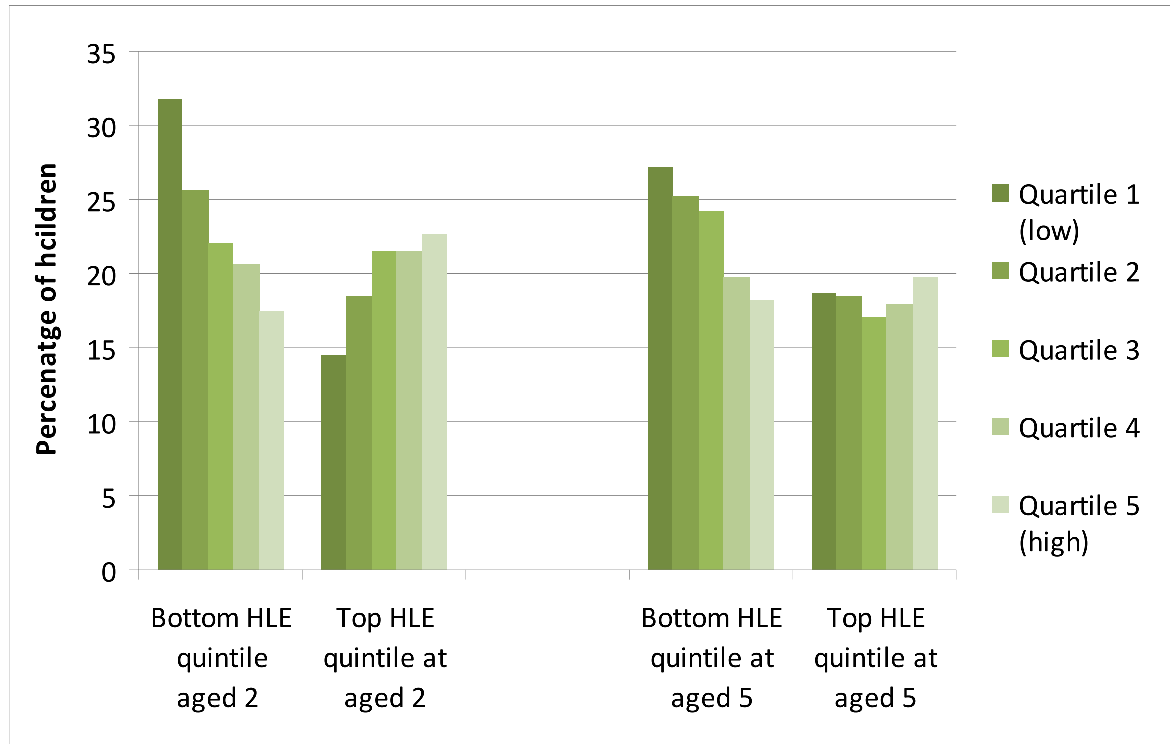
Evidence suggests the home learning environment accounts for between 16 and 21 per cent of the cognitive school readiness gap between low and middle income children.[162] But in environments where mothers provided more stimulation, child development on all measures was generally higher, regardless of maternal education level or indeed economic circumstance.[163]

One study, which focused on the home learning environment through the Home Observation for Measurement of Environment (HOME) inventory, found that measures of socioeconomic status such as occupation, income, education and home crowding accounted for up to 51 per cent of the variance in the environment, a finding which has been sustained in further research.[164] This echoed previous analysis that suggests that between 12 and 19 per cent of the difference in child language scores at age four can be accounted for by differences in the home learning environment.[165]

Children from poorer families have fewer experiences of a range of 'home learning' activities such as numbers/counting, learning songs, poems and rhymes, drawing and painting and being read to.[166] Parents from higher socioeconomic groups read to their children more frequently and took their children to the library more than families from lower down the social gradient.[167]

In an analysis of the Millennium Cohort Study, Dearden *et al* developed a home learning environment index comprised of seven specific activities. Figure 13 shows that the quality of the home learning environment followed the curve of the social gradient. Measures were taken when children were about 36 months old and again when they were five years old. By age five there were similar proportions from each socioeconomic position among those with the best home learning environment. However, a steep gradient remains among those with the poorest home learning environment. This may reflect the effect of starting school or even the success for some of Sure Start and other early intervention policies.

Figure 13 Quality of home learning environment against the social gradient[168]



Source: Dearden L, Sibieta L and Sylva K (2011)

*Children's socioeconomic position is an index based on a combination of income, mother's class, father's class, housing tenure and whether the family have experienced financial difficulties
** Home learning environment (HLE) is an index based on frequency of reading to child, library visits, play with ABCs/letters, teaching numbers/shapes, songs/nursery rhymes, drawing/painting

Analysis of key aspects of the home learning environment also shows a social gradient. There are differences in the quality of parental conversations with children. A number of studies suggest that mothers in more advantaged families spend longer in conversation with their children, have richer discussions, generate more responses and talking from their children and are more positively engaged during the discussion.[169]

Hoff's study showed mothers from higher socioeconomic status backgrounds spoke more, and used many more word types than mothers from mid socioeconomic backgrounds.[170]

Table 2 Average properties of maternal speech at Time 1

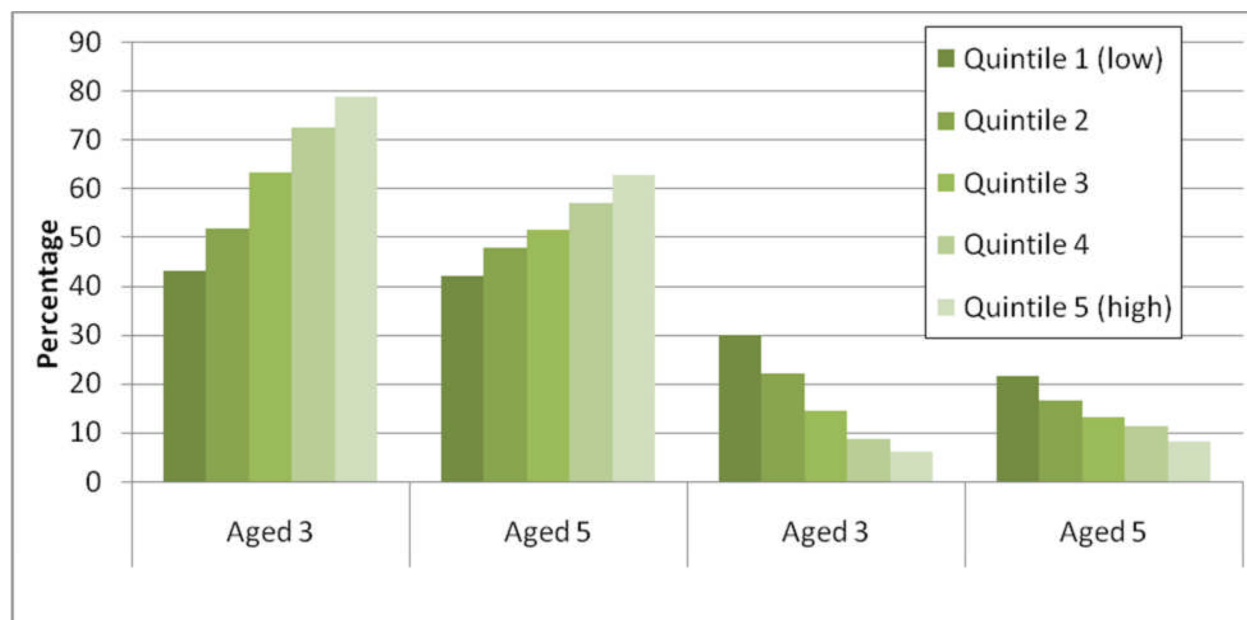
Maternal speech property	Mid socioeconomic status	High socioeconomic status
Number of utterances	522	697
Average number of words	3	4
Number of word types	269	324
Number of utterances in episodes of joint attention	101	101
Number of topic-continuing replies[6]	112	147

Source: Hoff E (2003) The specificity of environmental influence: socioeconomic status affects early vocabulary development via maternal speech

Children from families lower on the social gradient are also less likely to be read to on a regular basis; their parents are less likely to buy reading materials and more likely to allow them to watch a lot of television.[171] Dearden *et al* show that parents from the lower socioeconomic groups are significantly less likely to be read to on a daily basis at three and five years old.

