House of Commons

Science and Technology Committee

Evidence-based early years intervention

Eleventh Report of Session 2017–19

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 30 October 2018

HC 506
Published on 14 November 2018
by authority of the House of Commons

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Contacts

All correspondence should be addressed to the Clerk of the Science and Technology Committee, House of Commons, London SW1A 0AA. The telephone number for general inquiries is: 020 7219 2793; the Committee's e-mail address is: scitechcom@parliament.uk.

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Adverse experiences in childhood, such as abuse, neglect or difficult household situations, are associated with an increased risk of health and social problems in later life, with the prevalence of a range of these problems increasing with the number of adverse experiences suffered. Around one in every two adults in England is thought to have suffered at least one adverse childhood experience. There are, however, an increasing variety of early intervention programmes that have been shown to improve life outcomes for those affected by childhood trauma or adversity, while also saving long-term costs for the Government.

Despite the opportunity presented by such interventions, their provision is fragmented and highly variable across England, with inadequate effective oversight mechanisms for the Government and others to monitor what local authorities are delivering. There is no clear, overarching national strategy from the UK Government targeting childhood adversity or early intervention as an effective approach to address it. Co-ordination between the different Government departments whose areas of responsibility relate to childhood adversity or associated problems could be improved.

Where local authorities are not providing early intervention based on the best available evidence, vulnerable children are being failed. There is now a pressing need for a fundamental shift in the Government's approach to early intervention targeting childhood adversity and trauma. The Government should make early intervention and childhood adversity a priority, and set out a clear national strategy to empower and encourage local authorities to deliver effective, sustainable and evidence-based early intervention. The Government should also ensure that it has better oversight of the provision of early intervention around the country, so that it can identify approaches that are working well, detect local authorities in need of support and hold local authorities to account.

The collection and analysis of appropriate data can help to monitor the impact of early intervention initiatives to ensure that they are achieving the desired effect and to inform further improvements, as well as to support the identification of families that may benefit from early intervention. The new strategy should support local authorities in this, including by:

- promoting the importance of data collection and analysis and providing examples of good practice;
- identifying measures that local authorities can use to assess early intervention initiatives or to identify families who could benefit from early intervention;

- producing guidance on data privacy legislation and where appropriate, facilitating access to the infrastructure and licences required for efficient, interoperable data processing;
- reviewing what data should be collected during the health visits mandated under the Healthy Child Programme; and
- setting targets for improvement, to be reviewed to monitor progress.

The new strategy should also recognise the scope for improved awareness of the importance of adverse early years experiences on child development, and knowledge of the latest science in this domain, across the early years workforce. The Government should ensure that the accreditation criteria for social workers include knowledge of child development science, the impact of adversity and methods for addressing this, as well as good practice in collecting and using data. It should ensure that training is available to allow social workers to meet these criteria throughout their career.

The Government should also review the training curricula for other professions, such as teachers, health visitors and police officers, to achieve similar levels of knowledge across the early years workforce. The new national strategy must make clear that in commissioning evidence-based programmes, local authorities should ensure that there is sufficient accredited, ongoing, specialist supervision from qualified supervisors in that programme for the workforce, throughout the delivery of the programme. The Apprenticeship Levy offers an important potential source of new funding for training of the early years workforce. The Government should promote the opportunity presented by the Apprenticeship Levy as a source of funding for training early years practitioners.

Implementation science is a developing field focusing on methods and strategies that improve the uptake in routine practice of new interventions that have been found to be effective. The Government should ensure that its new national strategy for adversity-targeted early intervention incorporates the latest evidence from implementation science, as well as lessons learned from services that have successfully implemented evidence-based early intervention with positive outcomes.

In adopting a new national adversity-targeted early intervention strategy, the Government should see effective early intervention as an opportunity to save costs—as well as to improve people's lives—rather than a demand on resources. The new strategy should seek to drive a shift in the focus of current expenditure from 'late interventions', required where problems have escalated, to earlier intervention. Although this may require an initial increase in expenditure, there is good reason to expect this to lead to long-term savings across diverse sectors. These are reasons why central Government is best-placed to provide funding for early intervention initiatives. Local authorities and their partners should nevertheless be bold with the resources they have and invest in sustainable delivery of early intervention to save costs down the line.

As part of a new national strategy for evidence-based early intervention, the Government should review funding for the Early Intervention Foundation, to ensure that it has greater long-term security, and so that it can achieve for local authorities what the Education Endowment Foundation has achieved in schools. Local authorities would benefit from the support of a central specialist team with experience in effectively and

sustainably implementing early intervention programmes, to help with planning and delivering evidence-based early intervention and to overcome the various challenges we have identified. An expanded Early Intervention Foundation would be well-placed to host such a team, and the Government should invest in the Foundation to achieve this aim. The Early Intervention Foundation should identify local authorities willing to become 'Early Intervention Places', which would receive particular support from the new specialist team. Together with the central team, these local authorities would utilise implementation science to build sustainable implementations of evidence-based programmes, simultaneously generating new knowledge that can be rolled out to other local authorities at a pace consistent with the development of sustainable service transformation.

1 Introduction

Background

1. Early intervention is a loosely-defined term that refers to taking action as soon as possible, to tackle problems before they become more difficult to reverse. In this Report, we consider early intervention in relation to childhood adversity and trauma, to tackle the potential long-term problems that children who had such experiences appear to be more likely to encounter. Such intervention can take a variety of forms and covers an array of different sectors including education, health, social care and justice.[1] Examples include parenting programmes, behavioural classes for children or programmes supporting early years child development.[2]

2. In 2010, Graham Allen, the then MP for Nottingham North, was commissioned by the Coalition Government to review early intervention in the UK. Two reports were published by Mr Allen the following year.[3] Following his recommendations, the Early Intervention Foundation was established in 2013 as the 'What Works Centre' covering this area.[4] In 2016, the Early Intervention Foundation estimated that the cost of 'late' intervention in England and Wales reached at least £16.6bn,[5] and in 2017 reported a "significant gap between what is known to be effective from peer-reviewed studies and what is delivered in local child protection systems".[6] We consequently decided to launch an inquiry to examine the evidence base underpinning the arguments for early intervention as an effective strategy to address childhood adversity and trauma, and to assess the extent to which this evidence base was informing early intervention practice across England.

Our inquiry

3. As part of this inquiry, we launched a call for evidence seeking written submissions regarding evidence-based early years intervention on 26 October 2017. We received over 100 pieces of written evidence, and took oral evidence from 26 witnesses, including academics, charities, organisations delivering early intervention programmes, local authorities, the Early Intervention Foundation, Public Health England and Government Ministers. We also visited Cornwall Council and Tretherras School in Newquay, and the Blackpool Centre for Early Child Development to learn more about the HeadStart Kernow and Better Start Blackpool programmes respectively. To assist us in our work, we also appointed Dr Caroline White, Head of the Children and Parents Service in Manchester, as a Specialist Adviser for our inquiry.[7] We are grateful to everyone who contributed to our inquiry.

1 'What is Early Intervention?', the Early Intervention Foundation, accessed 4 May 2018
2 There is no universal definition of 'early years', with common interpretations including the first 1,001 days of a child's life, from birth to the start of compulsory schooling or other periods that can include pregnancy.
3 Graham Allen, 'Early Intervention: The Next Steps' (2011) and Graham Allen, 'Early Intervention: Smart Investment, Massive Savings' (2011)
4 The Cabinet Office, 'What Works?: Evidence for decision makers' (2014); the UK's network of seven independent What Works Centres and two affiliate members aim to promote the use of high-quality, independently assessed evidence at every level of policy-making.
5 Early Intervention Foundation, 'The Cost of Late Intervention: EIF Analysis 2016' (2016)
6 Early Intervention Foundation, 'Improving the Effectiveness of the Child Protection System: Overview' (2017)
7 Dr Caroline White declared her interests on 15 May 2018: accredited trainer in Incredible Years Parent Programmes and director of Evidence Based Psychology Hub Ltd.

4. In this Report we set recommendations for what the Government should do nationally, and what local authorities should do locally, to ensure that every child has access to evidence-based early intervention if they need it. Specifically:

- In Chapter 2, we examine the evidence regarding adverse childhood experiences and their links to a range of problems in later life, the effectiveness of early intervention programmes that seek to address the consequences of such experiences, and future research priorities in these areas.
- Chapter 3 reviews the current provision of evidence-based early intervention in England, including specific programmes such as the Healthy Child Programme, the Family Nurse Partnership and Sure Start Children's Centres.
- In Chapter 4, we explore some of the challenges local authorities and their partners face in delivering evidence-based early intervention targeting childhood adversity.
- Finally, in Chapter 5, we set out what we think the Government should include in a new national strategy for adversity-targeted early intervention, to ensure that the opportunity presented by evidence-based early intervention is seized and that every child has access to the support that they need.

2 The evidence behind early intervention

5. This Chapter examines the current state of evidence relating adversity and trauma suffered in childhood to a range of problems in later life, as well as the effectiveness of measures that aim to prevent adverse childhood experiences or mitigate their linked negative outcomes.

Adverse childhood experiences

6. There is no universally agreed definition of an adverse childhood experience (ACE), but studies addressing the issue have mostly converged on a similar set of experiences falling under this term.[8] A typical list of ACEs was used by Public Health Wales in a 2017 survey investigating the childhood experiences of approximately 2,500 Welsh adults. That survey used the following experiences:

- verbal abuse;
- physical abuse;
- sexual abuse;
- physical neglect;
- emotional neglect;
- parental separation;
- household mental illness;
- household domestic violence;
- household alcohol abuse;
- household drug abuse; and
- incarceration of a household member.[9]

The Public Health Wales survey reported that 50% of Welsh adults had experienced at least one ACE,[10] a figure that closely matches survey results in England (47%).[11] Comparable statistics have not been collected in Scotland or Northern Ireland, but a 2016 report by the Scottish Public Health Network estimated that prevalence in Scotland would be at least as

8 Hughes *et al.*, 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', Lancet Public Health vol 2 (2017)

9 Public Health Wales, 'Sources of resilience and their moderating relationships with harms from adverse childhood experiences' (2018)

10 Public Health Wales, 'Sources of resilience and their moderating relationships with harms from adverse childhood experiences' (2018)

11 Bellis *et al.*, 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England', BMC Medicine vol 12 (2014)

high.[12] The Children's Commissioner's Office estimates that at least 690,000 children aged 0–5 in England live in a household with an adult that has experienced domestic violence and abuse, substance misuse or mental health issues.[13]

7. A seminal 1998 study of over 9,000 adults in San Diego found a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults".[14] Similar studies have since repeatedly reported evidence of an increased prevalence of a range of problems in adulthood among those who suffered adversity in childhood.[15] In the UK, surveys by Public Health Wales have reported a significantly increased prevalence of problems including health-harming behaviour, poor mental wellbeing and chronic disease among those who had suffered four or more adverse childhood experiences compared to those who had suffered none.[16] Similar results have been found from large-scale surveys in England.[17]

8. Although most studies focus on a broad range of health-related outcomes, links have also been reported between ACE exposure and experience of wider social problems, such as reduced educational attainment, worklessness, diminished social mobility and lower socioeconomic status.[18] Professor Mark Bellis, of Bangor University and Public Health Wales, told us that experiencing ACEs also significantly increased the risk of an individual's involvement with the criminal justice system.[19] However, the Early Intervention Foundation warned us that the extent to which ACEs were associated with many negative adult outcomes beyond physical or mental health problems was still uncertain.[20]

9. Several submissions to our inquiry pointed to methodological challenges in gathering evidence relating to the link between ACEs and wider social problems. For example, retrospective studies rely on adults recalling their childhood experiences, which the Academy of Medical Sciences told us "can be biased by their subsequent health and wellbeing".[21] Others noted that studies often used small samples, focused on specific populations or asked only one relevant group (e.g. children, parents or teachers) meaning that the case is only reported from one perspective.[22] Nevertheless, the volume and diversity of supporting evidence appears to make clear the correlation between suffering adversity in childhood and experiencing further negative outcomes in later life.[23] Indeed,

12 Scottish Public Health Network, 'Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland' (2016), p16
13 Children's Commissioner, 'Estimating the prevalence of the 'toxic trio'' (2018)
14 Felitti *et al.*, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults', American Journal of Preventive Medicine vol 14 (1998)
15 For example, see Hughes *et al.*, 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', Lancet Public Health vol 2 (2017)
16 Public Health Wales, 'The Welsh Adverse Childhood Experiences (ACE) Study' (2016)
17 Hughes et al., 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England', BMC Medicine vol 12 (2014)
18 Professor Christine Power (EYI0056)
19 Q2
20 Early Intervention Foundation (EYI0061), para 8
21 The Academy of Medical Sciences (EYI0028), para 8
22 For example the Academy of Medical Sciences (EYI0028), the International Centre for Lifecourse Studies in Society and Health (EYI0043) or the University of Bristol (EYI0086)
23 The Academy of Medical Sciences summarised that "there is strong evidence linking adverse childhood experiences (ACEs) and poor outcomes in adulthood both in terms of mental and physical health"—Academy of Medical Sciences (EYI0028)

Professor Sue White, of the University of Sheffield, told us that correlations between childhood adversity and clinical problems, such as mental health conditions, were "totally unsurprising".[24]

Correlation versus causation

10. Experiencing childhood adversity is correlated only to a higher *risk* of experiencing certain problems in later life. Experiencing these problems is not guaranteed. Indeed, the English survey results referred to in paragraph 6 indicate that the majority of individuals, including those who have suffered four or more ACEs, do not engage in each of the correlated health-harming behaviours.[25] Furthermore, all of these health-harming behaviours were also exhibited by some of those who had experienced no ACEs. Nevertheless, the prevalence of some conditions, such as low mental wellbeing, rises significantly with the number of ACEs that individuals have experienced.[26]

11. Although the correlation between suffering ACEs and negative consequences in later life seems widely accepted, this does not necessarily demonstrate causation. The British Psychological Society outlined one possible mechanism by which ACEs could lead to negative later outcomes:

> Research indicates that experience of traumatic events in childhood can have a profound adverse impact on brain development leading to both physical and behavioural changes as the child tries to adapt to environmental stressors. If trauma occurs over a prolonged period, it can rupture the child's internal stress system which then contributes to physical and mental health problems over the life course, making children more vulnerable to difficulties with emotional regulation from birth and is often linked to difficulties with cognition such as problems with attention and focus in early and later childhood.[27]

Professor Eamon McCrory, of University College London, described changes in brain structure and function resulting from maltreatment, and said that these were thought to reflect adaptations to adverse childhood environments that become 'maladaptive' in later life.[28] However, he clarified that "we know very little about pure causation. Our understanding of the developmental mechanisms remains limited".[29] The Academy of Medical Sciences similarly told us that:

24 Q16

25 Bellis et al., 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England', BMC Medicine vol 12 (2014)

26 For example, low mental wellbeing affects 14% of adults who have experienced 0 ACES, 16% of those who have experienced 1 ACE, 23% of those who have experienced 2–3 ACEs and 41% of those who have experienced 4 or more ACEs (Public Health Wales, 'Adverse Childhood Experiences and their association with Mental Well-being in the Welsh adult population', 2016); 2.0% of adults who have experienced 0 ACES, 3.6% of those who have experienced 1 ACE, 8.7% of those who have experienced 2–3 ACEs and 13.9% of those who have experienced 4 or more ACEs have perpetrated violence (Bellis et al., 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England', BMC Medicine vol 12 2014)

27 The British Psychological Society (EYI0069)

28 Q27

29 Q27

> The degree to which negative outcomes are mediated through either continued adversity, or through the ACE being embedded within neuropsychological, immune, neuroendocrine or epigenetic change needs to be determined.[30]

12. The limited current understanding of causative mechanisms makes it difficult to eliminate all possible confounding factors underlying the apparent link between childhood adversity and negative outcomes in later life. In particular, socio-economic status was identified by a number of submissions as another factor that is also strongly correlated with negative outcomes,[31] and some advocated including it as an ACE itself.[32] Nevertheless, a range of studies that try to account for potential confounding factors still report correlation between ACEs and negative adult outcomes.[33]

The 'ACE Framework'