[6] *Joint attention is defined as periods of time when the mother and child are focused on the same activity or object. Topic-continuing replies are responses made immediately by the mother and that refer to something that the child has just mentioned.*

Figure 14 Percentage of families reading to their children every day by socioeconomic status and wave of the Millennium Cohort Study, and level of television watching[172]



Source: Dearden L, Sibieta L and Sylva K (2011)

Mothers' education is strongly associated with the home learning environment. Mothers who have more education are more likely to provide more interactive parenting both inside and outside of the home. Conversely, where a good level of maternal education is lacking, the effects of parenting style appear more marked, with a strengthening of the relationships between some aspects of parental behaviour and several child developmental outcomes.[173]

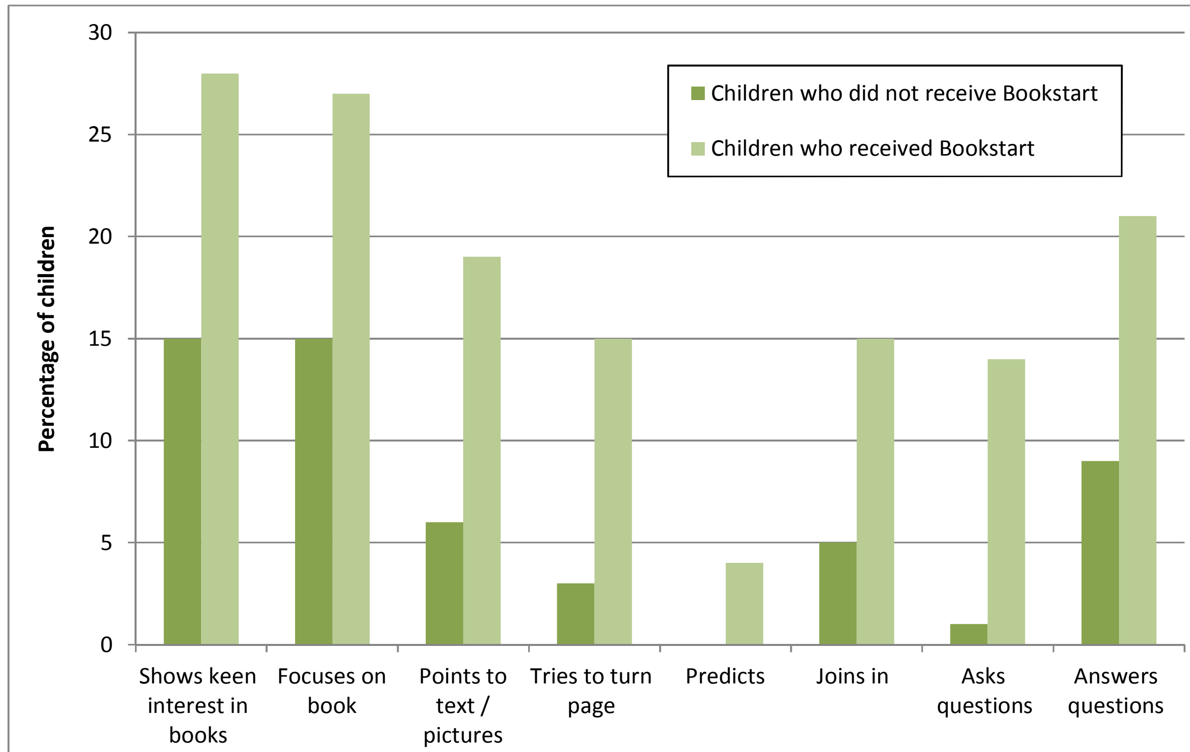
A strong home learning environment with parents reading to their children and taking an interest in their education is a protective factor against poor outcomes. Blanden found that being read to at age five was an important protective factor against poverty at age 30.[174] Evidence suggests that if half or all of the five-year-old children who are read to less than daily were instead read to on a daily basis there would be corresponding 10 per cent and 20 per cent reductions in the proportion of five-year-olds with socio-emotional difficulties.[175]

5.2.2 Improving the home learning environment

Children's Centres can influence the home learning environment. Book-giving initiatives have been shown to have a positive impact on children's engagement with reading, listening and speaking.[176] The Birmingham Bookstart programme provided families of nine-month-old children with a pack containing a book and information about literacy. Evaluations were conducted at six months, two and four years. The evaluations suggested increased levels of shared book reading, increases in active interaction with books, increased level of concentration and attention from the children and more encouragement by parents towards their children's enthusiasm and interest in books. The research also found that children who received the Bookstart bags were more involved than the comparison group children in the shared reading as indicated through things like asking questions, pointing,

and joining in with the reading. While these impacts are about the child they occur because of greater levels of reading from parents.[177] Bookstart is currently supported by government funding.

Figure 15 Child outcomes among those who participated in Bookstart compared to children who did not



Source: Wade B and Moore M (1996)

Kirklees Council built on this evidence and designed 'Babies into Books', providing parents with reading materials even earlier, when children were seven months old. The programme also provided literacy support groups for parents and children. Parents were interviewed at the outset of the programme and then again two months later. The research found that the number of books a child owned had increased (from an average of seven to fifteen) as had the frequency with which parents looked at books with their children. They had also increased the amount of painting or drawing that they did with their children.

The Peers Early Education Partnership (PEEP) programme provides parents with books and with support to read with their children through group sessions or home visits depending on need. A matched control study of PEEP has shown that children in the programme had greater improvements in their cognitive development than the control group.[178]

Further research suggests that the relationship between socioeconomic status and the home learning environment is complicated by wider factors including crowding in the home and number of siblings present, which research suggests may reduce both the amount and quality of parent/child interactions.

5.3 Positive parenting

Outcome 13: More parents are regularly engaging positively with their children

Outcome 14: More parents are actively listening to their children

Outcome 15: More parents are setting and reinforcing boundaries

Children need to interact with consistent care-givers with whom they develop a long-standing relationship.[179] The way that parents speak to each other and their children, how they solve disputes and problems, how they reward success and good behaviour, how they set and maintain authority and boundaries and the choices they make about nutrition all impact on their children.

In Norway increased paid and unpaid maternity leave reforms in 1977 led to an average increase in maternal leave by four months with no impact on family income. This presented an opportunity for assessing the impact of increased time with parents on children's outcomes including high-school drop-out rates, college attendance, IQ and height in men, and teenage pregnancy rates. The research found that the increased time led to a nearly three percentage point decrease in high-school drop-out rates for all children and a five percentage point decrease for children of mothers who had low-level education.[180]

Time is not the only necessary ingredient, however: children need a warm and nurturing environment to thrive and develop.[181] This is primarily to build the attachments and relationships that are so fundamental to early development. Bowlby's theory of attachment, first published in the 1950s, still influences our understanding today; much further research reconfirms that attachment is a foundational building block for social and emotional development. The quality of attachment is linked to the development of a number of children's characteristics including development of self, building a conscience, emotional understanding and self-regulation. Security of this attachment is also associated with self-worth and resilience.[182] Children with a strong sense of attachment ('secure histories') are more self-confident, have higher self-esteem and are more able to self-regulate. Those with the greatest level of security have a stronger ability to 'bounce back after stress or difficulty' and are more 'curious'. They are less likely to react negatively to stress or uncertainty and have a lower propensity to display aggression or frustration in the face of stress.[183]

Increased maternal responsiveness has also been shown to facilitate growth in children's social, emotional, communication, and cognitive competence, suggesting a causal role for responsiveness on infant development.[184] Our understanding of these interactions is growing. Children do not only need to be engaged but they also need a 'contingent' relationship, one in which they initiate interaction, and these advances are welcomed.[185] Studies suggest that mothers' efforts to maintain their child's attention have positive effects on cognition and socio-emotional skills.[186]

A mother's warmth does not only enable positive outcomes but also protects against poor outcomes.[187] One study found that a mother's flexibility in response to her child changing

tasks moderated the association between socioeconomic status and verbal-visual-spatial processing at 24 months.[188] Increased warmth of the mother's interaction supports children who have particularly high levels of negative emotional reactions to modify and calm their responses.[189] Her awareness of her child's emotional health and her capacity to prioritise the child's emotional needs over her own has significant impacts on that child's outcomes.[190] Parental attention can significantly reduce the risk factors of poor outcomes associated with poverty.[191] The impact of involvement is found to be particularly strong for children born with low birth weight.[192]

Conversation – interactive rather than passive – is also a critical part of this interaction. Conversation serves to both confirm children's feelings about the world and to extend their understanding of their environment.[193] It supports the development of children's own language skills.[194] Babies whose cooing (usually beginning around three months) receives positive responses feel confident and are more likely to engage in verbal exploration and development.[195]

Rewards can come from body language as well as verbal language. Children rely on body language to understand their environment before they understand words and they can misinterpret body language just as they can spoken language.[196] Eye contact is also critical: children use their parents' faces as sources of information about their environment.[197]

Dismissive or aggressive responses to children who attempt to engage with their parents have long-term effects on development which began even in the earliest years. One study found that a mother's vocal responsiveness and responsiveness to her child's distress explained 25 per cent of the difference in IQ as early as three months old.[198] Children in these types of interactions learn to withhold and ignore their feelings even though feelings are necessary for navigating the world.[199]

Positive reinforcement is critical as is setting appropriate boundaries and managing problematic behaviour in a nurturing way. Children need to be 'protected' from disapproval, teasing or punishment, particularly around behaviours that are part of their exploration and experimentation of the world. They need to have permission and safety to make mistakes and errors as they develop new skills or seek new information. Children also benefit from having their achievements and advances celebrated by the adults around them, particularly those they spend a lot of time with.[200]

This is particularly important for babies who have yet to develop physiologically to respond to punishment or reprimand.[201] Observations of the level of conflict in mother–child interactions found that it was the manner in which conflict was resolved including how and if the mother justified her actions and the level of compromise reached rather than the presence of conflict itself that had the biggest association with attachment security.[202]

Children also need to be protected from stress.[203] The National Scientific Council on the Developing Child in the United States identifies three types of responses to stress in young children based on the extent to which the responses may cause long-term psychological

disruption. The three types vary in two important ways: the length and severity of the adverse experience and, critically, the presence or absence of a responsive caring adult who is already a constant in the child's life. Stressors that are short and in particular where children are supported by a trusted adult do not have significant impact on children's development and can help build coping mechanisms that are useful throughout life.