13. The strongest criticism we heard regarding the uncertainty around causal pathways related to the validity of treating ACEs together, the practice of summing the number of ACEs experienced to determine an ACE 'score', and the misapplication of this 'ACE framework'. Professor Rosalind Edwards of the University of Southampton warned us that from a methodological point of view, considering ACEs together was a "chaotic concept", and that "conflating a lot of issues [means] that you cannot place much in the way of explanatory weight on them".[34] The NSPCC cautioned that ACE terminology could "encourage a reductionist view of very complex experiences":

> Within 'ACE-speak', one form of abuse is described simply as one 'type' of ACE. However, both in policy and practice, any form of abuse encompasses a very wide spectrum of abusive incidents and experiences, involving a very wide range of relationships between victims and perpetrators, occurring in many different contexts, of different durations, and whose impact on each individual is mediated by a range of factors.[35]

The Academy of Medical Sciences similarly noted that "it is not always clear where the line is drawn between normative stress experiences and ACEs".[36] The Early Intervention Foundation warned us that they had encountered the ACE framework being misused:

> Limitations to this framework are not always fully understood by those trying to apply ACEs to their work with children. This had led to ACEs research being misapplied in practice, and we have encountered the ACE framework currently being used inappropriately. It should not be used to identify need and determine thresholds for prioritising who needs early intervention services.[37]

30 The Academy of Medical Sciences (EYI0028), para 11
31 For example, CLOSER (EYI0020), the Royal College of Paediatrics and Child Health (EYI0054) and Emerita Professor Hilary Rose and Emeritus Professor Steven Rose (EYI0095)
32 For example, Dr Gill Main (EYI0049) and the Communication Trust (EYI0071)
33 For example, Public Health Wales, 'Sources of resilience and their moderating relationships with harms from adverse childhood experiences' (2018)
34 Q10
35 NSPCC (EYI0034)
36 The Academy of Medical Sciences (EYI0028), para 5
37 Early Intervention Foundation (EYI0061), para 37

Professor Sue White also expressed her concern that some descriptions of ACEs could lead to a "self-fulfilling prophesy", with people who are told that they are "damaged" having "lower expectations of themselves", and their behaviour being blamed on past experiences.[38] Kate Stanley of the NSPCC, however, rejected this view and told us:

> That sounds a bit like psycho-babble to me, if I am honest. [Through the ACE framework, people who have suffered ACEs] are having a conversation about their lives and what is important to them. That opens up a conversation with services and then services are being commissioned in a way that responds to what people say they need.[39]

14. We did, however, also hear of some benefits of the ACE framework. The Association for Child and Adolescent Mental Health noted the frequent co-occurrence of different ACEs and suggested that measuring exposure to different ACEs cumulatively represented a "solution to this complexity".[40] Professor Bellis, of Bangor University and Public Health Wales, acknowledged that "by looking at [ACEs] together, you do not disentangle all of them", but said that "for many people, that may be a more realistic way of looking at it, because these things do not often happen individually".[41] However, the real benefit of the ACE framework seemed to be in its use to raise awareness of the potential importance of early years experiences on outcomes throughout life, and to create a common language between early years practitioners working in different sectors.[42] Professor McCrory told us that the framework was valuable provided it was used appropriately:

> Within an epidemiological framework, I think that [the ACE model] can be incredibly helpful. I agree that taking it into a clinical context, as some kind of tool, or trying to have a conversation with individuals about ACE scores, is problematic.[43]

Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, added that the observed misapplication of the ACE framework meant that "clear messages about what it is for and what it is not for and how it might be used feels important".[44] The NSPCC similarly recommended that "any dissemination of the [ACE screening] tool should be accompanied by comprehensive staff training on its strengths and weakness. Specifically, staff must be alert to the fact that ACEs are not determinants of poor outcomes".[45]

15. The evidence of the influence of early years experiences on brain development and outcomes throughout life is not predicated exclusively on the ACE framework and the observed correlation between experiencing ACEs and encountering negative outcomes in later life. Although neuroscience cannot yet say with certainty how ACEs might cause negative outcomes, there is strong evidence to suggest that brain development is affected by external factors, and that the early years are a critical period for development with consequences that can last throughout life.[46] For example, Professor Edward Melhuish, of

38 Qq20 and 36
39 Q56
40 Association for Child and Adolescent Mental Health (EYI0070)
41 Q9
42 For example, see Q9, Q14, Q51 and Q188
43 Q14
44 Q189
45 NSPCC (EYI0034)
46 For example, see Save the Children, 'Lighting up young brains' (2016); Harvard Center on the Developing Child, 'The Science of Early Childhood Development' (2007)

the University of Oxford, told us that the 'Effective Pre-School, Primary and Secondary Education' project (see footnote for description[47]) had demonstrated the long-term consequences of the early home learning environment,[48] and that "for the vast majority of children, […] the end-of-school results are primarily predicted by the start-of-school results", adding:

> My work currently suggests that if you can get right language development and self-regulation, which is an aspect of socioemotional development, by the time children start school, almost everything else will fall into place.[49]

16. In addition to building the evidence base correlating childhood adversity to negative outcomes, Public Health Wales has also identified various 'resilience factors' that characterise those who tend not to encounter negative outcomes following exposure to ACEs.[50] These include having a relationship with a trusted adult, participation in sport, or engagement with the local community. Professor McCrory made clear that such resilience related to the environment around a child:

> It is not something that is in the child or individual; it is how the child is able to elicit help and use it from around them, but it is also about the social and physical resources around the child.[51]

Just like the evidence linking ACEs to negative outcomes, the relationship between resilience factors and improved outcomes demonstrates only correlation. Nevertheless, such findings suggest approaches that could be tried in order to improve the lifecourse of those who suffer adversity in childhood.

17. **Research into adverse childhood experiences (ACEs) has usefully raised awareness of the importance of early years experiences on child development, and of the potential consequences associated with childhood adversity or trauma. The ACE framework helps to provide a common language for early years practitioners working in different sectors. However, the simplicity of this framework and the non-deterministic impact of ACEs mean that it should not be used to guide the support offered to specific individuals.**

Early intervention

18. Within the context of childhood adversity and related outcomes, early intervention typically refers to measures intended to address problems such as mental or physical ill health, problematic behaviour or disengagement from the education system before their impacts require statutory intervention. The Government's statutory guidance on child safeguarding refers to early intervention as "early help" and outlines the kinds of support that this term describes:

47 The Effective Pre-School, Primary and Secondary Education project monitored the development of more than 3,000 children from the start of pre-school through to their post-16 education, training or employment choices in order to study the effectiveness of early years education.

48 Q131; Department for Education, 'Students' educational and developmental outcomes at age 16: Effective Pre-school, Primary and Secondary Education (EPPSE 3–16) Project' (2014)

49 Qq111 and 128

50 Public Health Wales, 'Sources of resilience and their moderating relationships with harms from adverse childhood experiences' (2018)

51 Q37

> In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues, including mental health, responses to emerging thematic concerns in extra-familial contexts, and help for emerging problems relating to domestic abuse, drug or alcohol misuse by an adult or a child. Services may also focus on improving family functioning and building the family's own capability to solve problems.[52]

This description hints at the variety of early intervention programmes that have been developed. The Early Intervention Foundation maintains an online guidebook detailing early intervention programmes and reviewing the evidence supporting their effectiveness.[53] This currently contains 81 programmes, but Tom McBride, Director of Evidence at the Early Intervention Foundation, indicated that this was only a fraction of the total number of programmes being developed.[54]

19. Early intervention programmes are developed and delivered based on the premise that intervening earlier is better.[55] The prevention of ACEs is justified simply by the aim to minimise children's exposure to the negative experiences they encompass. However, the evidence base around ACEs, resilience factors and negative outcomes in later life suggests that resources spent on addressing issues such as physical and mental health or criminal behaviour would be well-targeted at the earliest opportunities for intervention. In fact, Professor Feinstein told us that the strongest evidence for the benefit of early intervention came not from scientific research into childhood adversity, but from evaluating the real-world impacts of early intervention programmes:

> I do not come at this as somebody who thinks the evidence base on early childhood experiences is altogether the relevant evidence base. There is a lot of evidence in psychology and economics and a certain amount in neuroscience, although not at all necessary to the case for early intervention. There is a lot of evidence in the literature on programme evaluation and what is known when people try programmes, test them and they learn and adapt.[56]

Evidence for early intervention

20. Of the 118 programmes assessed for the Early Intervention Foundation's Guidebook:

- six were judged to have strong evidence of long-term positive impact;
- 39 had evidence of a short-term positive impact from at least one rigorous evaluation;
- 36 were considered to not yet have demonstrated any evidence of achieving positive outcomes; and

52 HM Government, 'Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children' (2018), para 12

53 'Early Intervention Foundation Guidebook', Early Intervention Foundation, accessed 2 May 2018

54 Q201

55 Professor Feinstein clarified that "it should be 'early' as in upstream of crossing the thresholds, not 'early' as in early in life necessarily, because early in life it can be very hard to identify accurately what the actual needs are, so there is a danger of very inefficient forms of identification"—Q62

56 Q63

- none had been found to be demonstrably ineffective by "at least one rigorously conducted study".[57]

Some studies of early intervention programmes have, however, found little evidence of impact,[58] and Cochrane reviews of different parent support and early intervention programmes have reported mixed results for effectiveness.[59] That said, some studies reporting little impact have been criticised for evaluating the wrong outcomes.[60] Dr Caroline White, Head of the Children and Parents Service in Manchester (who acted as our Specialist Adviser for this inquiry), also argued that evidence of ineffective interventions could result from poor implementation rather than an inherent failing of the intervention itself.[61] In addition to this range of results, many programmes are simply not evaluated at all.[62]

21. There is sometimes criticism that the evidence for early intervention comes mostly from randomised controlled trials of specific programmes, rather than from an assessment of the real-world impact on the communities where they are delivered. Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, noted that "it is much easier to evaluate a specific programme or intervention than to think about the system as a whole and all the different components of it and which bits might be performing well or otherwise", thus suggesting a possible reason for this lack of 'real-world' evidence.[63] Alison Michalska, the then President of the Association of Directors of Children's Services, also outlined the difficulty for local authorities in measuring the wider impact of early intervention:

> We all believe in its efficacy instinctively but if we are using it as a tool to manage demand on statutory children's social care services it could be perceived as failing—given the rising number of referrals, child protection plans and children in care. Or (and this is my preferred narrative) are we, through early help and early interventions, identifying children who need the protection of statutory services earlier, and as such, protecting them from further harm and making long term plans for these children to thrive?[64]

22. Despite the difficulty in measuring the real-world impact of early intervention, Martin Pratt, Chair of the Association of London Directors of Children's Services, told us that London boroughs had observed early intervention programmes to be effective:

57 'Early Intervention Foundation Guidebook', Early Intervention Foundation, accessed 25 July 2018

58 For example, see Robling *et al.*, 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial', The Lancet vol 387, pp 146–155 (2016); Marryat *et al.*, 'Parenting Support Framework Evaluation' (2014); or MacMillan et al., 'Interventions to prevent child maltreatment and associated impairment', The Lancet vol 373, pp 250–266 (2009)

59 For example, Barlow *et al.*, 'Group-based parent training programmes for improving emotional and behavioural adjustment in young children (Review)', Cochrane Database of Systematic Reviews (2016); Furlong et al., 'Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review)', Cochrane Library (2012)

60 For example, Jason Strelitz, Assistant Director Public Health, London Boroughs of Camden and Islington, 'The FNP evaluation: Inconvenient truth or a bump in the road?' (2015), accessed 3 May 2018

61 Q226

62 Q180

63 Q193

64 Alison Michalska, President of the Association of Directors of Children's Services, Early Intervention Foundation National Conference keynote speech, 11 May 2017 (accessed 29 May 2018)

> The key indicator for us is the proportion of families we become aware of who receive early help and who, a year later, are still free from further state intervention. The figure at the end of March this year [2018] is that 83% of families who were identified early and went into an intensive early help programme do not have a social work or child protection intervention a year later.[65]

Dr Caroline White told us that evidence collected in Manchester also demonstrated the effectiveness of early intervention (see Box 1, paragraph 109).[66] In 2011, a Government-commissioned study of five parenting programmes delivered across 47 local authorities in England found that the programmes improved self-reported parental wellbeing, parenting and child behaviour.[67] Pulling together disparate study results, Professor Feinstein summarised the current evidence base for early intervention:

> It always comes back to the question: do we know [if early intervention] works? We know that if you deliver high-quality services to people who need them—the right features of quality, delivered at the right time—they can be transformative in most circumstances […] the question is not whether it works; the question is when it works and how to make it work more.[68]

23. In addition to the impact on child and adult outcomes, proponents of early intervention frequently note its ability to save costs in the long-run, by avoiding expensive statutory interventions and lost productivity. In 2016, the Early Intervention Foundation estimated that the national cost of 'late intervention' (the acute, statutory and essential benefits and services that are required when children and young people experience significant difficulties in life that might have been prevented) was £16.6bn.[69] They noted that this "does not capture longer-term cumulative costs which will be considerably larger; it also does not capture wider cost to individuals and society".[70] The cost derived mostly from expenditure on children's social care, crime and anti-social behaviour and youth economic inactivity, and fell largely on local government, the NHS, the Department for Work and Pensions and the police and criminal justice system. The Early Intervention Foundation argued that although it did not think "the demand for late intervention spend can ever be brought down to zero, nor should it be",[71] this estimated cost of late intervention nevertheless "clearly represents a significant avoidable burden that could be better spent, and even modest reductions would equate to large savings".[72] Professor Feinstein told us that it might ultimately be reasonable to expect to save 30 to 40% of this 'late intervention' expenditure, and set saving 10% as a realistic immediate target.[73]

65 Q222
66 Q218; see also CAPS annual reports
67 Department for Education, 'Parenting Early Intervention Programme Evaluation' (2011)
68 Q63
69 Early Intervention Foundation, 'The Cost of Late Intervention: EIF Analysis 2016' (2016)
70 Early Intervention Foundation, 'The Cost of Late Intervention: EIF Analysis 2016' (2016), p7
71 Early Intervention Foundation, 'The Cost of Late Intervention: EIF Analysis 2016' (2016), p5
72 Early Intervention Foundation (EYI0112)
73 Q93

24. Associate Professor David McDaid, of the London School of Economics and Political Science, told us that evaluation of a variety of programmes provided strong evidence of the cost-effectiveness of early intervention.[74] Professor Melhuish similarly noted that, despite variation in the precise cost-benefit, studies of the economic impact of early intervention consistently found positive results.[75]

25. **There is now a body of evidence that clearly demonstrates a correlation between adversity suffered during childhood and an increased prevalence of health and social problems in later life. Despite a variety of proposed explanations for this correlation, the causal pathways linking childhood adversity or trauma to subsequent problems are less certain. Nevertheless, when delivered effectively, there is strong evidence that early intervention can dramatically improve people's lives and reduce long-term costs to the Government. *The Government should ensure that it is making the most of the opportunity for early intervention to effectively and cost-effectively address childhood adversity and trauma, and the long-term problems associated with such experiences.***

Research priorities

26. Despite the encouraging results regarding the efficacy and cost-effectiveness of early intervention, we heard some recognition of the evidence that remains to be gathered. The Early Intervention Foundation told us that, although reviews of the available evidence "highlight the crucial role early intervention can play in preventing childhood adversities and in helping children recover from the effects of early trauma […] the evidence base for early intervention in the UK is still at an early stage".[76] They added that "a sustained and substantive change [to child outcomes] will require an ambitious and long-term research strategy".[77] A literature review commissioned by the Big Lottery Fund similarly commented that although cost-benefit studies "appear to make a compelling case for investing in early childhood", the "economic evidence base from published reviews is not strong".[78] The importance of further research was stressed by many[79]—but not all[80]—submissions that we received. Particular research priorities that were frequently identified included:

- establishing the extent of the causality between ACEs and negative outcomes later in life, and the mechanisms through which this occurs;
- determining the relative risks of different ACEs, their severity and duration, and the stage of development at which they occur;
- the development and validation of preventative and remedial interventions, in particular regarding their long-term impact; and