However, stressors that are sustained, and/or occur when a child does not have an adult to turn to, cause significant changes in children's hormones and brain activity. These compound each other: children's brain activity is disrupted, their hormone levels are raised and organ function is disturbed. The impact is such that there are visible changes to the brains of children who suffer from toxic stress.[204]

Toxic stress is defined as:

> *The excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships.*[205]

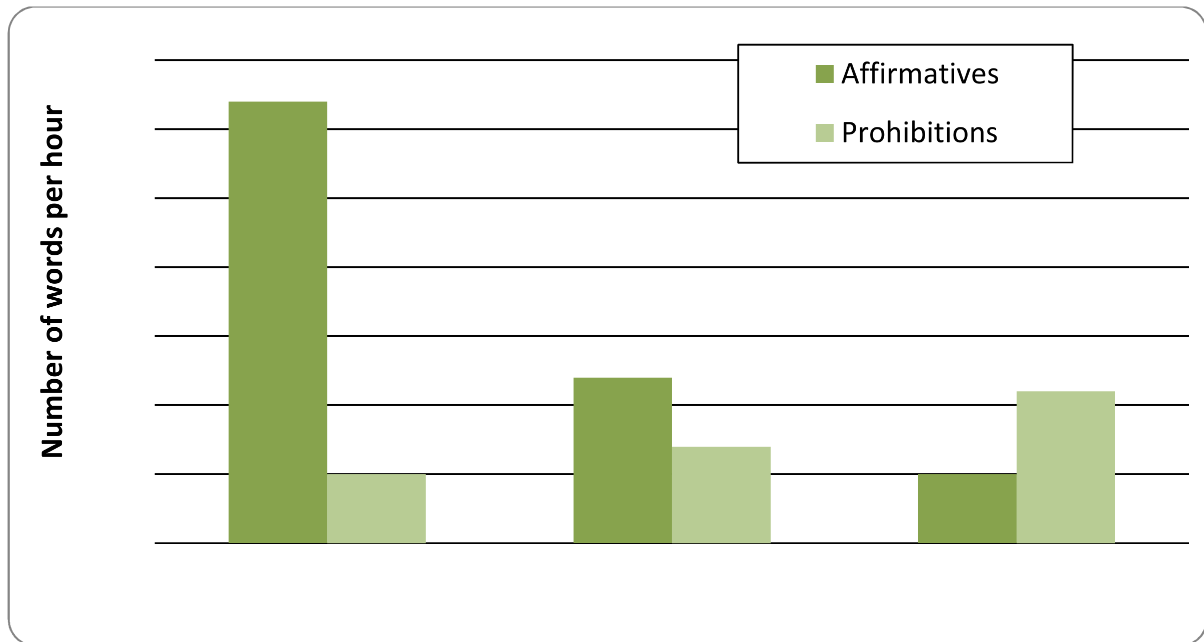
This biological impact of toxic stress is linked to a range of poor outcomes including poor health, poor cognitive development, social, emotional and linguistic deficits, lower levels of resilience and coping, higher rates of externalised behaviour, harmful health decisions and disproportionate responses to lower levels of stress – all of which we have shown to link to later life experiences. [206]

5.3.1 Inequality in the quality of parenting

While positive parenting is found widely across the social gradient, Bradley and Corwyn summarise a wealth of research that indicates that lower socioeconomic status is associated with behaviours that include harsh and negative parenting and an absence of positive parenting. The research suggests that the absence of positive parenting itself has detrimental effects – not just the experience of negative parenting.[207]

Hart and Risely, in a United States-based study, looked at the ratio of affirmations to prohibitions in different families. They found that in professional families in an hour there would be an average of 32 positive comments and five negative ones. In families in the middle of the socioeconomic gradient the ratio was 12 positive to seven negative comments. In families receiving benefits there were 11 prohibitions and five affirmations in an hour – more negative statements than positive.[208]

Figure 16 Average affirmations and prohibitions per hour by socioeconomic status in the US



Source: Hart B and Risely T R (2003)

Lack of boundaries also follows a social gradient. Dearden *et al* again provide useful insight into the distribution of particular characteristics across the social gradient at 36 months of age. This is summarised in Figure 18 below.[209]

Figure 18 Boundary and rule-making behaviour in households by socioeconomic position

Source: Dearden L, Sibieta L and Sylva K (2011)

5.4 Having an impact on parenting

Research by Belsky and Fearon found that children who were insecure and poorly attached

at 15 months, who then received very sensitive parenting, improve significantly, while children who were secure but then experienced a decline in their environment become less secure.[210] Other research suggests that programmes such as home visiting and maternal support can make a difference to levels of attachment between a mother and her child.[211]

Research by Hashim and Amato suggests that the level of punitive behaviour by low-income families can be positively influenced by social support. Families below the poverty line with two or fewer sources of support had a greater probability for punitive behaviour than families in similar socioeconomic circumstances but with three or more sources of support. For families above the poverty line, however, there was very little difference in probability.[212]

While parenting programmes represent a significant proportion of Children's Centres' provision, the evidence about what works is still developing.

There is an emerging menu of what works in general:

- *Home visiting:* All families in the UK receive some form of home visiting in the first few weeks of life from their Health Visitor but this is more frequent and focused for some than others. Home visiting programmes that are successful often focus on targeted populations with well-trained and adequately supervised staff delivering a range of services over a significant duration.[213]
- *Focusing on parents' own resources:* Parents want support to build their own confidence, develop their own skills as parents and access to local services and facilities, giving them the resources to have a positive influence on their children.[214] Pregnancy and just after birth are particularly effective times to do this. A review of 47 interventions of 'anticipatory guidance' given to mothers by health workers led to reduced stress and improved parenting confidence.[215]
- *Clear aims and objectives:* Sure Start evaluation suggests that in order for programmes to work they need to have clear objectives – and that parents and providers can measure progress against these. It is not enough for parents to enjoy the intervention: they must also achieve some sort of discernible change.[216] Programmes that translate these aims and objectives into a structured curriculum are more effective. The evidence does not suggest a specific curriculum, just that a curriculum followed with fidelity makes a difference.[217]
- *Enabling parents to practise at home:* Programmes that support parents to take the tools and approaches they learn and practise them at home also show promise. [218] The programmes should incorporate ongoing attention to ensuring attendance.[219]

- *Bringing together care and learning*: Programmes that do this, and focus on both cognitive and non-cognitive development for the child and the mother, were powerful as well.[220] Focusing on behavioural changes that require improvement in a number of parents' resources were found to be more effective than other approaches. [221]

Programmes with a curriculum, those covering positive parent–child interaction, emotional and communication skills, use of 'time-out', parental consistency and requiring parents to practise new skills were more effective. A review of health-led parenting programmes found that those that began ante-natally and worked through the first two years of life were particularly effective.[222]

The Family Nurse Partnership (FNP) provides nurse home visiting to low-income first-time mothers, delivering about one visit per month during pregnancy and the first two years of the child's life. Evidence from FNP's predecessor in the US has shown that this model significantly helps improve infant health and care of children early in life.[223]

Another programme, in use by a number of Children's Centres, is Incredible Years**.** This programme provides parent training through video-based learning. Primarily for families with children who have significant behavioural challenges, it has shown impacts on parents' ability to manage their children's behaviour and to contribute to improvements in both conduct disorder and attention.[224]

The Brazelton Neonatal Behavioural Assessment Scale is used to give parents a greater understanding of their baby's states of being to increase parental awareness and then respond to their children more effectively. A meta-analysis of interventions has found a small to moderate beneficial effect on parental behaviour.[225]

Parenting programmes can be effective in numerous ways, providing necessary knowledge and skills, building self-confidence and self-efficacy, contributing to greater resilience and offering support. Parenting programmes may also utilise the power of social networks, building on evidence that people often follow the behaviours of those around them. If few mothers in a neighbourhood are breastfeeding then new mothers are less likely to breastfeed.[226]

6 Parent context enables good parenting

Parents' lives influence their parenting. There are a number of factors that shape the way in which parents 'parent', in particular their mental wellbeing and the level of stress in their lives. Factors such as support networks and financial security can either be protective or can add to the stress and threaten mental wellbeing. The Core Purpose document for Children's Centres recognises this, placing the health and wellbeing of parents firmly within the remit of Centres.

Poorer parents operate in a particularly challenging context with many aspects of disadvantage influencing their lives.[227] In their book *The Spirit Level*, Wilkinson and Pickett show how so many of the factors that shape the context of family lives are socially graded. They argue that without tackling inequality at the basic societal level, it will be very hard to create more equal outcomes in particular areas.[228]

Many Children's Centres have taken the role of tackling inequality very seriously, helping parents to maximise their incomes, develop work-related skills and find jobs. At the same time there is evidence that Children's Centres can improve parenting but unless steps are taken to support parents' health and wellbeing these impacts may be minimal and limited.

6.1 Good mental wellbeing

Outcome 16: More parents are experiencing lower levels of stress in their home and their lives

Outcome 17: Increase in the number of parents with good mental wellbeing

Outcome 18: More parents have greater levels of support from friends and/or family

Good mental wellbeing puts parents in the position to nurture their children: it means low levels of stress and high levels of support from friends and family.

Low levels of mental wellbeing impact on children in different ways. Poor mental well-being can directly influence the parent–child relationship by making parents unpredictable or irrational, creating a harsher discipline environment, impacting on children's ability to form attachments and to create trusting and nurturing relationships with adults. Indirect effects of poor parental mental wellbeing can stem from insecurity and disruption in the child's environment and in the parent's capacity to focus on their child.[229] The impact begins before birth; antenatal maternal stress can impact on foetal development.[230]

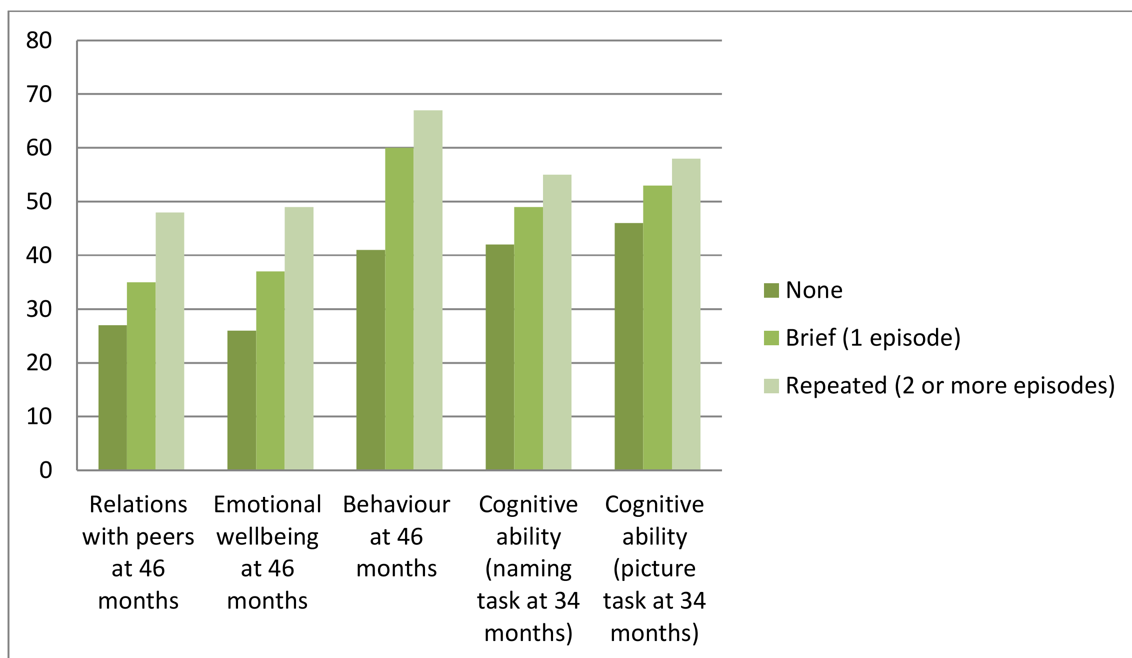
Parents' mental health is also associated with other positive outcomes. As de Coulen *et al* write: "...the greater parents' life satisfaction, the fewer behavioural and emotional problems their children exhibit".[231] Depression is the most prevalent form of mental ill-health: at least 10 per cent of women will have a depressive episode serious enough to be diagnosed and between 10 and 17 per cent of new mothers will suffer from some form of postnatal depression.[232] Estimates suggest that as many as 35 per cent of women of childbearing age suffer from depression at some time.[233] Parents who suffer from poor

mental health at some point in their lives are at greater risk of suffering it a second or even third time. Two-thirds of mothers with poor mental health in the first 'sweep' of the *Growing up in Scotland* research were in a similar situation during follow-up.[234]

The impacts of poor maternal mental health on children are significant.[235] They begin even before birth as maternal depression can contribute to low birth weight.[236] From birth they can impact with lower rates of breastfeeding.[237] Impacts of maternal depression on children include delayed language development, greater levels of misconduct, reduced social and emotional competence, sleeping problems, physical ill health and lower levels of attachment with its associated detrimental effects.[238] Even short periods of mental ill health can impair children's social, emotional and behavioural development, although not as significantly as for children who face prolonged or repeated exposure.[239]

Children's attachment levels are affected, with impacts for their cognitive development by the age of 18 months.[240] However, as Marryat and Martin show, at the age of 34 months mental wellbeing was no longer associated with children's cognitive development – and became more associated with their social and emotional skills. By the age of four, children living with mothers who had repeated and/or prolonged mental health problems were particularly likely to have poorer behavioural, emotional and social outcomes than their peers.[241]

Figure 17 Child outcomes in relation to maternal mental health status (per cent)



Source: Marryat L and Martin C (2010)

Children's behaviour is clearly significantly impacted by maternal mental health. However, the difference is less steep for their cognitive development. Further analysis suggests that the difference in cognitive development is no longer significant once other socioeconomic factors were considered (such as maternal educational attainment, living in areas of

deprivation and in urban areas, larger family size and persistent poverty).[242]

Friends and family provide a rich support basis whether or not one is a parent. This becomes even more important when the daily challenges of parenting begin as well as the desire to share joy and excitement. Social networks help people to manage their lives and the complexities that they face on a day-to-day basis. Other people act as role models for behaviours and approaches, and have a shared understanding of both the stresses and the rewards of parenting.[243] Strong social networks act as protection against other risk factors for poor outcomes and provide a buffer to the daily challenges of parenting.[244]

Evidence shows that strong networks for parents protect against poor outcomes for children.[245] Mothers with extensive social networks have more positive interactions with their children than mothers with smaller networks.[246] They tend to praise their children more and are less controlling than mothers who are not happy with their social networks. Higher rates of child abuse are found in socially isolated families, and social support has been found to moderate the impact on child harm.[247]

Low social support was found to be independently correlated with poor maternal mental health.[248]

Four types of social networks have been identified: emotional support involves providing love and empathy to another, instrumental support includes tangible assistance such as food or giving someone a lift somewhere, informational support delivers new knowledge for problem-solving and appraisal support provides someone with information about self and own behaviours.[249]

Social networks also shape values and behaviours; people often behave like those with whom they engage. This relationship may be partly mediated through improved maternal mental health, since the size of mothers' social networks is positively correlated with measures of their mental health. One study of teenage mothers (a risk factor for their children's later life outcomes) found that having nurturing grandparents was associated with greater levels of nurturing by the young mothers towards their children.

One key aspect of engagement with social networks is willingness to ask for help. Not seeking help or engaging with services is likely to impact on the ability to identify problems at all levels of intervention.[250]

The quality of the closest relationship – such as between partners – also shapes children's outcomes. Children whose parents (biological or not) had poor relationships are likely to have poorer preschool relationships with their peers, independent of any other factor. The poor parent relationships also affect maternal mental health and therefore have a secondary impact on children's outcomes.[251] Marital discord is one creator of stress. Within every study where it was assessed, there were highly significant associations between marital quality, particularly marital disharmony and conflict, and mental health.[252]

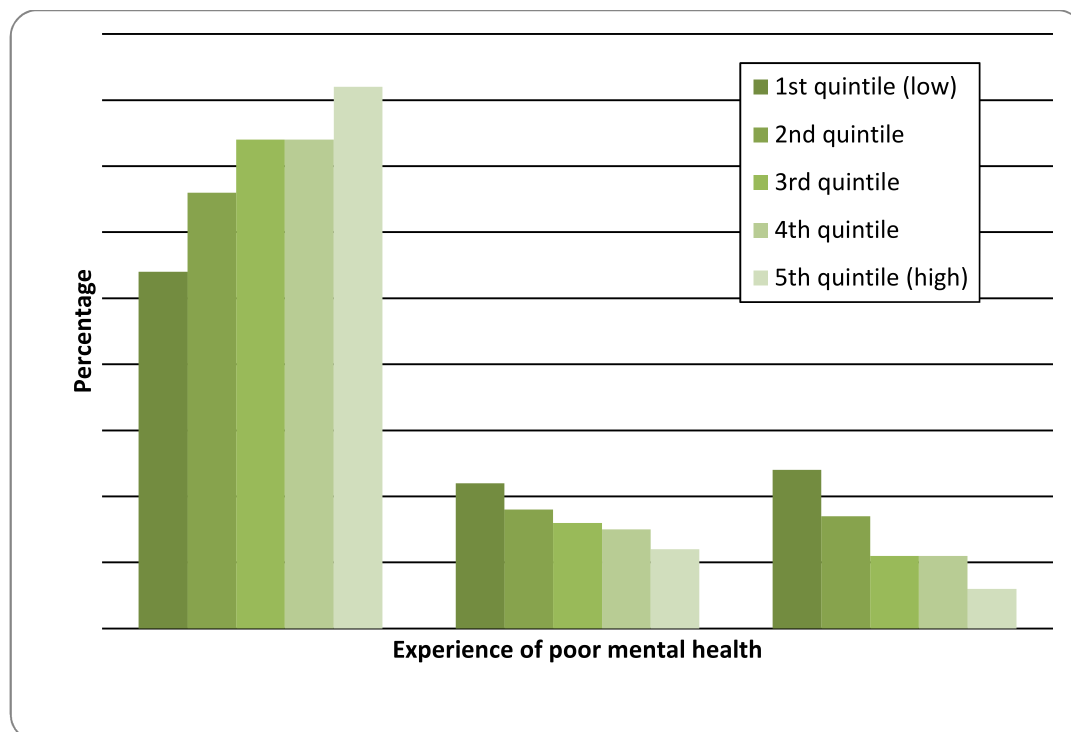
6.1.1 Inequality in mental wellbeing

Disparities in mental wellbeing exist across the social gradient. Levels of poor mental health are higher in poorer socioeconomic groups, as are the factors that lead to high levels of stress including lack of financial resources, low levels of social support and difficult relationships.[253]

Stress is distributed unevenly across the population: families from lower socioeconomic backgrounds carry a disproportionate share of the burden of stress including more fractious relationships, greater numbers of emergencies and less support to respond.[254] In a study of stress in the US those on lower incomes were more likely to experience stressful reactions (such as irritability or anger, feeling nervous or sad, lack of motivation or energy, feeling as though you could cry) than their better-off peers.[255] This leaves parents less resilient and the stress can account for a significant proportion of the difference in outcomes for children from different socioeconomic groups.[256]

Depression and poor mental health also follow the social gradient. *Growing up in Scotland* found that 82 per cent of families with higher incomes (over £33,571) had no instances of poor maternal mental health over the course of the study, while only 54 per cent of the families in the lowest quintile (under £8,410) had no instances of poor mental health. Twenty-four per cent of the poorest families had repeated mental health problems while for families in the highest income bracket this figure was only 6 per cent.[257]

Figure 18 Poor maternal mental health experience by quintile of household income (per cent)



Source: Marryat L and Martin C (2010)

Poor mental health was also associated with a number of socioeconomic factors that follow

the social gradient, including living in a low-income household, living in poverty (brief or persistent), living in an area of deprivation, having low social support or low relationship strength. Living without a garden in an area of deprivation and in an urban area was also associated with higher levels of poor mental health.