74 Q76
75 Q111
76 Early Intervention Foundation (EYI0061), paras 3 and 20
77 Early Intervention Foundation (EYI0061), para 21
78 Bonin *et al.*, PSSRU, London School of Economics and Political Science (EYI0081), Big Lottery Fund (EYI0091); Bonin *et al.*, ' What Pays? A 'Preventonomics' Study (2014)
79 For example, Newcastle University (EYI0007), the Academy of Medical Sciences (EYI0028) and the Association for Child and Adolescent Mental Health (EYI0070)
80 The Children and Parents Service in Manchester told us that "we already know what works in early intervention so it would benefit its implementation by ceasing to expend energy and resource looking for the next new thing or 'home grown' interventions and instead invest existing resources into what works" (Children and Parents Service (CAPS) Early Intervention (EYI0004))

- the development of methods for reliably identifying those who would benefit from early intervention.[81]

Professor McCrory underlined the importance of developing a better understanding of the fundamental science involved:

> If we do not understand the mechanisms by which disorders unfold, we are in a very limited place to develop preventive models of health.[82]

Professor Feinstein nevertheless stressed that enough was known to start delivering early intervention, and testing and evaluating innovative approaches to such practice:

> We cannot say that every bit of early intervention will work, but we know the principles—and if we can innovate and support innovation, and testing and learning, we will make this all much better.[83]

Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities at the Department of Health and Social Care,[84] acknowledged that waiting for the evidence base to be fully established could delay successful programmes from being developed and delivered:

> The biggest challenge in all this is to be sufficiently fleet of foot to make a real difference. You see a real success where there is really strong local leadership that has just grabbed something […] The outcomes are there to be proven and demonstrated.[85]

27. The Academy of Medical Sciences told us that "funding bodies such as the Research Councils appear to recognise that this field requires additional funding", but commented on the "need for better co-ordination between research about ACEs and associated outcomes including mechanisms and research on the effectiveness of interventions, which is separately funded".[86] The Association for Child and Adolescent Mental Health similarly told us that "there is no sense of a national strategy in this area", with the identification of research priorities appearing to be "ad hoc and based on individual funding bodies and their own priorities".[87] They advocated establishing a British equivalent to the Harvard Center on Child Development to "bring together evidence from social work practice to clinical psychology to neuroscience and paediatrics".[88] However, Professor Feinstein told us that he was "not at all convinced that a multidisciplinary centre on the American model is any kind of answer to the British problem".[89]

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81 For example, see the MRC/CSO Social and Public Health Sciences Unit (EYI0021), the Academy of Medical Sciences (EYI0028), the Association of Directors of Public Health (EYI0031), Public Health England (EYI0033), Barnardo's (EYI0037), the Early Intervention Foundation (EYI0061), the Association for Child and Adolescent Mental Health (EYI0070), the Centre for Longitudinal Studies, University College London (EYI0075) and Professor Peter Fonagy (EYI0097)

82 Q32

83 Q82

84 Since giving evidence to our inquiry, the Minister has had her portfolio expanded and is now the Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention. Throughout this Report, we refer to her Ministerial title as it was at the time she gave oral evidence to our inquiry.

85 Q419

86 The Academy of Medical Sciences (EYI0028), paras 28 and 31

87 Association for Child and Adolescent Mental Health (EYI0070), para 24

88 Association for Child and Adolescent Mental Health (EYI0070), para 22

89 Q97

28. Multiple research organisations flagged the use that could be made of administrative data held by the Government for investigating the impacts of ACEs and early intervention,[90] if such data were more easily accessible and if different sets of data could more easily be linked.[91] CLOSER, a consortium managing various UK-based longitudinal studies, told us:

> Gaps in the evidence base [concerning ACEs and later outcomes] are, in part, a result of not being able to link longitudinal survey data to administrative records to provide a more complete picture of participants' life stories and to better understand how different aspects of people's lives interrelate.[92]

Tom McBride, Director of Evidence at the Early Intervention Foundation, agreed that "there is a lot of opportunity" in improved data access and underlined the Government's responsibility in enabling this research to be carried out, citing records from the criminal justice, benefits, tax and education systems as examples of data that "could facilitate much deeper and higher-quality research in this space".[93]

29. Despite the importance of evaluating early intervention programmes being made clear during our inquiry (see paragraphs 26 and 83 to 88), to ensure that they are delivering the intended impacts and to inform improvements, Professor Melhuish, of Oxford University, argued that funding was currently too heavily skewed towards evaluation over innovation and development and complained that "this is a really big fault in current Government funding".[94] Jen Lexmond, CEO of EasyPeasy, agreed, noting that her company had received four times as much funding to support evaluation as it had for development.[95] She advised that she would expect the ratio to be closer to 10%. Despite arguing that funding was tight even for evaluation,[96] the Early Intervention Foundation highlighted the continuing need for new interventions to be developed, noting that it had so far found no interventions which demonstrated effectiveness in addressing sexual abuse, parental substance misuse or parental incarceration and crime.[97]

30. Although our inquiry has focused on opportunities to intervene early to address ACEs, we also heard of approaches that could be taken to support adults who had experienced ACEs in their childhood. In particular, we heard advocates of 'routine enquiry', who argued that support services—typically in health and social care—could benefit their service users by routinely asking at the initial point of contact if they had suffered ACEs in their childhood.[98] This was presented as a key part of providing 'trauma-informed' care, allowing professionals to tailor their support to the person's prior experiences, and potentially to help service users better understand how their experiences had impacted them. Dr Warren Larkin told us that without adopting a policy of routine enquiry,

90 For example, the Children Looked After registry, the National Pupil Database, Hospital Episode Statistics, HMRC employment data, Ministry of Justice police records, benefits data from the Department for Work and Pensions and Local Authority Management Information Systems data

91 For example, CLOSER (EYI0020), the Institute for Social and Economic Research (EYI0055) and the Centre for Longitudinal Studies, University College London (EYI0075)

92 CLOSER (EYI0020), para 1.4

93 Q209

94 Q170

95 EasyPeasy (EYI0100)

96 Qq195–196

97 Early Intervention Foundation (EYI0061), table 1

98 For example, YoungMinds (EYI0013), Dr Warren Larkin (EYI0015), Greater Manchester Combined Authority (EYI0047) and Mersey Care NHS Foundation Trust (EYI0074)

practitioners rarely asked about such experiences and it could take nine to 16 years of contact for disclosure.[99] He noted the importance of training practitioners to be able to ask about ACEs confidently and respond appropriately:

> Survivors of [adverse childhood] experiences can often be reluctant to disclose voluntarily, due in part to feelings of shame, guilt and anxiety about their experiences and the act or consequences of disclosure. However, survivors have suggested that these issues can either be exacerbated or alleviated by the responses of the person listening to their disclosure. Furthermore, health and social care practitioners have described an unwillingness or discomfort with the idea of having to ask people about childhood adversity and trauma.[100]

It is also important that services asking about childhood adversity can provide or refer people to the appropriate support following enquiry.[101] Although an initial study in the USA reported that introducing routine enquiry about ACEs into health appraisals undertaken for induction into private healthcare reduced visits to doctors' offices and emergency departments the following year,[102] evaluation of the effect on patient outcomes in the UK has been mostly restricted to proof-of-concept studies.[103] Nevertheless, routine enquiry is now starting to be introduced and tested around the UK, with NHS Scotland notably exploring routine enquiry as part of its strategy for tackling ACEs.[104]

31. **Important research questions regarding childhood adversity and early intervention remain. Progress on this front would benefit from a more co-ordinated approach across different academic fields, as well as greater access to relevant administrative data held by the Government.** ***As it starts working towards its goal of improved interdisciplinary collaboration, UK Research and Innovation should co-ordinate research into child development and early intervention methods for addressing childhood adversity, across different academic disciplines. Particular focus should be on developing interventions to address adverse childhood experiences for which no effective intervention has been demonstrated, including sexual abuse, parental substance misuse or parental incarceration and crime.***

32. ***Further, we recommend that the Government should ensure that academic researchers can access Government administrative data relevant to childhood adversity, long-term outcomes and the impact of early intervention, while ensuring appropriate privacy and safeguarding mechanisms are in place. UKRI should consult the relevant academic community to determine which data would be beneficial, and work with Government departments to ensure researchers can access that data as appropriate.***

99 Dr Warren Larkin (EYI0015)
100 Dr Warren Larkin (EYI0015), paras 4–5
101 Royal College of Paediatrics and Child Health (EYI0054)
102 Dr Vincent Felitti *et al.*, 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare', in 'The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease', Cambridge University Press (2009)
103 For example, Public Health Wales and Lancashire Care NHS Foundation Trust, 'Routine enquiry for history of adverse childhood experiences (ACEs) in the adult patient population in a general practice setting: A pathfinder study' (2018)
104 Scottish Public Health Network, 'Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland' (2016)

3 The current state of early intervention in England

33. The most significant policy areas for early intervention aimed at addressing childhood adversity and trauma—local authority children's services, public health and education—are devolved issues.[105] This Chapter examines the current state of early intervention in England, including specific national programmes.

Early intervention in England

Local and national policy

34. The responsibility for many of the most important policy areas for the delivery of early intervention falls to local authorities.[106] This includes a variety of statutory duties relating to child safeguarding.[107] Statutory guidance states that "early help is more effective in promoting the welfare of children than reacting later", and instructs local authorities to have measures in place to:

- identify those families who would benefit from early help;
- determine what form of early help they would benefit from; and
- provide evidence-based early help as appropriate.[108]

Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, explained that "fundamentally, we believe in a localised approach, because local leaders can respond best to their particular circumstances".[109] Martin Pratt, Chair of the Association of London Directors of Children's Services, told us that "the move to earned autonomy for successful authorities is welcome".[110] Nevertheless, he asserted the importance of "clarity about national policy, in particular that it is evidence-informed and that it is being supported".[111] This chimes with what the Mental Health and Inequalities Minister outlined as the role she saw for national Government:

> We want local leadership to take place against an overarching national policy framework in which we want to identify best practice and the measures that will tackle these issues.[112]

35. Nadhim Zahawi MP, Parliamentary Under-Secretary of State for Children and Families, assured us that "both the Prime Minister and the Secretary of State [for Education] are committed to making sure that we prioritise early intervention and the

105 'Early Intervention', Briefing Paper 7647, House of Commons Library (2017)
106 Ministry of Housing, Communities and Local Government, 'Review of local government statutory duties: summary of responses', accessed 9 May 2018
107 For example, the Children Act 1989, section 17 and section 47, the Children Act 2004, sections 9, 10 and 11, the Childcare Act 2006, sections 1, 2, 3 and 4 and the Health and Social Care Act, section 12
108 HM Government, 'Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children' (2018), paras 1–12
109 Q384
110 Q244
111 Q289
112 Q378

home learning environment",[113] and outlined a variety of initiatives targeting different aspects of early years education.[114] Jackie Doyle-Price MP, the Minister for Mental Health and Inequalities, made similar points:

> In the health context, we have tackled each component in turn […] We have separate workstreams. Perhaps there is an argument for bringing that thinking together in some way, but it probably reflects the fact that doing things in England is slightly more complex.[115]

Mark Davies, Director of Population Health at the Department of Health and Social Care, explained further that "the adverse childhood experiences research is quite new; we are still working out how to make best use of it".[116]

36. We heard, however, from several witnesses that these distinct initiatives did not constitute a clear national policy for local authorities to follow. For example, the Association of Directors of Public Health told us that there "has been a confused public policy approach [to early intervention] with varying definitions across different policy areas related to different approaches and different age groups", and that "early years intervention has, to some extent, got lost in this at the national and local policy level".[117] Dr Jeanelle de Gruchy, President of the Association, explained:

> It would be very helpful to have a much more strategic, overarching approach to what we do in terms of early years and children […] What we are getting at is something about definition on prevention, early intervention and early help, but also something more pertinent, which is about the different Departments having a shared understanding of what we are trying to do and what the evidence is for that. If we had that national strategic direction, it would be a very helpful framework for what then comes down to local level, and for what we do and how we join it up locally.[118]

37. The importance of cross-Governmental co-ordination was made clear by Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation:

> A lot of the work we do is to try to give Government a more holistic view on the complexity of child development and some of the specific departmental agendas on issues such as child sexual exploitation, youth violence or knife crime. The best way to tackle some of those things are not very specific knife crime initiatives, or whatever it might be, but building investment in a common core of interventions that build children's social and emotional competency, strengthen parent-child interactions and so on.[119]

113 Q381
114 For example, the Minister referred to funding for early language and literacy initiatives, the social mobility action plan and the Troubled Families Programme—Qq379 and 381–384
115 Q378
116 Q380
117 Association of Directors of Public Health (EYI0031)
118 Q311
119 Q207

Tom McBride, Director of Evidence at the Foundation, additionally told us that "there needs to be a bringing together of that agenda across those Departments to focus on early intervention and vulnerability in a much more coherent way", such as through "an inter-ministerial group; it could involve a strategy on vulnerability and early intervention that starts to join up this disparate agenda".[120]

38. These views corresponded with an apparent confusion of responsibilities in Government. Nadhim Zahawi MP, Parliamentary Under-Secretary of State for Children and Families, told us that "as the children's Minister, I take the lead on [early] intervention" for children.[121] However, Professor Viv Bennett, Chief Nurse at Public Health England, told us that "it was agreed that Public Health England would take the lead in bringing together the cross-Government and national [oversight of] local work on early years, including early intervention", adding that one of its aims was to "reduce the plethora of separate policy initiatives" in this space.[122] The Government does, however, seem to be aware of the problem. It has recently announced the formation of a cross-Government working group to review the support available to families from the period around childbirth to the age of two.[123] One of the main aims of this group is to "make recommendations on how co-ordination across Departments can be improved". Both the Children and Families Minister and Mental Health and Inequalities Minister additionally told us that collaboration between their Government departments "is getting better".[124]

39. The national policy on childhood adversity and early intervention in England was contrasted with the situation in the devolved nations. In 2017, the Scottish Government stated that it would "embed a focus on preventing ACEs and supporting the resilience of children and adults in overcoming early life adversity across all areas of public service, including education, health, justice and social work".[125] The Welsh Government similarly listed 'early years', 'social care' and 'mental health' as three of the five priority areas in their national strategy to 2021, and emphasised that early intervention was an important element of tackling each of them.[126] The public health authorities in Scotland and Wales have also made ACEs a priority and each established an ACEs 'Hub' to co-ordinate action on this front.[127] We heard repeatedly that England would benefit from a similar policy focus.[128] For example, Dr Marc Bush, Chief Policy Advisor at YoungMinds, told us:

> Scotland and Wales are not perfect, but their national leadership on the issue and also their want for local ambition, to address it on a population and individual level, is the kind of ambition that we need to see coming through to England as well.[129]

120 Q206
121 Q386
122 Q309
123 'Leader of the Commons to Chair Ministerial Group on Family Support from Conception to the Age of Two', Cabinet Office, accessed 27 July 2018
124 Q385
125 Scottish Government, 'A Nation with Ambition: The Government's Programme for Scotland 2017–18' (2017), p73
126 Welsh Government, 'Prosperity for All: The National Strategy' (2017), p4
127 'Adverse Childhood Experiences', NHS Health Scotland, and 'Hub to tackle Adverse Childhood Experiences', Welsh Government, both accessed 18 July 2018
128 Q88, Q98, Q185 and Association of Directors of Public Health (EYI0031)
129 Q88

Monitoring the provision of early intervention

40. In addition to providing national strategy and guidance, there is a role for Government to play in monitoring what local authorities are doing to fulfil their early help responsibilities and in holding them to account. However, the Early Intervention Foundation told us that "there is not any reliable information about the extent to which evidence-based interventions are used and taken up by local authorities and partners".[130] Mark Davies, Director of Population Health at the Department of Health and Social Care, accepted that this was a "fair challenge", saying that although "the Early Intervention Foundation has given us good information about what works […] we have not looked systematically at how that is applied".[131] The Children's Minister agreed that ultimately the Government did not have "enough evidence that, at local authority level, we are delivering value for money and the right interventions".[132]

41. The Mental Health and Inequalities Minister told us that the Government saw Public Health England "as our method of trying to ensure that we are spreading good practice and holding local areas to account for the responsibilities that we are giving them".[133] However, Public Health England described their main roles to us as "supporting local authorities [in meeting] their responsibilities to commission the Healthy Child Programme locally" and in "providing data and evidence on alcohol and drug harm to support policy making and local commissioners and which will contribute to reducing Adverse Childhood Experience (ACE) risk factors for adults and children".[134] Mr Davies told us that Public Health England collated "very good data on outcomes", but accepted that there was not a "consistent approach to collecting information [on the extent to which different local authorities use evidence-based interventions]".[135]

42. Local authority children's services are inspected by Ofsted, whose evaluation criteria have included the provision of early help since 2012.[136] Most local authorities are inspected approximately every three years, although those that have been judged 'inadequate' are inspected more frequently. Local authorities additionally share an annual self-evaluation of the quality and impact of their social work with Ofsted. However, a 2015 'thematic inspection' of early help, undertaken by Ofsted, reported that "the current approach to quality assuring and monitoring the effectiveness of early help is disparate, disjointed and significantly underdeveloped":[137]

> Local authorities and their partners were not fully evaluating the impact of their early help work. The majority of their audits focused too much on process and compliance and not enough on the quality of the service and the extent to which it helped improve children's lives. Many partnerships had not yet developed systems to evaluate whether the right children were receiving early help at the right time.[138]

130 Q175
131 Q388
132 Q389
133 Q384
134 Public Health England (EYI0033)
135 Q388
136 Ofsted, 'Framework, evaluation criteria and inspector guidance for the inspections of local authority children's services' (2017), p50; Ofsted, ' Early Help: Whose Responsibility?' (2015), p11
137 Ofsted, 'Early Help: Whose Responsibility?' (2015), p23
138 Ofsted, 'Early Help: Whose Responsibility?' (2015), p5

The current state of early intervention services

43. The localised approach to early intervention, combined with this lack of national guidance and oversight, appears to have led to variable practice and outcomes across the country.[139] We heard anecdotal evidence of local authorities delivering interventions later than would be optimal, and providing programmes that were not based on the latest evidence. For example, the Early Intervention Foundation told us that through their work, they had encountered "lots of examples where we see a gap between what we know from robust, peer-reviewed literature and what happens in local services and systems".[140] Ofsted's 2015 thematic inspection of early help found that "opportunities to intervene earlier were missed in over 40% of the cases" they had reviewed.[141] Ofsted concluded that, despite local authorities and their partners placing increasing priority on early help, and children consequently "benefiting from better focused and co-ordinated support earlier […] the quality and effectiveness of early help services […] remains too variable both between areas and within the same services".[142] Dr Caroline White, Head of the Children and Parents Service in Manchester, told us that even where local authorities were trying to provide evidence-based early intervention, the programmes were often not delivered as originally designed.[143] This risks hindering the effectiveness of those programmes, and undermining the apparent case for early intervention in general.

44. The Government did not dispute that there was significant variability between different local authorities' approaches to early intervention, with both Ministers acknowledging variability.[144] For example, the Children and Families Minister admitted that:

> If you take two neighbouring local authorities with a very similar demographic and very similar funding, you may find that one has much better outcomes for children's services than the other.[145]

45. **Whilst there is evidence of good practice in some local authority areas in England, there is no clear, overarching national strategy from the UK Government targeting childhood adversity and early intervention as an effective approach to address it. Nor does there seem to be effective oversight mechanisms for the Government or others to monitor what local authorities are doing. This has led to a fragmented and highly variable approach to early intervention across England, with evidence of a significant gap between what the latest evidence suggests constitutes best practice and what is actually delivered by many authorities. Where local authorities are not providing early intervention based on the best available evidence, vulnerable children are being failed.**

46. ***There is now a pressing need for a fundamental shift in the Government's approach to early intervention targeting childhood adversity and trauma. The Government should match the ambition of the Scottish and Welsh Governments, and build on the example set by certain English councils, to make early intervention and childhood adversity a***

139 See, for example, The British Psychological Society (EYI0069), p11 and Qq176 and Q216
140 Q175
141 Ofsted, 'Early Help: Whose Responsibility?' (2015), p14
142 Ofsted, 'Early Help: Whose Responsibility?' (2015), pp28–29
143 Q226
144 Qq384, 390 and 412
145 Q412

priority, and set out a clear, new national strategy by the end of this Parliamentary session to empower and encourage local authorities to deliver effective, sustainable, evidence-based early intervention.

47. ***The Government should ensure that it has better oversight of the provision of early intervention around the country, so that it can identify approaches that are working well, detect local authorities in need of support and hold local authorities to account. It should determine what information is needed to be able to assess the local provision of early intervention and set out a framework as part of the new national strategy that ensures that all local authorities will provide such information, with as little disruption to their working practice as possible.***

48. **Co-ordination between the different Government departments whose areas of responsibility relate to childhood adversity or problems associated with this could be improved. We welcome the formation of the new ministerial group working to improve family support for those with young children.** ***This group should: make tackling childhood adversity a focus of its work; improve cross-Government co-ordination on this issue; and ensure that there is clear accountability for driving this agenda across all Government departments.***

National Programmes

49. Despite there being no overarching national strategy on childhood adversity and early intervention in England, there are nevertheless a range of specific programmes targeting different aspects of early years development, children's social care or childhood adversity and trauma. We discuss the most relevant of these below.

The Healthy Child Programme

50. The Healthy Child Programme comprises screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. It has two strands—one for pregnancy through to age 4,[146] and one for children aged 5–18.[147] The programme uses a 'progressive universalism' model, with all families receiving basic elements of the programme and additional services being provided to those with specific needs and risks. A key component of the 0–5 years strand is a series of health and development reviews for each family, conducted at set periods. A 2015 statutory instrument mandated local authorities to provide five 'health visitor reviews' to all families within their area, during set periods in a child's development:

- after 28 weeks into pregnancy;
- 1 day to 2 weeks after birth;
- 6 to 8 weeks after birth;
- 9 to 15 months after birth; and
- 2 to 2.5 years after birth.[148]

146 Department of Health, 'Healthy Child Programme: Pregnancy and the first five years of life' (2009)
147 Department of Health, 'Healthy Child Programme: From 5–19 years old' (2009)
148 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015 (SI 2015/921)

This duty was initially due to last until March 2017, but following a review by Public Health England,[149] it was extended indefinitely.[150] Public Health England told us that the Healthy Child Programme was the "foundation of public health services for children and families",[151] and the Programme guidelines stated that it was "a core programme for delivering national priorities and statutory responsibilities on local partnerships".[152] Public Health England's 2016 review of the mandatory service reported that:

> Local authority colleagues highlight the fact that safeguarding all children is a defined responsibility and without this service it is possible for children not to be seen by any professional until they start school or not at all if they are home educated.[153]

The Institute of Health Visiting similarly told us that "home visiting and needs assessment are key to the identification of ACEs in families that would not access other services and that cannot be targeted because they are (otherwise) unknown".[154]

51. Despite the importance of the Healthy Child Programme reaching all children, the most recent data published by Public Health England showed that—other than for the neonatal check—only around 80% of children were receiving the visits required.[155] Professor Viv Bennett, Chief Nurse at Public Health England, told us that Public Health England did not currently have the data necessary to be able to characterise those who did not receive the checks.[156] Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, told us that the Government was "quite clear" that all children should receive the mandated health visits, but that:

> There is a judgment as to how far we should worry if they do not happen. The fact that areas such as Blackpool and Thurrock, which have higher deprivation than their neighbours, are achieving better, is a good indication that the resourcing is happening. But we should never be complacent.[157]

However, ACEs do not necessarily occur in deprived areas. Indeed, the Institute of Health Visiting noted that:

> Proportionately [ACEs] occur to a greater extent in the section of society not normally classed as being vulnerable as, although more diluted, the number of children in this cohort is significantly larger than in the conspicuously vulnerable group.[158]

149 Public Health England, 'Review of mandation for the universal health visiting service' (2016)
150 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) (Amendment) Regulations 2017 (SI 2017/505)
151 Public Health England (EYI0033)
152 Department of Health, 'Healthy Child Programme: Pregnancy and the first five years of life' (2009), p63
153 Public Health England, 'Review of mandation for the universal health visiting service' (2016), p32
154 Institute of Health Visiting (EYI0107)
155 Public Health England, 'Health Visitor Service Delivery Metrics: Quarter 4 (January to March 2018) Statistical Commentary' (2018); Public Health England, 'Health Visitor Service Delivery Metrics: 2016/17 annual data' (2017); and Q313
156 Q319
157 Q438
158 Institute of Health Visiting (EYI0107)

52. In addition to problems with the coverage of the mandated health visits, we heard concerns around the number of health visitors and their consequent ability to do their job to the quality required. The National Health Visiting Programme ran from 2011 to 2015 and aimed to increase the number of health visitors by 4,200.[159] This was in response to falling numbers between 2004 and 2010, and an acknowledgment by the Department of Health and Social Care that "in too many areas, there are just not enough health visitors to offer all families the support they need".[160] The exact number of health visitors currently is unknown, as data is no longer collected centrally for all health visitors. However, NHS workforce data—which does not include health visitors commissioned by private providers—recorded 8,205 health visitors in February 2018, compared to a peak of 10,309 in October 2015 (a roughly 20% reduction) and 8,092 in May 2010 (prior to the national health visiting programme).[161] Professor Bennett acknowledged that "the peak of health visitor numbers in this country was clearly at the end of the national health visiting programme".[162] Dr Jeanelle de Gruchy, President of the Association of Directors of Public Health, clarified that "recruitment and retention is such that we have vacancies and we struggle to fill them for a range of reasons" and added that "the focus that has been brought to bear [on the health visitor workforce] has been really helpful, but it is about sustaining that".[163]

53. The decline in health visitor numbers appears to be stretching the workforce thin. The Institute of Health Visiting's 2017 survey of English health visitors found that one in five health visitors had caseloads of over 500 children,[164] compared to the maximum of 333 children targeted by the Department of Health and Social Care,[165] and double the 250 children recommended by the Institute themselves.[166] The survey also found that one in three English health visitors worried that their capacity was "so stretched that there may be a tragedy in their area at some point".[167] Professor Bennett stated that "if you reduce a workforce, it will have an impact on the level of service being delivered", but explained that "the impact on the mandated elements of service is, anecdotally, less than the non-mandated elements".[168] In this context, the Institute of Health Visiting warned against prioritising 100% coverage of the mandated health visits without consideration of the impact on the quality of health visits that could be delivered.[169] Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, noted the

159 Department of Health, 'Health Visitor Implementation Plan 2011–15' (2011)
160 Department of Health, 'Health Visitor Implementation Plan 2011–15' (2011), p8
161 NHS Digital, 'NHS Workforce Statistics, February 2018 Staff Group, Area and Level', accessed 31 May 2018
162 Q332
163 Q332
164 Institute of Health Visiting, 'Health Visitors in England fear for some children's futures as their numbers are reduced: Results from a Survey of English Health Visitors' (2017)
165 Department of Health, 'Transfer of 0–5 children's public health commissioning to Local Authorities' (2015)
166 Institute of Health Visiting, 'Health Visitors in England fear for some children's futures as their numbers are reduced: Results from a Survey of English Health Visitors' (2017)
167 Institute of Health Visiting, 'Health Visitors in England fear for some children's futures as their numbers are reduced: Results from a Survey of English Health Visitors' (2017)
168 Q332
169 The Institute of Health Visiting told us that "the translation of the mandation of the five reviews into key performance indicators as measures of service performance can have distorting effects that can subvert the intentions of the Healthy Child Programme" and that "to be effective health visitors need to know the families they look after, the current contact rather than outcome driven culture has rendered this impossible"—Institute of Health Visiting (EYI0107)

"massive increase in investment" in health visitors between 2011 and 2015 and suggested that "shakeout" from that investment could have caused some drop in numbers.[170] She nevertheless asserted that:

> I am not complacent, because I really do view the health-visiting workforce as being absolutely crucial in getting intervention right between nought and five.[171]

The Minister did not, however, outline any strategy or action the Government was pursuing to increase or sustain the number of health visitors, or ensure that workloads were manageable.

54. **The Healthy Child Programme is the only mechanism in place through which all children in England should receive early years practitioner support before the age of five. Its coverage is therefore critical for identifying ACEs and other child development issues early. *The Government should review the current provision of the Healthy Child Programme across England and set out, as part of the new national strategy, a date for achieving complete coverage in the number of children who receive all five mandated health visits. Given existing workforce pressures, the Government must ensure that this required increase in coverage does not negatively impact the quality of health visits. It should consult the Institute of Health Visiting on how this can be managed, and be ready to recruit additional health visitors as required.***

The Family Nurse Partnership

55. The Family Nurse Partnership (FNP) offers a schedule of structured home visits by registered nurses, from early pregnancy until the child reaches the age of two.[172] It is commissioned by local authorities,[173] and in those local authorities that offer it, FNP nurses can deliver the mandated elements of the Healthy Child Programme as part of their service.[174] Enrolment and participation is voluntary, and open to women who are:

- first-time mothers aged 19 or under at conception (mothers with previous pregnancies that ended in miscarriage, termination or still-birth are eligible);
- living in an agreed catchment area;
- not yet in their 29th week of pregnancy (enrolment should be as early as possible in pregnancy, 60% should be enrolled by the 16th week of pregnancy); and
- not planning to have their child adopted.[175]

170 Q439
171 Q439
172 Department of Health, 'The Family Nurse Partnership Programme' (2012)
173 Q151
174 Department of Health, 'Transfer of 0–5 children's public health commissioning to local authorities—Overview 2: Health Visiting and Family Nurse Partnership Services' (2014), p3
175 Department of Health, 'The Family Nurse Partnership Programme' (2012), p5

Ailsa Swarbrick, Director of the FNP National Unit, outlined the aims of the programme:

> The aim is to improve the mother's pregnancy outcomes, the child's wellbeing, health and development as it grows to two and in the long term, and the mother's own long-term health and wellbeing—for example, going back into employment.[176]

In 2017, FNP was offered in over 80 (of the 152) local authorities in England and worked with over 10,000 children.[177] On average, families receive around ten visits per year—in 2016 the average incremental cost for a place on the FNP (above usual care) was estimated to be between £1,993 and £4,670 a year.[178]

56. The Department of Health and Social Care commissioned a major study of the impact of the Family Nurse Partnership, which was published in 2016.[179] Using a randomised controlled trial of 1,430 women, the study found "no evidence of benefit from FNP for smoking cessation, birthweight, rates of second pregnancies, and emergency hospital visits for the child", and concluded that:

> Continued provision of the Family Nurse Partnership programme cannot be supported on the basis of the trial evidence found for its effectiveness in the UK setting. Subsequent changes to the intervention itself, to [the care that is] usually provided , or to the population targeted would justify re-examination. Similarly, any positive benefits observed through longer-term follow-up of the current trial cohort might shift the evidentiary balance in favour of the intervention and warrants continued evaluation of the trial cohort.[180]

The study did, however, report that "some secondary outcomes suggested small positive impacts of the FNP". These included:

- intention to breastfeed;
- maternally reported child cognitive development (at 24 months only);
- language development using a modified maternal-reported assessment (at 12 and 18 months) and using a standardised assessment (the Early Language Milestone at 24 months); and
- levels of social support, partner-relationship quality, and general self-efficacy.

176 Q102

177 Q102; In two-tier local council systems, the county councils hold responsibility for public health which leads to the figure of 152 cited here—see 'The new public health role of local authorities', Department of Health and 'Local government structure and elections', Ministry of Housing, Communities & Local Government, both accessed 11 September 2018

178 Robling *et al.*, 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial', Lancet vol 387 (2016)

179 Robling *et al.*, 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial', Lancet vol 387 (2016)

180 Robling *et al.*, 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial', Lancet vol 387 (2016), p147

The negative conclusions of the study were in contrast to previous studies of partner programmes in other countries.[181] Accounting for the difference in impact found in the USA and the UK, the authors of the British study noted that:

> Unlike women in the US settings in which the intervention originated, teenage mothers in England can access many statutory supportive health and social services, including community based family doctors, midwives, and public-health nurses, and, in most trial sites, specialist teenage pregnancy midwives.[182]

They suggested that this level of care available to mothers who did not receive FNP support might have diluted any relative benefits of the programme.