Social networks and strong relationships also follow the social gradient. Mothers living in poverty are more likely to be socially isolated than non-poor mothers.[258]

The three specific outcomes we focus on often co-exist: mothers who experience a significant stress in their lives and have low levels of support are more likely to become depressed after another stressful episode as are mothers who are not employed outside of the home. Mothers who did not have supportive partners (either they were single or in an unsupportive relationship) and/or lacked economic resources were more likely to be depressed during pregnancy and after birth.[259]

6.1.2 Improving parents' mental wellbeing

Recent developments in how to improve mental health and wellbeing have focussed both on the potential benefits of more clinical, individual focussed interventions such as cognitive behavioural therapy, through group work into more population based interventions including mental health promotion. [260]

A 2007 NICE published review of programmes aiming to support mental health and wellbeing concluded that while there are many evaluated interventions the quality of evaluation is often lacking. However it did identify that both behavioural and cognitive behavioural interventions have been shown to improve levels of confidence in parenting skills and self-esteem, and reduce levels of guilt and the frequency of automatic negative thoughts. [261] Since then there has been the roll out of the Increasing Access to Psychological Therapies programme. On the mental health promotion side there has been increasing interest in the 5 a day approach. This approach is about encouraging people to take 5 simple steps in their lives which have been shown to lead to better mental wellbeing (see box below),

Five Ways to Wellbeing

Connect…
With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active…
Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice…
Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

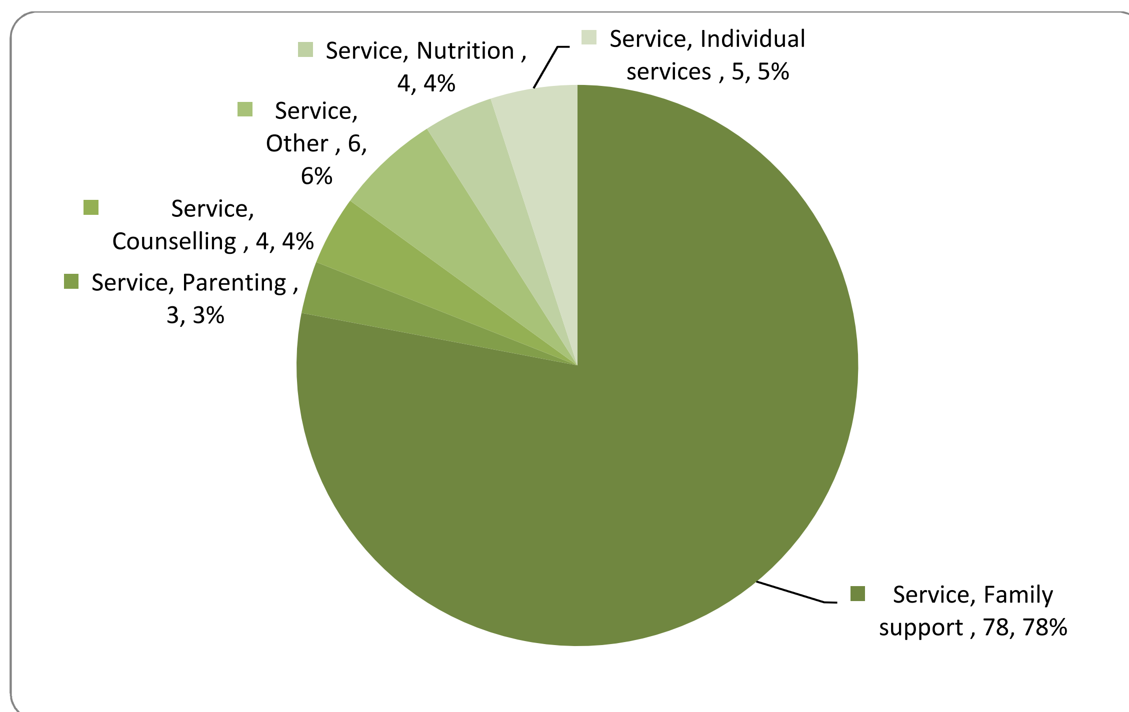
Keep learning…
Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give…
Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Source: NHS Confederation / New Economics Foundation (2008)[262]

Family support represents a significant proportion of what Children's Centres provide. There is no single definition of family support. It can – and often does – include one-to-one support to a family from a named 'family support worker' and may also include group activities run by the Children's Centre. Research by Tunstill and others explored what was being delivered in Children's Centres run by Action for Children. Seventy-eight per cent of services were classified as 'family support'. The remaining 22 per cent was allocated between individual services, counselling, parenting and nutrition.[263]

Figure 19 Distribution of services in Children's Centres



Source: Blewett J, Tunstill J, Hussein S, Manthorpe J and Cowley S (2011)

The evidence base about the impact of family support, particularly intensive family support, is growing. Intensive family support brings together a number of services. This is coordinated by a family support worker rather than by the family itself. Further research by Action for Children found that this type of support can raise the self-esteem and self-efficacy of parents. Other studies find that intensive family support helps improve relationships between family members and reduced feelings of depression, and reduces levels of anxiety, anger and stress in children.[264]

Features of successful family support include: ongoing support when the intensive phase has ended, a strong relationship with a significant professional and working from a universal centre so as not to introduce a sense of stigma. Programmes with an intensive period of home visits from the same and consistent professional are also very important.[265] These themes, particularly the need for a trusted single professional, were echoed by the parents and frontline professionals that we met. Often the parents that we met ascribed their attachment and engagement with the Centre as being dependent on one or two specific members of staff.

In March 2010 the Department for Education released data about the impact of the Family Intervention Projects (FIPs). FIPs are a targeted programme of support to families with multiple risk factors across social, economic, behaviour and health domains. In total the service was supporting about 4,800 families. Among other changes, the evidence showed a 46 per cent reduction in marriage and relationship breakdown, an 18 per cent reduction in families with mental health problems and a 15 per cent reduction in families where no adult

was in education, employment or training (although 59 per cent of families still had this risk factor at the end of the evaluation).[266]

Specific interventions such as the UK Parent Advisor Service, which provides counselling to parents through health professionals acting as parent advisors, also show promise. Parents reported reduced levels of stress, anxiety and more positive attitudes towards their children. They also reported improvements in their children's behaviour.[267]

6.2 Knowledge and skills

Outcome 19: More parents are improving their basic skills, particularly literacy and numeracy

Outcome 20: More parents are increasing their knowledge and application of good parenting

One factor that shapes parenting is the knowledge and skills that underpin an individual's approach. This incorporates their understanding of how to keep a child safe and help them thrive physically, the importance they attach to stimulation and activities such as play and reading, as well as the necessary capabilities, such as sufficient literacy to do so, the way they seek to build a relationship with the child and how they manage behaviour and set boundaries.

The concept of a 'good' parent is still emerging and is complex given the variety of factors that operate in the transmission between parenting and children's outcomes. However, the pressure on parents to perform and to support their children is very evident.

Evidence suggests that parents are becoming less confident and sure about how to nurture their children.[268] The academic findings are echoed by the parents we spoke to – mothers and fathers – who repeatedly credited the Children's Centre with helping them to learn new and improved ways to support their children, particularly how to nurture them and how to discipline them appropriately.

Research suggests that parents have their own schemas for parenting that are shaped in large part by the way they were parented themselves. Parents are not always aware of these traits and how they do or do not align with what works best for children – and for *their* children. For example, a parent who has experienced overly rigid parenting themselves may apply this to their own children, or a parent who grew up with too much freedom may follow the same pattern.[269]

There is a large body of evidence which shows links between parenting knowledge and outcomes for children. A study by Benaish and Brooks-Gunn of parents of children born prematurely showed an association between parenting knowledge and the quality of the home environment, behavioural problems and cognitive outcomes in young children.[270] Of course, the host of modelled interventions discussed in the previous chapter are based on the idea that knowledge and understanding of parenting leads to better outcomes.

Parents, particularly new or young parents, may not be aware of how much their child depends on them to learn to talk and communicate effectively, particularly when they are babies.[271] Understanding when and how to support children is particularly important. Parents whom we met throughout our work said that they needed to know more about how to support their children and that the information and knowledge that they received from the Children's Centre was invaluable. This was particularly true for parents of children with learning difficulties and other special needs. Their qualitative input echoed evidence that parents can develop more effective parenting skills, in particular if they pay close attention to a child's responses.[272]

6.2.1 Inequality in knowledge and skills

As Table 3 shows, parents' own perceptions of themselves as good parents follow the social gradient, with poorer parents (mothers and fathers) having lower perceptions of their effectiveness. Measures were taken when children were about 36 months old.[273] It is also noticeable that across the population, few parents rate themselves well.