57. Many commentators have cautioned against responding too decisively to the findings of the UK study.[183] Jason Strelitz, Assistant Director of Public Health for the London Boroughs of Camden and Islington, has said that although the results of the study should form the basis for future discussion and scrutiny of the FNP, the primary outcomes measured by the study did not match the aims of the Family Nurse Partnership as much as the secondary outcomes (which recorded small positive outcomes). He also noted that the evaluation started not long after the Family Nurse Partnership programme had started, and therefore potentially before its delivery had been fully developed.[184] Professor Melhuish similarly told us that there "was a fundamental mistake that was made at the Department of Health in choosing which outcomes were critical in the randomised control trial".[185] He noted that a similar study conducted in the Netherlands with different outcomes found "entirely positive results". Based on the British and international evidence, the Early Intervention Foundation continues to list the FNP as one of three early intervention programmes with the strongest evidence of effectiveness.[186] Ailsa Swarbrick, Director of the FNP National Unit, told us:

> The trial was disappointing, obviously. FNP is a very complex programme […] It is therefore very difficult to measure it absolutely and to say, 'This has passed', or, 'This has failed'. Your view of it depends very much on what outcomes you choose and the point in time at which you measure it.[187]

Ms Swarbrick added that the FNP National Unit had introduced a "significant and ambitious improvement programme" to learn from, and act upon, the study findings.[188]

181 These results came from studies in New York, Tennessee and Colorado, USA, and the Netherlands. Full details can be found in the Family Nurse Partnership entry in the Early Intervention Foundation Guidebook.

182 Robling *et al.*, 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial', Lancet vol 387 (2016), p152

183 For example, see Qq109–110 and 205

184 'The FNP evaluation: Inconvenient truth or a bump in the road?', Early Intervention Foundation, accessed 21 June 2018

185 Q109

186 'Early Intervention Foundation Guidebook', Early Intervention Foundation, accessed 21 June 2018

187 Q115

188 Q103; see also Family Nurse Partnership National Unit, 'FNP ADAPT Interim Report' (2018)

58. Asked for the Government's interpretation of the study's findings and how widely it would like to see FNP used across England, the Parliamentary Under-Secretary of State for Mental Health and Inequalities told us that the Family Nurse Partnership was an "important aspect" of the Healthy Child Programme but that ultimately its use "comes down to local commissioning".[189]

59. **There appears to be significant concern within the early years community at the outcomes for assessment chosen by the then Department of Health for the major study it commissioned of the Family Nurse Partnership. We therefore do not encourage national or local Government to act upon the study's overall recommendation to discontinue provision of the Family Nurse Partnership. Nevertheless, the study's findings should be considered and where they can be used, to improve the impact of the Family Nurse Partnership programme such action should be pursued. We commend the Family Nurse Partnership National Unit for implementing its 'ADAPT' initiative to learn from the study's findings, and we urge local commissioners and providers to act upon the conclusions reached by this initiative.**

60. **Although we commend the Government on its willingness to commission a significant study of the effectiveness of the Family Nurse Partnership, such studies are only of value if their findings are widely supported and acted upon. The provision of evidence-based early interventions will clearly benefit from studies that can provide a strong evidence base. *If the Government commissions future major studies of significant early intervention programmes—which we would welcome—it must ensure that the outcomes it decides are to be assessed, and other elements of the design of such studies, are supported by the early years practitioner community. The Government must then act upon the evidence generated by those studies.***

Sure Start children's centres

61. The Sure Start programme started in 1998 and has evolved considerably since then.[190] Sure Start children's centres currently provide or co-ordinate a variety of early years services (such as education, childcare, health services, social services and information, advice and training), based around a broadly-defined 'core purpose' to improve child and family outcomes and reduce inequalities in child development, parenting, health and life chances.[191] A national evaluation of Sure Start found in 2012 that Sure Start local programmes had beneficial effects on family functioning and maternal wellbeing, but not on child outcomes at age seven.[192] Professor Edward Melhuish, who led the national evaluation study, told us that changing formats and funding over the life of the Sure Start programme had led to varied success, but said that "the children's centre model can work, when it is done properly" and indicated that the model for effective centres was known.[193] He endorsed the House of Commons Education Committee's 2013 Report on Sure Start,[194] which recommended a more detailed core purpose, better evaluation and more focused

189 Q440
190 'Sure Start (England)', Briefing Paper 7257, House of Commons Library (2017)
191 Department for Education, 'Sure Start children's centres statutory guidance' (2013), pp 6–7
192 Department for Education, 'The impact of Sure Start Local Programmes on seven year olds and their families' (2012)
193 Qq113–114
194 Q114

delivery to those most in need.[195] Instead, he told us that the Report "has just been sitting on the shelf somewhere" and that the children's centre approach "has been left to wither on the vine, by and large, by central Government".[196]

62. After initially intending to target Sure Start children's centres in the most disadvantaged communities,[197] the then Government decided in 2004 that there should be one in every community in England.[198] However, after a peak of 3,632 centres in 2009, the number of centres has since fallen.[199] The Sutton Trust estimated that at least 14% of children's centres closed between August 2009 and October 2017, with closures concentrated in certain areas but equally distributed between more and less-deprived communities.[200] It also reported that the children's centres that remained open offered fewer services and had shorter opening times. Martin Pratt, Chair of the Association of London Directors of Children's Services, attributed these closures to limited available funding and told us that they should not be interpreted as "a loss of faith in the model but simply as the prioritisation of a shrinking resource".[201] The Sutton Trust similarly reported local authorities citing financial pressures as the principal driver of reduced services, just ahead of changing strategies and priorities.[202] The Children's Minister, Nadhim Zahawi MP, told us that he wanted to focus on outcomes rather than "obsess about bricks and mortar",[203] and suggested that some local authorities had achieved more by investing in direct outreach programmes instead of infrastructure.[204] The Minister added that children's centres would be reviewed as part of the Government's social mobility action plan, to identify good practice.[205]

63. The Government first announced that it would review children's centres in 2015, with a proposed consultation on the future of Sure Start children's centres.[206] The same year, it also suspended Ofsted's regular inspections of children's centres "on a short term basis" to await the results of the consultation;[207] this suspension was reconfirmed this January (registered early years provision within children's centres continues to be inspected as part of the Common Inspection Framework).[208] The consultation on the future for Sure Start children's centres has still not been launched. The Minister declined to give us a date for the launch of the consultation,[209] and later suggested that it might not happen at all:

195 Education Committee, Fifth Report of Session 2013–2014, 'Foundation Years: Sure Start children's centres', HC 364-I
196 Q114
197 HC Deb, 20 January 1999, cols 501–502W
198 This amounts to 3,500 Children's Centres in total—HM Treasury, 'Choice for parents, the best start for children: a ten year strategy for childcare' (2004), para 5.10
199 The Sutton Trust, 'Stop Start: Survival, decline or closure? Children's centres in England' (2018)
200 The Sutton Trust, 'Stop Start: Survival, decline or closure? Children's centres in England' (2018)
201 Q284
202 The Sutton Trust, 'Stop Start: Survival, decline or closure? Children's centres in England' (2018)
203 Q458
204 Q384
205 Q459–462
206 Nursery World, 'Exclusive: Gyimah launches children's centre consultation', accessed 4 June 2018
207 Letter from Sam Gyimah MP to Sir Michael Wilshaw, dated 25 September 2015, accessed 4 June 2018
208 PQ 124199 [on Children's Centres: Inspections], 22 January 2018
209 Qq459–464

> The [Early Years Social Mobility Peer Review Programme] will spread best practice and help councils looking to close the gap between disadvantaged children and their peers. This will inform the next steps in our strategy to close the development gap, including considering any future consultation on the role of children's centres.[210]

Martin Pratt told us that London councils wanted to see the consultation happen "so that we can be clear about the position Sure Start centres have in national policy going forward".[211]

64. **The delay in launching a consultation on the future of Sure Start Centres is regrettable and has meant that Ofsted has not inspected children's centres since 2015. Local authorities have been left unsure of the status of children's centres in future policy. *The Government should clarify its position on Sure Start centres. In response to this Report, it should specify if—and when—it intends to hold a consultation. If it intends to proceed with a consultation, this should be held within three months. The Government should also set out the focus and purpose of such a consultation. If a consultation is not going to be held, the Government must urgently reinstate Ofsted inspections of children's centres and make clear its thinking on the role and value of children's centres.***

The children and young people's mental health green paper

65. The Department of Health and Social Care and the Department for Education jointly published a green paper outlining the Government's strategy for "transforming children and young people's mental health provision" in December 2017.[212] The paper acknowledged the "emerging evidence that Adverse Childhood Experiences in infancy may have negative impacts on future mental health and wellbeing outcomes", and put forward a number of ways in which the Government intended to address this issue, such as:

- commissioning "further research into interventions that support parents and carers to build and/or improve the quality of attachment relationships with their babies";
- updating guidance for schools on promoting good behaviour to take into account the "impact of trauma, attachment issues or post-traumatic stress experience on individual children"; and
- working with the What Works Centres to produce guidance for local authorities on commissioning evidence-based interventions to improve mental health.[213]

210 Department of Health and Social Care and Department for Education (EYI0109)
211 Q288
212 Department of Health and Department for Education, 'Transforming Children and Young People's Mental Health Provision: a Green Paper' (2017)
213 Department of Health and Department for Education, 'Transforming Children and Young People's Mental Health Provision: a Green Paper' (2017), paras 12, 97, 118 and 124

However, the main focus of the green paper's proposals related to delivering mental health support through schools and colleges. The Centre for Mental Health, a mental health charity, expressed its concern to us that "the green paper is limited in its focus on prevention and early intervention".[214] Dr Marc Bush, Chief Policy Adviser at YoungMinds, flagged similar "obvious gaps" in the paper:

> One is around the early years, where there can be good-quality early intervention […] Does [the green paper] carry the level of ambition and make [childhood adversity and trauma] a national priority, with a public health priority and a commitment to co-ordinated commissioning across the board? No. Do we think that that should be there? Yes.[215]

Kate Stanley, Director of Strategy, Policy and Evidence at the NSPCC, told us that the green paper lacked ambition, describing it as "meek overall".[216]

66. The House of Commons Education Committee and Health and Social Care Committee heard similar evidence during their joint inquiry into the Green Paper, and recommended that the Government should "place a greater emphasis on, and provide a strategy for, prevention, early intervention and dealing with some of the root causes of child mental health problems".[217] In its response to the Committees' Report,[218] the Government outlined a variety of measures it was taking to address prevention and early intervention but these still mostly relate to training for school teachers or pupils (including the establishment of Public Health England's Special Interest Group, whose findings "will feed into the prevention work that is supported in schools"[219]). The Prevention Concordat on Mental Health that the Government also referred to provides no focus on childhood adversity.[220] Respondents to the consultation launched by the Green Paper also recommended broadening its remit to include support during the early years, but in its response to the consultation the Government simply committed to "considering further analysis" in areas such as low-stress pregnancy, perinatal mental health and healthy childhood.[221]

67. Overall, Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, acknowledged that:

> If you look at the statistics, there is a good chance that, if there is a contributor to poor mental health, it will come in the first five years, within traumatic environments and so on. That is why I am very keen to see what else we

214 Centre for Mental Health (EYI0050)
215 Q90
216 Q90
217 Education Committee and Health and Social Care Committee, First Joint Report of Session 2017–19, 'The Government's Green Paper on mental health: failing a generation', HC 642, paras 26 and 42–46
218 Department of Health and Social Care and Department for Education, 'Government Response to the First Joint Report of the Education and Health and Social Care Committees of Session 2017–19' (2018), pp 11–13
219 Department of Health and Social Care and Department for Education, 'Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps' (2018), p35; the Mental Health Support Teams that will carry out this work will all be linked to groups of primary and secondary schools and to colleges
220 Public Health England, 'Prevention Concordat for Better Mental Health: Prevention planning resource for local areas—Summary' (2017)
221 Department of Health and Social Care and Department for Education, 'Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps' (2018), pp 14–15

> can do in that nought-to-five space. You are right that it is not a big feature of the Green Paper, but the important thing about the Green Paper is that, finally, we have broken down the silo between our two Departments.[222]

68. **We welcome Minister Doyle-Price's ambition to do more in this area. However, there was a disappointing level of ambition and focus on pre-school aged children in the Government's 2017 Green Paper on 'transforming children and young people's mental health provision'.** ***As it develops its action on children and young people's mental health, the Government should recognise the importance of child development and the impact of adversity in the early years, and ensure that it adopts 'transformative' ambitions and policies for pre-school aged children alongside its work targeting schools and colleges.***

69. In keeping with the early intervention ethos, one strategy for improving mental health in schools is through 'social and emotional learning'. This aims to promote children's social and emotional competency from the outset, instead of seeking to identify emerging problems as soon as possible. The Education Endowment Foundation has said that "on average, social and emotional learning interventions have an identifiable and valuable impact on attitudes to learning and social relationships in school", with evidence of positive impact in early years, primary and secondary school settings, and particular benefit for disadvantaged or low-attaining pupils.[223] However, this approach was not an area of focus in the Government's green paper. Indeed, the Centre for Mental Health told us:

> It is also disappointing that the green paper dismisses Social and Emotional Learning programmes despite the strong evidence of their benefits. Classroom based programmes that seek to build resilience and wellbeing are among the few examples of universal mental health promotion programmes that have been shown to be cost-effective over time.[224]

70. **Prevention of mental health problems can start before signs of low mental wellbeing start to appear, through promotion of healthy mental wellbeing to all children.** ***The Government should set a policy for primary and secondary schools that seeks to promote wellbeing as well as improving the early identification of, and support for, emerging problems.***

Other programmes

71. The Government administers other programmes and strategies that affect early years children or their families. The most prominent examples of these are outlined in Table 1, along with an assessment of how directly they address childhood adversity or trauma.

222 Q452
223 'Social and emotional learning', Education Endowment Foundation, accessed 30 August 2018
224 Centre for Mental Health (EYI0050)

Table 1: Other early years programmes

Programme	Description	Relation to childhood adversity and trauma
Children's Social Care Innovation Programme	The Children's Social Care Innovation programme aims to "support local efforts to transform services for the most vulnerable children by providing tailored funding and professional support to innovative projects",[225] and will see £200m invested into 98 projects by 2020.[226] Alongside the Innovation Programme, there is a 'Partners in Practice' scheme that tasks leading local authorities with: • continuing to demonstrate what works and drive innovation to build understanding of the conditions needed for excellent practice to flourish; • driving sector-led improvement through peer support to authorities who need to improve; and • supporting the Department for Education to shape and test policy on wider programmes and reforms.[227]	The final wave of the programme to 2020 is focusing on four policy areas "where there is a need to quickly develop and test new approaches";[228] all of these relate to children who have already received some form of statutory support and hence fall outside of our focus on early intervention to address childhood adversity and trauma.[229]
The Troubled Families Programme	The Troubled Families Programme has run since 2012, with a second phase starting in 2015. Under the programme, local authorities are asked to identify and support families with multiple problems (at least two of six defined problems, including domestic abuse, physical or mental health problems and having children in need),[230] and can claim funding if the family achieves "significant and sustained progress" against all identified problems or if an adult in the family moves into continuous employment.[231] The Children's Minister told us that 40% of the 400,000 families involved in the programme have a child under the age of five, and that they present with "all sorts of different traumas and problems".[232] The Early Intervention Foundation described the programme as "an important vehicle for reaching vulnerable families who may be at risk of exposing children to adverse experiences".[233]	The Government said in 2017 that it would use the next phase of the programme to "encourage a greater emphasis on tackling worklessness and issues associated with it".[234] Although it went on to say that "this will be done without diminishing the other vital work the programme does across the many other problems that families experience",[235] the Government's latest report to Parliament on the programme re-iterated that it "will be encouraging local authorities to prioritise families experiencing worklessness".[236] The Kidstime Foundation and the Children's Society told us that this new prioritisation "does not make it easy for the programme to adequately address ACEs and improve long term outcomes for future generations".[237]

225 Department for Education, 'Children's Social Care Innovation Programme: Final evaluation report' (2017), p13
226 'The Children's Social Care Innovation Programme', Spring Consortium, accessed 25 June 2018
227 'Partners in Practice', Spring Consortium, accessed 25 June 2018
228 'The Children's Social Care Innovation Programme', Spring Consortium, accessed 25 June 2018
229 Department for Education briefs: 'Staying Close'; 'Testing the use of social investment to improve outcomes for care leavers'; 'Alternative delivery models'; and 'Targeted Support', accessed 25 June 2018

Programme	Description	Relation to childhood adversity and trauma
Social Mobility Plan	The Government announced a new strategy to improve social mobility in 2017, with £800m funding to "deliver equality of opportunity for every child, regardless of where they live".[238] The strategy set out ambitions for the four key life stages of people's education, including "closing the 'word gap' in the early years".[239] It highlighted the importance of the early years in the development of "strong cognitive, social and emotional foundations on which future success is built", and proposed a range of measures intended to improve early years literacy and communication.[240]	Despite the importance of the announced measures to improve early years education and reduce inequality, it is clear that the social mobility strategy is focused on educational attainment, and does not directly relate to early years adversity or trauma.

72. In addition to these programmes, all three and four-year-olds in England are currently able to receive 570 hours a year of Government-funded childcare or early years education, commonly taken as 15 hours per week for 38 weeks.[241]Parents who are in work and earning at least the National Minimum Wage for 16 hours a week qualify for 570 further hours per year.[242] Some two-year-olds also qualify for 570 hours of childcare or early years education, these are typically children whose parents are receiving certain benefits.[243] Professor Melhuish told us that the childcare offer for two-year-olds had achieved "positive results",[244] but that "the Government are missing a trick" in its deployment by not being more prescriptive of the childcare or education provided. He explained that:

> The two-year-old offer is targeting the 40% most disadvantaged families in the country […] You have a ready-made audience for a range of strategies for improving children's development. At the moment, all that [the

230 Department for Communities and Local Government, 'Financial framework for the Troubled Families programme' (2018), p18
231 Department for Communities and Local Government, 'Financial framework for the Troubled Families programme' (2018), p24
232 Q379
233 Early Intervention Foundation (EYI0061), para 26; The Foundation cautioned that "much of the focus [of the Troubled Families Programme] to date has been on making the system work for complex families rather than expanding the availability of evidence-based provision", but suggested that "this may now be changing"
234 Department for Work and Pensions, 'Improving Lives: Helping Workless Families' (2017), para 49
235 Department for Work and Pensions, 'Improving Lives: Helping Workless Families' (2017), para 49
236 Department for Communities and Local Government, 'Supporting disadvantaged families—Troubled Families Programme 2015–2020: progress so far' (2017), p24
237 Kidstime Foundation and the Children's Society (EYI0082), para 32
238 'Plan to boost social mobility through education', Government Digital Service, accessed 18 July 2018
239 Department for Education, 'Unlocking Talent, Fulfilling Potential' (2017), p11
240 Department for Education, 'Unlocking Talent, Fulfilling Potential' (2017), pp12–15
241 'Help paying for childcare', Government Digital Service, accessed 26 June 2018
242 'The Government made clear that this extended entitlement to childcare for 3- and 4-year-olds is "primarily a work incentive" (HC Deb, 25 January 2016, col 58)
243 Help paying for childcare: Free education and childcare for 2-year-olds', Government Digital Service, accessed 18 July 2018
244 Q141

> Government] are doing is paying for this provision, regardless of what it is. There is no specification of what it should be, apart from the rules that Ofsted lays down.[245]

73. **There are a variety of programmes beyond the Healthy Child Programme, the Family Nurse Partnership and the Sure Start initiative that reach children who are experiencing or have experienced adversity and trauma. However, none of these programmes specifically target these children and they do not prioritise preventing ACEs or mitigating their effect. This reinforces the need for the Government to develop a new national strategy specifically focusing on childhood adversity and trauma, and on evidence-based early intervention initiatives that can address these issues.**

74. **There is an opportunity for the Government to increase the provision of evidence-based early years programmes, without increased cost, by setting more prescriptive specifications on the content of childcare eligible for Government funding. *The Government should work with researchers and practitioners to examine how new specifications on the free childcare it funds could increase the use of evidence-based programmes, and what the impact would be on the families affected. Such specifications could rapidly increase the number of families receiving evidence-based programmes and we call on the Government to review this by the end of this Parliamentary session, although local providers should be given a period of time to adjust to any new specifications.***

245 Q145

4 Key Challenges to Delivering Early Intervention

75. In this Report, we have so far identified the potential for effective early intervention targeting childhood adversity and trauma to improve lives and save costs, and urged the Government to set out a national strategy to seize this opportunity. This Chapter explores the main challenges that local authorities and their partners face in delivering evidence-based early intervention, specifically: funding constraints; challenges in collecting and analysing data; and skills gaps in the early years workforce.

Funding

76. In 2017, the Association of Directors of Children's Services warned that the ability of local authorities to provide early intervention was "being eroded due to the lack of available financial resources", which it said was "driving up both referrals to, and demand for, statutory child protection services".[246] The Association of Directors of Public Health similarly told us that evidence-based early intervention programmes can often be too expensive for local authorities to deliver widely, and that "progressing this long-term preventative agenda with no additional funding will be a challenge".[247] A group of academics from the London School of Economics and Political Science further noted that "current expenditure patterns from both the US and the UK show that little is spent on young children", with social services expenditure peaking for children aged 15.[248]

77. Multiple changes to the funding structure for local authorities over recent years, combined with flexibility in how local authorities spend their funding, makes it impossible to say exactly how spending for early intervention has changed in recent years. The Children's Minister told us that "the investment profile has shifted from bricks and mortar towards direct intervention to the individual child" and outlined £6bn of spending on childcare.[249] However, there appears to be reasonable agreement that the spending levels for early intervention specifically have fallen. The Ministry of Housing, Communities and Local Government has continued to publish estimates of the nominal early intervention funding that English local authorities have received since the end of the Early Intervention Grant in 2013.[250] According to these figures, early intervention funding has reduced from £1.71bn in 2013–14 to £1.21bn in 2017–18, and is forecast to reach £1.02bn in 2019–20 (a ~40% reduction from 2013–14 levels).[251] A coalition of UK children's charities estimated in 2017 that local authority spending on early intervention had fallen by £1.4bn between

246 Association of Directors of Children's Services, 'A Country that Works for All Children' (2017), p8
247 Association of Directors of Public Health (EYI0031)
248 Bonin *et al.*, London School of Economics and Political Science (EYI0081)
249 Q399; The Department for Education clarified that local authorities' self-reported spend on children's services was approximately £9.2bn in 2016–17, with around £6.5bn spent on "the most vulnerable children" (for example looked after children or adoption services) and around £1.1bn spent on family support services—Department of Health and Social Care and Department for Education (EYI0109)
250 The Early Intervention Grant was introduced in 2011–12 to enable local authorities to respond to local needs, drive reform and promote early intervention more effectively. In 2012–13, the Grant was one of nine rolled into the 'Start-Up Funding Assessment' funding for local authorities, with the introduction of the business rates retention scheme.
251 'Breakdown of Start-Up Funding Assessment 2013–2014' and 'Core spending power: visible lines of funding 2018–2019', Ministry of Housing, Communities and Local Government, accessed 19 July 2018

2010–11 and 2015–16, from £3.6bn to £2.2bn.[252] The Minister for Mental Health and Inequalities acknowledged that "local authorities have borne the brunt of significant cuts".[253]

78. It is important to look at the specific funding allocated to early intervention because such services can be de-prioritised relative to other children's services. The Association of London Directors of Children's Services noted that they had already seen a "reduction in investment in early intervention as local authorities have been under increasing financial pressure, on the basis that preventive services are often discretionary and late intervention services mandatory".[254] The Greater Manchester Combined Authority similarly told us that the funding requirements of statutory services can put pressure on resources for early intervention:

> The challenge is sustaining non-statutory services at times of reducing budgets coupled with rising demands for statutory interventions, determined often by wider issues than the quality of the early intervention offer e.g. poverty, quality of housing stock.[255]

79. The impact of financial pressures on local authority decision-making is not only early intervention programmes being cut because of priority being given to statutory services. In 2017, the Social Mobility Commission reported that local authorities often provided cheaper, un-evidenced programmes rather than more expensive programmes with proven effectiveness. It cited a 2013 evaluation of children's centre services that found "in many areas, just a dozen or so parents per year were benefiting from programmes known to be effective", and stated that "matters are not likely to be any better today".[256] Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, told us that local authorities were also reluctant to invest in evaluating the programmes they were delivering because "it is expensive to evaluate interventions, and most people would prefer to deliver a service rather than invest in a research project".[257] She said that this "drive to prioritise getting services to people" was "completely understandable", but "leaves us with a context in which we know very little about the performance of some of the things that are being delivered in this space".[258]

80. George Hosking, CEO of the WAVE Trust, told us that the Trust had also found funding constraints to be one of the main barriers to early intervention cited by local authorities and early years practitioners,[259] but he argued that:

> We did not believe that the [financial] reason was a valid one because we found that quite a significant number of local areas were implementing prevention and early intervention, and reporting that they were saving money by doing

252 Action for Children, the National Children's Bureau and The Children's Society, 'Turning the tide: Reversing the move to late intervention spending in children and young people's services' (2017)
253 Q415
254 Association of London Directors of Children's Services (EYI0105); Tom McBride, Director of Evidence at the Early Intervention Foundation, similarly told us that "we are talking about a constrained system that prioritises statutory services over prevention and early intervention, and that is one of the barriers to implementing early intervention, let alone evidence-based early intervention"—Q194
255 Greater Manchester Combined Authority (EYI0047)
256 The Social Mobility Commission, 'Time for Change' (2017)
257 Q193
258 Q194
259 WAVE Trust, 'A preventive and integrated approach to early child development: What's Missing?' (2014)

> so—for example, Essex and Gloucestershire. Therefore, the areas that said they could not afford to do it were not grasping the opportunity provided to bring in approaches that, when they were implemented by slightly more courageous areas, were proving beneficial.[260]

However, Martin Pratt described two "inherent system difficulties" that local authorities faced in investing in early intervention:

> First of all, the beneficiaries of the investment in early intervention—either particular budget holders or particular departments—are not necessarily those that have to make the investment. Secondly, [the benefits do not accrue] necessarily over a timescale that fits with either the electoral cycle or the priorities of those organisations.[261]

The Greater Manchester Combined Authority noted similar challenges.[262] Action for Children, a UK children's charity, has also noted the short-term duration of the spending review cycles and the consequent difficulties for local authorities in planning or commissioning early intervention programmes.[263] Dr Caroline White, Head of the Children and Parents Service in Manchester, similarly complained that "there is often short-term funding":

> We are very short-sighted in how to implement things, rather than building for sustainability. I am always thinking five years ahead, even though I have never had a five-year contract in my service; it has often been for 12 months.[264]

81. Even with constraints in funding, we heard that this did not mean no progress on early intervention could be made. Professor Alan Harding, Chief Economic Adviser for the Greater Manchester Combined Authority, told us that although "cutbacks clearly give local authorities incredible challenges", "the sense of comments from colleagues is that it is not purely about resourcing".[265] Instead, he said that system change was more important than restoring funding. Similarly, Dr Caroline White told us that "generally, we could be doing a lot better, even with the resources we have, before we even start thinking about additional resources".[266]

260 Q194
261 Q244
262 Greater Manchester Combined Authority (EYI0047); problems with siloed funding was also raised by George Hosking, CEO of the WAVE Trust (Q206) and Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation (Q207)
263 Action for Children, 'Early intervention: Where now for local authorities?' (2013)
264 Q226
265 Q240
266 Q216

82. **Despite the long-term savings associated with effective early intervention, the amount of funding available to local authorities that is nominally destined for early intervention is declining.[267] This can result in early intervention activity being sacrificed in favour of statutory duties, in addition to the commissioning of cheaper, unproven interventions as well as a reluctance to properly evaluate interventions that are being delivered. Nevertheless, funding constraints should not be used by local commissioners and others as an excuse to avoid acting upon the latest evidence regarding childhood adversity and early intervention—especially given the savings that some programmes can deliver for local authorities, particularly in the long-term, and given the positive impact on the life chances of children.**

Data collection and analysis

83. As discussed in Chapter 2, although early intervention programmes can demonstrate strong evidence of long-term positive impact, this is not true of all interventions that have been evaluated. Professor Feinstein, Director of Evidence at the Children's Commissioner's Office, told us that "the general case that early intervention can work can never support the specific case of a specific service or activity for a specific client group".[268] Alison Michalska, the then President of the Association of Directors of Children's Services, has stated that "it is rarely the case that any initiative or intervention can be simply lifted and shifted wholesale from one place where it appears to work, to another place, without contextualized modifications".[269] Dr Caroline White, Head of the Children and Parents Service in Manchester, took a slightly different view and told us instead that "where we fall down [nationally] is in the implementation of those programmes".[270] In either case, the importance of data collection and analysis for evaluation of early intervention programmes was stressed by many of our witnesses.[271] Donna Molloy pointed out simply that local authorities "will not know [if a service is effective] if they have not evaluated it".[272]

84. In the UK, statutory guidance for local authorities, clinical commissioning groups and police forces requires only that information on "how the safeguarding partners will use data and intelligence to assess the effectiveness of the help being provided to children and families, including early help" be published.[273] Dr Caroline White told us that

267 We note that the 2018 Budget contained two announcements of potential relevance to funding for early intervention: "5.16: The Budget provides a further £410 million in 2019–20 for adults and children's social care. Where necessary, local councils should use this funding to ensure that adult social care pressures do not create additional demand on the NHS. Local councils can also use it to improve their social care offer for older people, people with disabilities and children." and "5.18: The Budget provides £84 million over 5 years for up to 20 local authorities, to help more children to stay at home safely with their families. This investment builds on the lessons learned from successful innovation programmes in Hertfordshire, Leeds and North Yorkshire."—HM Treasury, 'Budget 2018' (2018), paras 5.16 and 5.18

268 Children's Commissioner's Office, 'Leon Feinstein writes about early intervention ahead of Select Committee appearance', accessed 27 March 2018; Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, similarly told us that "nothing works everywhere and for all families, and what works in one context might not work in another"—Q178

269 Alison Michalska, President of the Association of Directors of Children's Services, Early Intervention Foundation National Conference keynote speech, 11 May 2017 (accessed 29 May 2018)

270 Q215, Q225 and Children And Parents Service (CAPS) Early Intervention (EYI0004); The Centre for Mental Health, a mental health charity, similarly told us that programmes often fail "because of poor quality implementation or ineffective delivery—Centre for Mental Health (EYI0050)

271 For example, see Better Start Bradford (EYI0113) and Qq82, 98, 107, 193, 249–250, 276

272 Q194

273 HM Government, 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (2018), paras 38–39

guidelines for evaluation of early intervention services were also frequently missing from NICE guidance.[274] Alison Michalska, the then President of the Association of Directors of Children's Services, argued in 2017 that the lack of statutory data collection requirements was responsible for the fact that "local authorities do different things in respect of recording and monitoring early help—indeed some do not record at all".[275] The Early Intervention Foundation has similarly found that data collection for monitoring early intervention is not common practice in the UK, leaving a "vast amount of services being delivered in many local areas [that] are not well evaluated".[276] Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, explained that "without that basic monitoring of data and understanding, it can be quite hard to have a sound basis for making decisions about how things might need to change in local service configuration".[277]

85. In addition to using routine administrative data to help assess the impact of specific early intervention programmes, Martin Pratt, Chair of the Association of London Directors of Children's Services, told us that there was also a second, "broader" use of data:

> We refer to it as forensic visibility, thinking about the information that is gathered from the earliest opportunity. It begins to identify children who have had adverse childhood experiences, where there are developmental issues emerging and there may be other warning indicators. This is not to get into a situation where we are thinking in a deterministic way, but a number of those indicators should cause us to pay attention and therefore to work with the family and think about that child's circumstances.[278]

In this context, the Greater Manchester Combined Authority noted that "when you look at human potential and adversity, it is crystal clear that gestation to aged 2 years are the most critical years, and yet we have no measure of progress tracking those time frames from a child development viewpoint".[279] This echoes the 2011 Allen Review, which identified a similar gap and recommended that "all children should have regular assessment of their development from birth up to and including 5, focusing on social and emotional development".[280]