Table 3 Parents' self-reported views of their parenting quality (per cent, figures rounded up)

Per cent	Quintile				
	Bottom	2nd	3rd	4th	Top
Mother rates herself as a good parent	16	21	25	29	37
Mother rates herself as a very good parent	27	30	28	29	27
Father rates himself as a good parent	18	19	26	30	37
Father rates himself as a very good parent	27	31	32	31	30

Source: Dearden L, Sibieta L and Sylva K (2011)

De Coulon *et al* showed that parents' literacy and numeracy skills have an independent impact on children's cognitive development even when a number of other potential explanatory variables such as parents' qualifications, socioeconomic status, the home environment and parents interactions are taken into account. The research also found that parents' basic skills impact on children's social and emotional outcomes. There was no difference in impact levels between mothers and fathers although mothers' skills seemed to be more associated with their daughters' outcomes while fathers were more significant for their sons.[274]

Poor parental literacy is related to poor child health, and children whose parents improve their literacy skills have fewer health problems, better nutrition and fewer negative life problems including teenage pregnancy and exclusion from the workforce. In the United States poor literacy skills are closely linked with poor health and higher rates of earlier mortality.

Parents' own experience of education also has an impact. Parsons and Bynner found that 17 per cent of parents with low levels of literacy had children who at 34 months reported

having challenges with reading (currently or previously) versus six per cent of those with parents who had competent literacy skills.[275]

6.2.2 Improving knowledge and skills

There is evidence that boosting the literacy skills of parents translates into improved outcomes for children. As Carpentieri *et al* write, "Family literacy programmes are effective, both in improving child literacy and improving parental support skills."[276]

For example, the Turkish Early Enrichment Project and the Mother-Child Education Programme show that the children of mothers who engage in improving their literacy through the programmes perform significantly better at school. At age 13–15, children whose mothers were involved in TEEP had much higher vocabulary scores and were more likely to be in school than children whose mothers were not involved and this increase in vocabulary was sustained until they were 25–27 years old. The Mother-Child Education Programme focuses on training mothers to develop 'co-work' with their children.[277] The use of at-home work focusing on the mother–child interaction shows positive results across a number of studies.[278]

A review of literacy programmes in the United States shows that literacy skills can be improved and that they lead to improvements in other areas of people's lives. Programmes such as Even Start, a family literacy programme, show that parents' written and oral literacy skills improved. Parents then increased the following: their interest and engagement in their children's learning at home; the amount they read to their children by 40 per cent; the number of bought or borrowed books for their children by more than 40 per cent; and the amount that children asked their parents to read to them increased 20-fold compared with before their involvement in programmes.[279]

Knowledge is not enough: parents also need to believe that they – and their actions – can have an impact on outcomes for their children.[280]

The evidence on the impact of literacy programmes across the socioeconomic gradient is mixed. Some studies suggest that literacy programmes have a smaller impact on families lower down the socioeconomic spectrum than their more affluent peers while other evidence suggest that there is no difference between the socioeconomic groups.[281]

6.3 Being financially self-supporting

Outcome 21: Parents are accessing good work or developing the skills needed for employment, particularly those parents furthest away from the labour market

Throughout, this report highlights the way that many key outcomes of childhood and their drivers are distributed unevenly by social background and economic situation. There is a gradient where adverse outcomes are experienced most often by the poorest and best outcomes experienced most frequently by the most affluent. A wide range of evidence throughout this report has highlighted this stark reality. Figure 20 shows this on a key

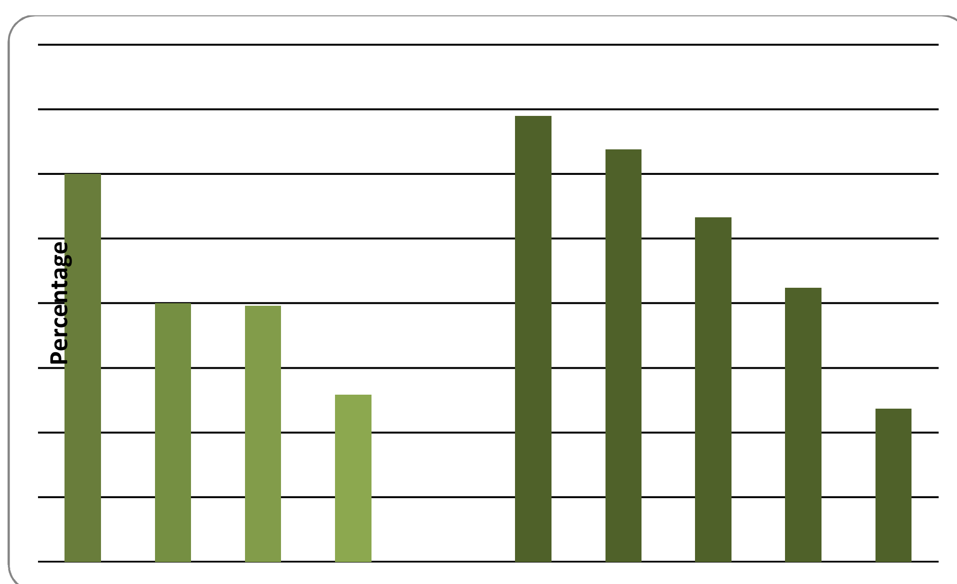
indicator of early child development: the Early Years Foundation Stage Profile. The proportion of those who experience persistent poverty in the early years who then reach a good level is much less than half of those who do not experience any poverty. Among the poorest quintile of children, just over 30 per cent reach this level compared with nearly 70 per cent in the top quintile.

Poverty is associated with the quality of parenting, as we have explained above. It is also independently associated with poor outcomes for children. The impact of poverty varies in large part by the duration (short spells are significantly less harmful) and by the timing (poverty in the earliest years has a greater impact than in later life). Duncan *et al* looked closely at the independent impact of poverty on children's outcomes and found it to be significantly correlated with IQ, internalising and externalising behavioural problems. Children in poor families who were in poverty for a long time were found in one study to have IQs that were nine points lower than their peers. They found that the effects of persistent poverty on behaviour problems at age five were 60 to 80 per cent higher than the effects of transient poverty.[282]

Recent evidence suggests that income effects are strongest during preschool/early school years and that the impact varies by outcome, with stronger influence on education and cognitive achievement.[283]

Children who experience financial difficulties in their family lives are less likely to stay on in school and are outperformed by their peers.[284] Children in low-income families had poorer behaviour at 46 months than their peers, as well as lower performance on cognitive tests at 34 months.[285] Their performance is also poorer once they reach age five. Using the EYFS profile, research shows that poor children have lower levels of achievement.[286]

Figure 20 Percentage achieving good development on early years Foundation Stage Profile and family poverty and family resources



Source: Kiernan K E and Mensah F K (2011)

There are many reasons why poverty impacts on children's life chances. Poverty exerts stress on family life, which impacts on physical and mental health of adults and children and puts great pressure on relationships. This may impact the greatest on mothers, both because lone parenthood is a key risk factor for poverty and because women are the 'shock absorbers' of poverty, making personal sacrifices to protect their children from the worst impacts.[287] Poverty means living with material hardship and very often debt, and going without things that many take for granted: healthy, nutritious food, adequate heating at home in winter, holidays and breaks to take time out and refresh batteries. Poverty saps resilience and the ability to face the great number difficult choices people need to make in their lives. Families living in fuel poverty and cold housing are more likely to suffer from poor mental health as a result.[288]

Figure 21 Fuel poverty across the social gradient

Source: The poverty site (2009) Fuel poverty summary statistics

The causes of poverty and inequality are many and complex. The fiscal policy regime including tax and benefit policy, the structure of the labour market, and geographical patterns of economic opportunity are three of the main drivers. Children's Centres can exert little influence over these. However, Children's Centres have an important role to play in this area at the individual level, whether through providing welfare benefits advice, offering work-related education or training or providing direct support around accessing work. Children's Centres managers we spoke to were conscious that the need for this type of support was likely to increase as Universal Credit is implemented. Children's Centre managers were already looking at budgeting and financial management programmes they

could offer to parents.[289]

Given the gap between what is provided by out-of-work income supplements and the poverty line, accessing employment is the most sustainable way of lifting a family out of poverty.[290] However, work will not necessarily lift a family out of poverty: more than half of children in poverty live in a household where someone works. In addition, work will not necessarily lead to better outcomes for children. Work can also worsen individuals' health and can mean children receive less attention and support. Indeed, the prevailing political attitude that requires women to move into the labour market when their children are at younger ages is built on a limited evidence base, particularly in relation to children's outcomes.

Yet there is good reason, beyond the consistent and strong associations between poverty and poor outcomes, to believe that accessing work or developing better skills with a view to employment will be beneficial. As *Fair Society, Healthy Lives* argued:

> *Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health…. the quality of work matters. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option.*[291]

For parents of young children, the quality of work is not the only important factor, as the quality of childcare will also need to be high in order to maximise the chances of positive outcomes for children.

It is methodologically difficult, particularly without experimental studies, to look directly at the impact of going into work, link this to increased incomes and then show impact on children's outcomes, but there is a small amount of evidence to suggest positive outcomes for both parents and young children from policies that have increased parents' income as they have moved into work. Disentangling the income and work effects is difficult, however.[292]

Low skills and being out of work both make it hard to access any employment, let alone good employment. Hillage *et al* in a review of adult learning present a range of evidence to show that adult learning can provide not only the skills to help access work but also the benefits on a wide range of outcomes including mental health, self-efficacy and confidence, improved social networks and reduced health risk behaviours.[293] Many parents who are not in work may fit into a category that Gregg has called the "progression to work group": those not necessarily ready to actively seek work but ready to take steps to prepare them for

return to work.[294]

Worklessness is associated with poor outcomes including poor educational attainment[295] and with poor maternal mental health. In the Scottish Government's investigation into maternal mental health, only 51 per cent of families with no one in work were free from poor maternal mental health episodes in the first four years of a child's life, compared with 74 per cent of those with some employment (at least one parent or carer in part-time employment) and 72 per cent of families with at least one parent or carer in full-time employment.[296]

7 Ensuring access and engagement

While debate persists about the most appropriate configuration of services for families with young children, there is evidence that services based in and around Children's Centres can have an impact on outcomes for children and their families.[297]

Engaging families is as important as the quality of what is offered: clearly, if no one comes to the Centre than the quality is irrelevant. Engagement and ensuring access is a fundamental role of Centres. While Children's Centres provide a universal service, they are expected to prioritise supporting 'target' families.[7]

This section reviews the evidence on engagement and inclusion. We must remember that parents need to want to participate. Parents have differing views of where the boundaries are for services. In general, parents think that services should intervene with children and support children's development but not force interventions on parents. As Gosling and Khor write:

> *Participants often wanted advice on a take it or live it basis but were prepared to accept services of advice on quite intimate subjects or areas. Conversely any suggestion of mandatory programmes tended to be received poorly; similarly programmes framed as correcting a deficit in parenting rather than offering support were not well received.*[298]

As one manager put to us, "you have to find everyone's carrot" to successfully engage parents.[299] While there is a sense from professionals and from families that Children's Centres are welcoming and engaging, ensuring access, particularly from families who may feel less comfortable, is still important.[300] Some parents still have negative associations with Children's Centres and feel that the language used is not engaging or accessible.[301]

Some families do not want to access early-years services outside of their home and rely on informal networks for care and support; others will continue to feel threatened or unwelcome in services that "aren't for me".[302] However, as Katz *et al* write, "it must be stressed that the vast majority of barriers are not of parents' making. Parents generally want to receive help if it is appropriate to their needs."[303]

Most of the information about who accesses Children's Centres sits with the individual Centres. Research in 2011 identified characteristics of families who made use of a group of Children's Centres. As Figure 22 shows, among those attending Children's Centres, 94 per cent of families had 'parenting issues' while 81 per cent had 'family social issues'. The research also found that families have multiple health needs including general and mental health issues and physical disability issues.[304]

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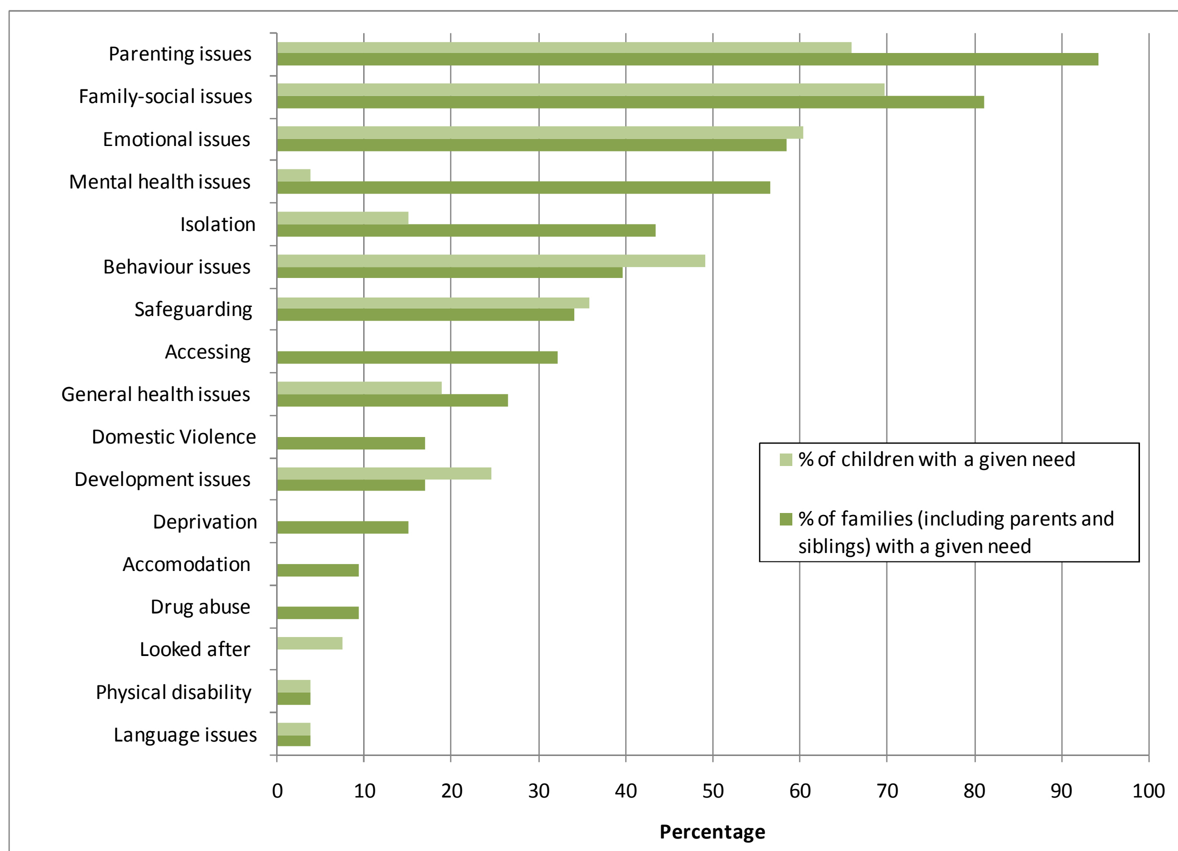
[7] See language in Ofsted (2011), *The framework for Children's Centres inspection*, Crown Copyright, and *The Core Purpose* for Department for Education (2012), *The core purpose of Sure Start Children's Centres*, Crown Copyright.

Figure 22 Reasons why families are using Children's Centres



Source: Blewett J, Tunstill J, Hussein S, Manthorpe J and Cowley S (2011)

While this research looked at the needs of parents and families when they first attended the Centre, we also asked parents to reflect on the reasons that they came. Mothers talked about meeting people, making friends, being around people like themselves. They also talked about the Centres providing opportunities for their children that they were not able to provide at home. Their children got to meet other children, play with new toys and play outside. The parents also watched the staff and learned from the modelling around them.

Non-users have identified a number of reasons for not attending a Centre. In general they either do not know about the services or feel that they do not need them. Some parents in the latter group see Children's Centres as explicitly a service for at-risk or disadvantaged families, a group that parents are unlikely to put themselves into whether or not they may fit that profile.[305] This sense of stigma was particularly strong from families at the lower end of the socioeconomic spectrum.[306]

7.1 Inequality in access

There are particular groups of parents who are less likely than others to engage in mainstream services. This includes fathers, disabled parents, BME groups, homeless families or families who are frequently moving ('peripatetic' families), and rural families.[307]

Children's Centres are acutely aware of the need to engage fathers and while we met some fathers on our visits, the vast majority of the parents we met were mothers. The fathers we spoke to did feel some trepidation about joining predominately female groups and feel some concern about community impressions of men who spend significant time around children. However, they did welcome specific father groups that were often held at weekends. Research echoes this: fathers feel that centres are run by women, for women.[308]

7.2 What works to engage people

"Everyone here talks to you and welcomes you and smiles at you – even the receptionist. It's like one big family."

Mother at focus group

The evidence base for access is still developing and as Katz *et al* write, it is "rather thin" and groups that are "hard to reach" for services have also been less involved in research. However, there is more to be learnt from existing evidence to draw on what parents relate.[309]

Successful approaches to increasing engagement include the development of trusting personal relationships between providers and service users; getting the practical issues right (such as whether the parent had previous experience of being turned down when asking for help, opening times, availability of childcare and cost of services); service culture; and responsiveness to what parents want. Other reviews have also summarised the characteristics of services that parents and children in need of support particularly value and take up: easily accessible services, practitioners who are approachable and responsive, culturally sensitive services, attention to strengths as well as needs, and a focus on supporting both child and parent.[310]

The parents we spoke to echoed this research: they wanted to speak to someone who listened, who understood and who did not judge. The most frequent refrain on our visits was, "They don't judge you. They just listen and try and help."

Outreach can also be a way to engage families in other services that they may need. Successful outreach often sees project staff make individual contact with families in the community (in their own homes in the first instance), and is essential to make a reality of access for those families who are seen as being the hardest to reach.[311] Other approaches include having existing service users act as advocates and mentors for other families.[312]

This was echoed by the parents we spoke to in our visits who credited both individual workers and their own friends and social networks as key to their involvement. Other research suggests that individual contact from project staff is critical to encouraging access by harder-to-reach families.[313]

Katz *et al* identified three barriers to access. **Physical and practical barriers** included lack of

knowledge about what was available – a finding echoed by our conversations with parents who said, "I didn't come in the beginning because I didn't know what was here." Other physical barriers include transport, particularly for families reliant on public transport and with pushchairs. The majority of parents we met on our visits did not have cars and accessed the Centre by walking; this was particularly true for the young mothers we met who said that they would not have attended if it required a significant journey by public transport. Many of the parents reflected that having the Centre within their local community encouraged them to participate and to access the services.