86. Public Health England does publish indicators of public health from data supplied voluntarily by local authorities,[281] which Professor Viv Bennett, Chief Nurse at Public Health England, told us could be used to identify families who could benefit from particular

274 Q252

275 Alison Michalska, President of the Association of Directors of Children's Services, Early Intervention Foundation National Conference keynote speech, 11 May 2017 (accessed 29 May 2018)

276 Q193

277 Q193

278 Q261

279 Greater Manchester Combined Authority (EYI0047) and Qq258–259; the Association of London Directors of Children's Services also stated that "the most critical years are 0–2 but there is no consistent measure for tracking child development at that age" and highlighted this as a key challenge to evaluating early intervention (EYI0105)

280 Graham Allen, 'Early Intervention: The Next Steps' (2011), p56; this was reiterated in NICE guidelines on social and emotional wellbeing in early years that stated that "there is limited UK data on the indicators that provide an overall measure of the social and emotional wellbeing of children aged under 5 years"—NICE, 'Social and emotional wellbeing: early years' (2012)

281 These indicators of public health are listed under Public Health England's Public Health Outcomes Framework, for more information see Department of Health, 'Improving outcomes and supporting transparency' (2016); Prof Bennett told us that local authority data submission is currently voluntary but "very well subscribed to"—Q306

support.[282] However, none of the 67 'early years' indicators correspond directly to ACEs[283] and only three relate to child development.[284] NHS Digital collects data from providers of health visiting services for all five mandated health visits of the Healthy Child Programme as part of its Community Services Data Set, but currently receives this data from under half of all local authorities (Public Health England told us that it is working with NHS Digital to increase this number).[285] NHS Digital has started publishing experimental statistics[286] on breastfeeding rates at the 6–8 week visit and child development scores at the 2–2½ years visit,[287] and is hoping to publish experimental data covering all five visits by the end of 2018.[288] NHS Digital is also "in the early stages of exploring the longitudinal potential of the Maternity Services Data Set and the Community Services Data Set".[289] For example, data covering the maternity period through to starting school could be linked with other datasets such as the national pupil database.[290] However, Professor Bennett indicated that this would not be achieved for some time:

> If there was a perfect system tomorrow, it would still take five years, because clearly it takes five years for children to reach that level of maturity. As to how quickly we think the system will start to do that work, I hope that within the next two years we will start to see some of that improvement. Some of it will depend on investment.[291]

In addition to working to ensure data collection from each mandated visit of the Healthy Child Programme, NHS England is also working to digitise children's health information (including the 'Red Book') so that it can be more readily accessed by the variety of agencies that need it.[292] The Government told us that "the digital child health programme's transformation strategy will be in development until at least 2020", although it qualified that "it may be brought forward once technological advances with e-messaging and digital self-care applications come on stream".[293]

87. The Government's 2016 vision for children's social care acknowledged that "we still do not get full value out of the wealth of data we collect", and set out measures to address this, including:

282 Q355
283 Two indicators of adult health corresponding to ACEs are collected (1.11 'Domestic abuse' and 2.15 'Drug and alcohol treatment completion and drug misuse deaths') but are not focused on adults with young children—Department of Health, 'Improving outcomes and supporting transparency' (2016)
284 Public Health England, 'Public Health Outcomes Framework: Early years', accessed 6 June 2018—the three indicators relating to child development are: school readiness; average strengths and difficulties questionnaire score for looked after children; and proportion of children aged 2–2½ offered ASQ-3 as part of the Healthy Child Programme or integrated review. Professor Bennett acknowledged that "most of those are factors relating directly to what you might term physical health", but argued that they identify risk factors and correlate with the need for additional support—Q355
285 Public Health England (EYI0104)
286 Experimental statistics are new official statistics undergoing evaluation, published "in order to involve users and stakeholders in their development and as a means to build in suitability and quality at an early stage"—Public Health England (EYI0104)
287 'Community Services Statistics for Children, Young People and Adults—March 2018', NHS Digital, accessed 27 July 2018
288 Public Health England (EYI0104)
289 Public Health England (EYI0104)
290 Q321
291 Q321
292 NHS England, 'Healthy Children: Transforming Child Health Information' (2016)
293 Department of Health and Social Care and Department for Education (EYI0109)

- working with local partners to improve the collection, sharing, analysis and use of data;
- exploring the use of technology to support data-driven practice; and
- developing a framework of best practice in this area.[294]

88. **The collection and analysis of appropriate data is vital to monitoring the impact of early intervention initiatives to ensure that they are achieving the desired effect and to inform further improvements. It can also help to identify families that may benefit from early intervention. Despite these critical uses, the local collection and analysis of data is not conducted as widely or as thoroughly as it should be around the country. Collation of relevant data at a national level is also insufficient, with fewer than half of local authorities submitting data on the five mandated visits of the Healthy Child Programme to NHS Digital. Public Health England's public health indicator data does not appear to include any measures sufficiently focused on childhood adversity or early intervention. The early years are a critical period for child development so it is unacceptable that there is no national system of data collection assessing such development before the age of two. Two years on from the publication of the Government's 'vision' for children's social care, it is clear that there is still significant work to be done to achieve its aim of making full use of data in the early years system.**

Obstacles to collecting and using data

89. During our inquiry, we heard of a variety of challenges local authorities and their partners face in collecting and analysing data to evaluate early intervention initiatives. Martin Pratt, Chair of the Association of London Directors of Children's Services, suggested that it was a matter of prioritising limited capacity:

> In the busyness of trying to deliver a wide range of services, we have to be able to collect the right [data] simply; otherwise, we are deploying more resource on gathering the data than on delivering the interventions. That is the balance that we are constantly trying to strike.[295]

Dr Caroline White accepted that data collection could be "hugely time-consuming", but argued that it was "crucial" to ensuring the effectiveness and cost-effectiveness of interventions.[296] She added that there was "some good evidence" that "having practitioners collect data improves their practice".[297]

90. Ailsa Swarbrick, Director of the Family Nurse Partnership National Unit, suggested that sometimes the required data was often already captured, but was held by different organisations:

294 Department for Education, 'Putting children first: Delivering our vision for excellent children's social care' (2016), pp38–41

295 Q262

296 Qq253–256

297 Q266; Dr White suggested, for example, Bickman *et al.*, ' Effects of Routine Feedback to Clinicians on Mental Health Outcomes of Youths: Results of a Randomized Trial', Psychiatric Services vol 62 (2011)

> There is plenty of information around. Rather than collect lots of new data, it is important to think about ways of streamlining data matching, about the information governance arrangements around that.[298]

Many others also reported problems related to data-sharing between the different organisations of relevance to early intervention.[299] Reporting on projects trialled as part of the Children's Social Care Innovation Programme, the evaluation team recounted that:

> Despite recognising the importance of multi-agency data-sharing in principle, this was not realised in practice in many projects with any degree of success, due to the complexity of different organisational targets, systems and priorities.[300]

Dr Caroline White told us that data-sharing problems could arise from inadequate technological infrastructure.[301] As an example, the Greater Manchester Combined Authority noted that the Department of Health and Social Care's decision to purchase only the paper version of the ASQ-3 licence "makes the fast-paced sharing of this evidence and tracking very cumbersome".[302] Dr Woods-Gallagher told us that their analysis suggested that digitising ASQ-3 assessment would increase the capacity of their frontline health visiting workforce by 40%.[303] In addition to challenges with infrastructure, we heard that data-sharing could be hindered by concerns regarding privacy requirements. The Children's and Mental Health and Inequalities Ministers acknowledged that professionals could be wary of sharing data, and assured us that the UK Government was working to ensure data protection concerns did not get in the way of safeguarding child welfare.[304] The Minister did not make clear, however, whether or not this extended as far as facilitating sharing of routine data for evaluating early intervention programmes.

91. Besides challenges in finding capacity for data collection and in sharing data, Dr Woods-Gallagher made the point that "people tend to go into frontline practice roles because they passionately care about the work that they do", and they typically did not have an interest in analysing and interpreting data and did not think that it was core to what they did.[305]

92. **Local authorities and their partners face a combination of challenges in collecting, sharing and interpreting data relevant to childhood adversity and early intervention. These include a lack of capability or capacity, as well as problems with sharing data between different services and systems. However, robust data collection and analysis is critical to the delivery of effective evidence-based early intervention. Although data collection can be time-consuming, it can improve frontline practice and—implemented properly—lead to efficiencies elsewhere.**

298 Q107
299 For example, see Greater Manchester Combined Authority (EYI0047), Association of London Directors of Children's Services (EYI0105), Better Start Bradford (EYI0113) and Qq83, 262 and 324
300 Department for Education, 'Children's Social Care Innovation Programme: Final evaluation report' (2017), p63
301 Q257
302 Greater Manchester Combined Authority (EYI0047)
303 Q263
304 Qq426–429; the new statutory guidance for safeguarding child welfare includes a 'myth-busting' guide to data-sharing for safeguarding purposes—HM Government, 'Working Together to Safeguard Children' (2018), p20
305 Q256

Workforce training and capacity

93. The early years workforce comprises a range of different professions. Teachers, social workers, health visitors, midwives, other medical practitioners and the police can all come into contact with young children who may benefit from early intervention, in addition to those specifically running early years services, such as in children's centres. We heard from a variety of sources that there should be greater awareness of the importance of early years experiences for child development, and of the potential efficacy of appropriate early intervention, across this diverse workforce.[306] For example, in a joint submission, the First Step children's psychological health service and the Tavistock and Portman NHS Foundation Trust told us that:

> Despite overwhelming evidence from research, the perception that young children are somehow immune from and unaffected by early experience remains pervasive, particularly in social care settings. This results in a 'wait and see' approach that means that interventions are not offered until the difficulties have become entrenched in later childhood, and more difficult to treat.[307]

Barnado's, a children's charity, similarly told us that "there is a need for a much wider public and professional understanding of the impact of ACEs and the tools and approaches required to mitigate and reduce their negative impact on the outcomes for children and young people".[308] Beyond leading to missed opportunities for early intervention, the Early Intervention Foundation warned that "there is also some evidence that underskilled and undersupervised practitioners can make things worse for vulnerable families and even, in some cases, cause harm".[309]

94. Dr Shirley Woods-Gallagher, Special Advisor on School Readiness for the Greater Manchester Combined Authority, summarised some of the specific aspects of child development and early intervention that she felt professionals in the early years workforce should know:

> There will be something about screening tools, something about pre- and post-[intervention] measures, something about being system ready and something about being able to navigate your role as a professional in an interdisciplinary team, and being confident about that […] There is also child development, and understanding the difference between chronological child development and neurological child development, and the disconnect between the two and what we can do to address some of those things.[310]

306 In addition to examples listed in main text, see also: Association of Child Psychotherapists (EYI0042); OXPIP (EYI0068), para 2; and Adoption UK (EYI0072)

307 First Step, Tavistock and Portman NHS Foundation Trust (EYI0023), para 5

308 Barnardo's (EYI0037), para 18

309 Early Intervention Foundation (EYI0061), para 23

310 Q269

Noting the low rate of referrals of infants and young children to child and adolescent mental health services, the Association of Child Psychotherapists suggested that "training and opportunities for specialist consultation are therefore needed for health and social care professionals to develop skills in recognising and addressing dysfunctional interactions and in enhancing sensitivity and responsiveness in caregivers".[311]

95. Building on the discussion of the importance of data collection and interpretation in the last section, Dr Woods-Gallagher added that training should also "include evidence, interpretation and data interpretation", and should ensure that practitioners understand the importance of this to their practice.[312] Martin Pratt, Chair of the Association of London Directors of Children's Services, told us that an increased priority on literacy in evidence and making use of the evidence base was needed for early years practice leaders, from initial training onwards:

> On the development of practice leaders, being literate in the understanding of the evidence base is increasingly important for lead practitioners, managers and practice leaders. That is something to pay attention to across the system, not just in initial training, although that is certainly where the foundations are laid.[313]

Dr White stressed the value of those in leadership positions having a thorough understanding of the interventions being delivered, and experience of frontline work, as well as knowledge of policy, strategy and funding.[314] Where this is not available internally, she said that specialist expertise should be "bought in".[315]

96. In a 2016 policy statement, the Government conceded that "excellent practice [in social work] is not found consistently across the country" and stated that the Health and Care Professions Council (the then regulator for health and care professionals) "has an approach designed to maintain minimum standards of public safety and initial education across a range of professions, rather than drive up standards in any one profession".[316] The Children and Social Work Act 2017 subsequently made provisions for the establishment of a new regulator specifically for the social work profession, Social Work England.[317] The Government said that Social Work England would drive improvements in social work practice by:

- "setting profession-specific standards that clarify expectations about the knowledge, skills, values and behaviours required to become and remain registered as a social worker in England;
- setting profession-specific standards for initial education and training to ensure that newly qualified social workers are prepared for the challenges of direct practice with service users;

311 Association of Child Psychotherapists (EYI0042)
312 Qq256 and 276
313 Q273
314 Q264
315 Q267
316 Department for Education and Department of Health, 'Regulating Social Workers' (2016)
317 Children and Social Work Act 2017, sections 36–45

- ensuring that all social workers maintain their fitness to practise by setting out expectations for continuous fitness to practise and operating a system to identify and support those social workers that are not meeting the standards; and
- having the power to set standards and approve and recognise post-qualification specialisms, helping to bring consistency to social work career pathways".[318]

The Government's initial aim was for the new regulator to have fully assessed and accredited every children's social worker by 2020.[319] However, Nadhim Zahawi MP, the Parliamentary Under-Secretary of State for Children and Families, told us that there would instead now be a "phased roll-out" of this process, with the new system being applicable in five local authorities in 2018 and ten more in 2019.[320]

97. The establishment of Social Work England constitutes an opportunity to review and transform children's social worker skills and update the practice to reflect the latest science in child development, adversity and trauma, as well as the importance of data collection and interpretation. Martin Pratt, Chair of the Association of London Directors of Children's Services, told us that the new regulator should seek to balance practical experience during pre-qualification training with more theory:

> We have moved to a degree programme over the last few years as the social work qualification. It is clearly focused on practice, but you cannot really develop your practice unless you understand both child development and the evidence base. They try to squash quite a lot in, and there should be greater emphasis on that area.[321]

98. The Government has published statements of the knowledge and skills that will be expected of social work practitioners, supervisors and leaders under the new system.[322] Although these statements cover the impacts of different adverse childhood experiences and include the need to make use of research and evidence, they refer to data collection only as a means of managing demand, rather than recognising the importance of data collection and interpretation for ongoing evaluation of the impact of services being delivered.