Social barriers also played a role. There is ongoing discussion about parents feeling that Children's Centres are "not for me" and feeling nervous about entering the building. Clearly, the parents we spoke to did not have that concern (or at least no longer had it), as we met them in the Centre. When we asked parents why they had not come in the past and/or why people they knew did not come, lack of confidence and comfort came up a number of times. They reflected that some parents might not know that the staff were friendly and there to help and might be worried that staff would be patronising and stigmatising. Katz *et al* found that cultural barriers may be particularly strong for minority ethnic families and in particular for groups who are isolated or culturally meant to 'stay at home' with their children.

The final barrier was **social stigma**, with parents fearing that they would be labelled as bad or failed parents. The parents we spoke to emphasised how important it was that staff at the Children's Centre were seen not to judge and to "meet you on your level" to help parents. This was particularly important to the teenage mothers we spoke to, who reflected that most people "looked down on you" for being a young mother but that the staff at the Centre did not make judgments and were just there to help.[314]

7.2.1 Keeping people engaged

"I came here the first time with my sister and then we just kept coming back – and if she can't come I can come on my own now because I know everybody."

Mother at parent workshop

Retention is as important as ensuring initial access. Reviews of some programmes suggest that participant attrition is particularly high for parents who are 'hard to reach' or whose cultural context for parenting is at odds with parenting courses that tend to be shaped around particular models of good parenting. One particular risk is that if parents find support stigmatising or at odds with their own views, they simply stop accessing support. For example, if health visitors gave new mothers advice on weaning that was at odds with mothers' beliefs on weaning (often based on advice from their own mothers), the mothers simply stopped seeing the health visitor.[315]

Parents who do use Children's Centres tend to rate them highly, attributing improvements in confidence and self-esteem to involvement in courses and programmes. They felt that

involvement in the Children's Centre also helped their children develop what they needed for school.[316] This sense of direct benefit contributes to ongoing engagement and involvement.

Less is known about supporting fathers although the need to include fathers is growing, not only as parents but also in their role as contributing to the financial security of the household, and as partners and support for mothers.

8 The Outcomes Framework

The Outcomes Framework we have developed is based on the evidence presented in the preceding pages. It 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 told us, and it aligns where possible to the existing frameworks.

We have started from the principle that we need to be measuring what is important – not be guided by what we can measure. We have defined as 'important' what the research suggests plays a particularly significant role in children's early lives – and where possible where research suggests that particular factors have more impact than others.

8.1 The Outcomes Framework

Areas for focus		Proposed outcomes
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 birth-weight 8. Reduction in the number of children with high or low Body Mass Index
Parenting promotes 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

Areas for focus		Proposed outcomes
		15. More parents are setting and reinforcing boundaries
Parent context enables good parenting	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
	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
	Be financially self-supporting	21. Parents are accessing good work or developing the skills needed for employment, particularly parents those furthest away from the labour market

9 Next steps

We have shown above, the rationale and thinking behind an evidence based outcomes framework which, if followed, will make a real improvement to children's lives and to their outcomes in the future.

However what we have not done, is look in depth about how easy this will be for children's centres to follow and measure. The next stage of our work will be to set out how to achieve this, working closely with children's centres and linking in with the existing measurement regimes that exist, wherever possible.

For example, *Development Matters* provides in-depth suggestions for observation of development. It is particularly strong in looking at how a consistent set of outcomes manifests across different ages in the early years, which is critical.[317] The Early Years Foundation Stage Profile Total Score correlates strongly with predictions made on earlier tests and can be a useful measure of understanding spoken language. The language scale of the EYFSP also correlates very strongly with all of the other scales, and is therefore associated with progress in all other domains of development.[318]

This is less true when looking at parenting and the parent context. While there are a number of measurement tools that have been used in the academic research, these tools are unsuitable for Children's Centres. They are too resource-intensive and too complex to provide the quick and accessible information that Children's Centres need on an ongoing basis to assess their impact.

Children's Centres 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. The availability of high-quality yet easy-to-use measurements varies across the areas of responsibility and focus, and indeed within some.

Development Matters already contains a wealth of suggestions for behaviours and attributes that Children's Centre staff may observe in children. It is particularly good at identifying age-appropriate manifestations of outcomes across the early-years age range.[319] We suggest a few additional tools that may supplement what is in *Development Matters* and may be particularly useful in comparing outcomes between families and between Children's Centres.

Measuring aspects of parenting and parent context is significantly less developed. What is used tends to either focus on inputs (such as attendance at courses) or qualitative scales to assess change. The measures tend to be several steps removed from children's outcomes.

Appendix A Our outcomes aligned against existing frameworks

The Outcomes we propose map closely to existing and emerging statutory frameworks at both a high level and in the detail. At a high level our proposed outcomes echo the themes of children's personal, social, emotional and physical development that form the basis of the Ofsted Inspection Framework for Children's Centres, Early Years Foundation Stage (EYFS) Framework, and the Healthy Child Programme. These Frameworks also promote the social and emotional development of parents. The outcomes we have included are all critical for ensuring that children and their families are prepared for school and able to thrive and grow when they enter formal education. We are aware of the investment and efforts underway as part of the Payment by Results trials. As these are continuing to emerge all the time, we have not included them here. However, we will aim to share our analysis and thinking with the programme as it develops.

Our work also focuses on the need to support all families, not just the most disadvantaged. As the risk of poor outcomes exists across the social gradient, we urge an approach based on proportionate universalism, supporting all families to thrive.

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
Children are developing well	Cognitive development	All children developing age-appropriate skills in drawing and copying Children increase the level to which they pay attention during activities and to the people around them	Child development and school readiness	All children and parents, including those from target groups, enjoy and achieve educationally and in their personal and social development (A2.3)	Specific areas: Literacy, mathematics, and expressive arts and design	
	Communication and language development	Children are developing age-appropriate comprehension of spoken and written			Prime area: Communication and language and all associated early	

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
		language Children are building age-appropriate use of spoken and written language			learning goals Specific areas: Literacy and mathematics	
	Social and emotional development	Children are interacting appropriately with other children and with adults Children increase their engagement with various forms of play Children have age-appropriate self-management and self-control	Personal, social and emotional development, physical development and communication and language so children develop as curious learners and are able to take full advantage of the learning opportunities in school	Percentage of children who achieve a total of at least 78 points across the EYFS profile with at least six points scored in each of the personal, social and emotional development (PSED) and communication and literacy (CLL) scales The extent to which all users enjoy and achieve educationally and in their personal and social development. (A2.3) The extent to which children engage in positive behaviour and	Prime area: Personal, social and emotional development and all associated early learning goals	

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
				develop positive relationships (A2.4)		
	Physical development	Reduction in the numbers of children born with low birth weight Reduce the number of children with high *or* low Body Mass Index	Child and family health and life chances – good physical and mental health for both children and their family	Percentage of children in reception year who are obese Children, including those from vulnerable groups, are physically, mentally and emotionally healthy and families have healthy lifestyles. (A2.1)	Prime area: Physical development and all associated early learning goals	Incidence of low birth weight of full-term live births, with gap narrowing, in the local authority area Prevalence of healthy weight at age 4-5 years, with gap narrowing, in the local authority area
Parenting promotes development	Creating safe and healthy environment	Reduction in the numbers of mothers who smoke during pregnancy Increase in the number of mothers who breastfeed	Parenting aspirations, self esteem and parenting skills	Percentage of infants being breastfed at 6–8 weeks after birth Children, including those from vulnerable groups, are physically, mentally and emotionally healthy and families have healthy lifestyles (A2.1) Children are safe and		Smoking status at time of delivery Breastfeeding prevalence (at 6-8 weeks after birth), with gap narrowing, in the local authority area

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
				protected, their welfare concerns are identified and appropriate steps taken to address them (A2.2)		
	Promoting active learning	Increased number and frequency of parents regularly talking to their child using a wide range of words and sentence structures More parents are reading to their child every day More parents are playing with their child – and encouraging their child to explore				
	Positive parenting	More parents are regularly engaging positively with their children More parents are actively listening to	Parenting aspirations and parenting skills – building on strengths and supporting aspirations so			

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
		their children More parents are setting and reinforcing boundaries	that parents and carers are able to give their child the best start in life			
Parent context enables good parenting	Good mental wellbeing	More parents are experiencing lower levels of stress in their home and their lives Increase in the number of parents with good mental wellbeing More parents have greater levels of support from friends and / or family	Child and family health and life chances			
	Knowledge and skills	More parents are improving their basic skills, particularly literacy and numeracy More parents are increasing their knowledge and application of good	Supporting parents to improve the skills that enable them to access education, training and employment			

Areas for focus		Proposed outcomes	Core Purpose of Children's Centres	Ofsted (KPIs and SEF areas)	EYFS: March 2012	Public health outcomes
		parenting				
	Be financially self-supporting	Parents are accessing good work or developing the skills needed for employment, particularly those parents furthest away from the labour market	Children and families are safe, free from poverty, and able to improve both their immediate wellbeing and their future life chances	Percentage of children age 0-4 living in households depending on workless benefits Percentage of eligible families benefiting from the childcare element of Working Tax Credits Parents are developing economic stability and independence, including access to training and employment (A2.5)		

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