99. **The establishment of Social Work England constitutes an important opportunity to review the training given to children's social workers. *The Government should ensure that the accreditation criteria for social workers include knowledge of child development science, the impact of adversity and methods for addressing this, as well as good practice in collecting and using data. The knowledge required should be tailored to the different roles and responsibilities of practitioners, supervisors and leaders. The Government must further ensure that training is available to allow social workers to meet these criteria.***

318 Department for Education and Department of Health and Social Care, 'Social Work England Secondary Legislative Framework: Government consultation response' (2018), pp5–6
319 'Delivering a revolution in children's social care', Department for Education (2016), accessed 21 August 2018
320 Q469
321 Q273
322 Department for Education, 'Social work post-qualifying standards: knowledge and skills statements' (2018)

100. The Early Intervention Foundation highlighted the contrast between the opportunity presented by the establishment of Social Work England for raising awareness of trauma-focused early intervention among social workers, and the attention given to other professionals:

> There is currently no common approach, central support or guidance covering how best to train, develop and supervise early intervention practitioners and the children's sector more generally. This is in stark contrast to the attention given by the Department for Education to supporting social work practice.[323]

Dr Woods-Gallagher told us that pre-qualification curricula for professions outside of social work should be reviewed, giving the example of midwives and health visitors:

> They will be taught about things such as the Healthy Child Programme, and that is brilliant, but we know that the [Newborn Behavioural Observations tool] and the [Neonatal Behavioural Assessment Scale] are really important screening tools that should be used on wards, and it is really important to think about the home learning environment—past trauma of the parent as well as current trauma, and not just a safeguarding issue—as part of midwifery practice.[324]

In a similar vein, the Institute of Health Visiting warned that "there is no nationally agreed competency framework either for health visitors or skill-mix roles to deliver the Healthy Child Programme".[325]

101. Addressing early intervention training outside of the social work profession, the Children's and Mental Health Ministers flagged ongoing development of speech and language training for health visitors and elements of the *Transforming Children and Young People's Mental Health Provision* Green Paper that aimed to share innovative practice for school workers.[326] However, neither of these focused on early years adversity or trauma. The Government's 2017 *Early Years Workforce Strategy* focused on early years provision in an educational setting and did not explicitly target increased awareness of addressing adversity and trauma, or skills in using data.[327]

102. In addition to building the required knowledge and skills among the early years workforce, it is important that the services they deliver are based upon up-to-date science and evidence of local impact. However, Dr Caroline White told us that the extent to which the different roles across the early years workforce are currently delivering evidence-based practice seemed to her to be "very small", and said that the workforce represented a resource that could be used "much more effectively".[328] Newcastle University agreed:

323 Early Intervention Foundation (EYI0111)
324 Q268
325 Institute of Health Visiting (EYI0107); 'skills mix' practitioners are staff who are not fully-qualified health visitors but who perform elements of the health visitor role
326 Q435
327 Department for Education, 'Early Years Workforce Strategy' (2017)
328 Q267

> There remains an important job to do in skilling up the relevant practitioners and indeed the commissioners of services so that they are able to make judgements about the quality of intervention evidence and engage with and trust these resources to inform their practice.[329]

103. Accounting for the "very variable" use of evidence-based interventions found by the Early Intervention Foundation across the country, Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, told us that "a lot depends on local leadership and the extent to which evidence is prioritised by local lead members, senior officers and so on".[330] She went on to explain that:

> We come across some council leaders who very clearly create a culture in which evidence is prioritised, questions are asked about any changes and the extent to which there is evidence to support those changes and shifts in investment and spending and so on, but there are other areas where evidence seems slightly less of a priority.[331]

Donna Molloy added that part of the problem was the complexity of engaging with evidence and told us that in the Early Intervention Foundation's experience, "one of the biggest reasons" for the gap they observed between the latest evidence and local practice was a "lack of capacity in local government and public services to engage with evidence".[332]

104. **There is scope for improved awareness of the importance of early years experiences on child development, and knowledge of the latest science in this domain, across the early years workforce. The capacity and motivation to engage with evidence should also be improved, in particular for those in leadership positions. The establishment of Social Work England constitutes an important opportunity to review the training given to children's social workers, but the early years workforce encompasses a much broader range of professions than social workers alone.**

105. A further workforce issue raised repeatedly during our inquiry was the importance of families maintaining contact with the same practitioner throughout their interaction with a particular service. Ailsa Swarbrick, Director of the Family Nurse Partnership National Unit, highlighted the ongoing relationship built between a family and their dedicated family nurse as a particular advantage of the FNP programme, saying that the nurse "can role-model, in a sense, how a trusting, respectful relationship can continue over the course of the two years", providing a "template for the client's relationship with her child":

> There is something about the long-term trusted relationship that enables the mother to feel confident in her ability to parent and to make the right choices both for herself and for her child in the long term.[333]

106. Better Start Bradford, a charitably-funded local partnership, agreed in the value of families building a relationship with a specific practitioner—especially in relation to ACEs—but warned us that stretched resources meant this was often not being delivered.[334]

329 Newcastle University (EYI0007)
330 Q176
331 Q176
332 Q176
333 Q104
334 Better Start Bradford (EYI0113)

The Institute of Health Visiting similarly told us that "the most valued and effective element of health visiting is the quality of relationships with families, but this is diluted by lack of continuity of carer", reporting that 49% of English health visitors stated 'lack of continuity' as one of the biggest barriers they faced in "making a difference" to families.[335] The Association of Child Psychotherapists told us that their members "regularly encounter older children who have suffered terribly as a result of being cared for in hospital by a team of shift nurses, rather than having the essential and consistent attention of a secure attachment figure".[336]

107. **Although many organisations report that intervention outcomes benefit from families receiving support from the same practitioner throughout their interaction with a particular service, constraints in capacity are a major contributory factor resulting in many services not consistently achieving such continuity of care.**

335 Institute of Health Visiting (EYI0107)
336 Association of Child Psychotherapists (EYI0042)

5 A new national strategy

108. In Chapter 3, we recommended that the Government should draw up a new national strategy for evidence-based early intervention aimed at addressing childhood adversity and trauma. Drawing upon the evidence we have heard for what makes early intervention successful, and the challenges local authorities faces in delivering effective early intervention, we outline here what such a national strategy should include. The overall aim of the national strategy should be to ensure that the provision of early years intervention is available everywhere as required and that all interventions are evidence-based.

109. During the course of our inquiry, we encountered examples of successful early intervention services and ongoing efforts to develop 'trauma-informed' services across local communities (see Box 1). The new national strategy should aim to learn from these efforts and replicate these and other initiatives, where local success can be demonstrated.

Box 1: Model examples of early intervention services

The Children and Parents Service, Manchester

The Children and Parents Service (CAPS) in Manchester has been identified by the National Institute for Health and Care Excellence as a service that has achieved success in recognising and managing antisocial behaviour and conduct disorders in children and young people.[337] CAPS is a jointly commissioned, multi-agency, early intervention service for pre-school children and their families.[338] The service identifies early social and emotional problems in pre-school children, provides thorough psychological assessment for them and then offers intervention as appropriate. Families can be initially referred to the CAPS service from multi-agency staff across the early years workforce; CAPS psychologists provide one day training to frontline staff to improve communication across the workforce and establish referral pathways as well as to develop a consistent approach to parent support strategies across the workforce. CAPS also conducts outreach work to raise awareness and engage with local families. Referred families are assessed using the Eyberg Child Behaviour Inventory, the Beck Depression Inventory and the Abidin Parenting Stress Index as standardised and validated outcome tools to measure child behaviour problems, parental depression and parental stress respectively, as well as the 'Index of Need' tool to identify families at risk of developing any of these problems.[339] Where families meet the thresholds for intervention, CAPS uses the 'Incredible Years' Parent Programmes,[340] a series of evidence-based interventions which focus on:

337 'Manchester CAPS: A Sustainable Implementation of Incredible Years', National Institute for Health and Care Excellence, accessed 24 October 2018

338 More information about CAPS and lessons learned from its development and implementation can be found in Julia Faulconbridge, Katie Hunt and Amanda Laffan, 'Improving the Psychological Wellbeing of Children and Young People: Effective Prevention and Early Intervention Across Health, Education and Social Care' (London, 2018), Ch. 3

339 Eyberg Child Behaviour Inventory', Psychological Assessment Resources; 'Beck's Depression Inventory', Boston Medical Center; 'Parenting Stress Index', American Psychological Association; Kevin Browne, Jo Douglas, Catherine Hamilton-Giachritsis and Jean Hegarty, 'Community Health Approach to the Assessment of Infants and their Parents: The CARE Programme' (New Jersey, 2006), Ch. 3

340 'The Incredible Years Parents, Teachers and Children Training Series', The Incredible Years, Inc., accessed 5 October 2018

- strengthening parenting competencies to improve the parent-child relationship;
- promoting children's academic, emotional and social skills; and
- reducing conduct problems.

CAPS additionally provides 'wrap-around' support to help families complete the courses, such as the provision of childcare or interpreting services, and aims to offer seamless access to other services from which families would benefit.

Between September 2017 and August 2018, CAPS delivered 75 Incredible Years parent courses to approximately 989 parents of 0–4 year olds. The impact of these interventions, as determined by the proportions of families in the clinical ranges for each of the outcome measures before and after the intervention, are shown in Table 2 below.

Table 2: Impact of CAPS intervention on clinical conditions and risk factors

	Pre-intervention (%)	Post-intervention (%)
Proportion of families at risk of neglect or abuse*	86	56
Proportion of parents with clinical depression	68	19
Proportion of parents with clinical stress	72	12
Proportion of children with clinical behaviour problems	69	32

* Some risk factors are stable (for example having a parent with a learning disability or giving birth to twins) and so cannot be influenced by an intervention

Source: Children and Parents Service Early Intervention, Manchester

High parent retention rates are achieved by the programme, with around 81% completing it. As well as reducing the prevalence of clinical conditions and the proportion of families at risk of developing clinical problems, the programme was found to also help parents engage in work or education. Three months after completing the course, 24% of parents were back in work, 21% were attending college and 10% were doing voluntary work.

A Better Start Blackpool

During the course of our inquiry, we visited Better Start Blackpool, a multi-agency initiative aiming to develop 'trauma-informed' early years services across Blackpool. This involved outreach and training programmes for all professionals in the early years workforce, as well as across the wider community, to raise awareness and understanding of child development and the impact of trauma. Specific interventions were also being delivered, focusing on improving social and emotional development, communication and language, and diet and nutrition for children from conception through to the age of three. Examples of these interventions included:

- dedicated mental wellbeing support for pregnant women with a history of child abuse and maltreatment;
- dietary and nutrition advice for overweight mothers during pregnancy;
- initiatives to encourage fathers to read to their children; and
- refurbishment of parks combined with 'park ranger'-led activities to create community garden spaces for use by local families with young children.

A Centre for Early Child Development was established to help co-ordinate the programme and deliver full-system transformation to ensure that families accessing different services encounter a consistent and seamless experience. Better Start Blackpool is a ten-year programme funded by the Big Lottery Fund.

HeadStart Kernow, Cornwall

We also visited Cornwall Council and Tretherras School in Newquay to learn more about the HeadStart Kernow programme, a Big Lottery Fund-supported initiative focusing specifically on adverse childhood experiences. HeadStart Kernow aims to improve the mental resilience of 10 to 16-year olds by giving every local young person access to an 'emotionally available adult'. The programme provided training for school staff to equip them with conversational and relational tools for directly supporting children with specific mental health problems resulting from childhood adversity. Training was also provided to primary school staff and relevant members of the local medical, police and voluntary sector workforce. Funding had been made available for schools to develop action plans aimed at supporting emotional wellbeing and resilience. A HeadStart Young People's Board had been set up to allow young people to contribute to the direction of the programme, and research projects focusing on online behaviour and the development of digital resources were also being supported.

Essex County Council Children's Services

In March 2018, Essex County Council was selected as one of eight local authorities to develop and share good practice in children's social care as part of the Department for Education's Partners in Practice Programme.[341] The council has reduced its number of children in care from 1,615 in 2010 to 1,055 in 2018, while reducing spending on children's social care from £148m to £118m. It achieved this through a plan of:

- developing quality assurance methods (such as team diagnostics, internal inspections and case audit systems);
- investing in quality training—informed by academics—in strengths-based approaches to relationship practice, for practitioners and managers; and
- avoiding prescriptive management to instead allow innovative services designed around vulnerable children.

341 'Minister announces £17 million to improve children's services', Department for Education, accessed 28 October 2018

Essex County Council has identified early intervention as a key strand of this success, with initiatives such as a voluntary, family-oriented support service and an intervention service that identifies young people aged 8–17 on the edge of care who have suffered a breakdown in family relationships or who are at risk of custody.

Essex County Council's Cabinet Member for Children and Families chaired the Local Government Association's national Children's Social Care Taskforce, which published a report in 2017 outlining key issues and solutions for children services.[342] Of the seven recommendations it made:

- one called for "stronger investment in early help";
- one advocated an evidence-based approach to determining 'what works' for children's services; and
- one argued that local authorities should monitor outcomes and be held accountable for them, to ensure continuous improvement.

Better use of data

110. The importance of data collection and analysis for assessing the effectiveness of early intervention initiatives and for identifying families who would benefit from early intervention was outlined in paragraphs 83 to 88 of this Report. Challenges to collecting and using data were also identified, including the time it takes frontline practitioners to collect data, obstacles to sharing data between different organisations and practitioners focusing on aspects of their service other than data collection or analysis. The variation in local practice and lack of consistent national measures were also highlighted.

111. Tom McBride, Director of Evidence at the Early Intervention Foundation, acknowledged that it would be unfeasible for local authorities to run high-quality randomised controlled trials to evaluate the impact of their services, but argued that they should nevertheless be collecting and using routine administration data to monitor their impact.[343] Matt Buttery, CEO of Triple P UK, told us that this was starting to happen in conjunction with the delivery of the Triple P programme in the USA.[344] Martin Pratt told us that local authorities needed measures to be identified that would provide the information needed to be able to assess interventions while being simple to collect and easy to analyse.[345]

112. The Greater Manchester Combined Authority described the current measure of social and emotional development used at age two—the Ages and Stages Questionnaire (usually referred to as 'ASQ-3')[346]—as "the best evidenced measure to assess the progression of child development from two months to five years", and advocated extending its use to cover

342 Local Government Association, 'Bright Futures: Getting the Best for Children, Young People and Families' (2017)
343 Q195
344 Q106
345 Q262
346 ASQ-3 comprises a series of 21 questionnaires, covering ages 0 to 5½ years, which parents use to test their child's abilities, for evaluation by early education or healthcare professionals (Welcome to ASQ', Paul H. Brookes Publishing Co., accessed 27 July 2018). Public Health England currently recommend its use during the 2–2½ year health visit; in 2016–17, 89% of 2–2½ years health visitor reviews used ASQ-3 (Public Health England, 'Health Visitor Service Delivery Metrics 2016/17 annual data' (2017)).

this full period.[347] Dr Shirley Woods-Gallagher, Special Advisor on School Readiness for the Greater Manchester Combined Authority, told us that, in combination with measures following Key Stage 1:

> [Using ASQ-3 throughout the early years] would enable us to track child development from the age of two months all the way through to the age of 16, using a tracking system, with digitised means of doing that, for the best understanding of domains of child development, potential gap areas and things that we need to do and uplift on.[348]

Professor Bennett told us that Public Health England was "absolutely committed to using ASQ at two", and noted that "some areas are already using the ASQ for various other developmental programmes", but said that she did "not have the evidence to say whether it would be beneficial to make that almost mandatory across the country".[349] She indicated that such evidence could be gathered, but that it would be "quite a big piece of work" that would need to be commissioned by Public Health England or the Department of Health and Social Care.[350]

113. Social and emotional development is not the only characteristic affected by childhood trauma and adversity, and Dr Woods-Gallagher cautioned that ASQ-3 did not necessarily "give the whole picture", adding that the Greater Manchester Combined Authority was looking at the "broader information" it also needed to collect.[351] Professor Melhuish suggested language development and self-regulation as two attributes that depended upon mother-child attachment and which were critical for future life prospects.[352] Dr Caroline White told us that the Children and Parents Service in Manchester used measures of behavioural problems, emotional difficulties and mental health problems in parents as key indicators to assess the success of interventions.[353] The Social and Public Health Sciences Unit at the University of Glasgow advocated "inclusion of ACEs measures in routine child health surveillance".[354] Whichever indicators are chosen, Dr White cautioned against the temptation to use free measures instead of the 'gold standard' measures used in research, which she said was common but could impact the significance of the data collected.[355] We also heard that self-reported measures (where families are asked to assess impacts themselves) should be avoided.[356] Better Start Bradford additionally stressed the importance of choosing measures that could be used with families whose first language was not English.[357]

114. Despite the obstacles that exist, Kate Stanley, Director of Strategy, Policy and Evidence at the NSPCC, indicated that data-sharing could be achieved. She explained that the NSPCC had recently set up a data-sharing agreement between themselves, the council, the NHS Foundation Trust and the police in Blackpool.[358] Dr Caroline White similarly told

347 Greater Manchester Combined Authority (EYI0047)
348 Q258
349 Q362
350 Q364
351 Q258
352 Q128
353 Q249
354 MRC/CSO Social and Public Health Sciences Unit (EYI0021), para 1.4
355 Qq250–252
356 For example, see Sue Gerrard (EYI0025) and Q126
357 Better Start Bradford (EYI0113)
358 Q84

us that her service was now collecting and analysing data from a variety of agencies, but emphasised the importance of stipulating data collection requirements in multi-agency contracts and of appointing a dedicated information analyst, to achieve this.[359]

115. ***The Government's new strategy for adversity-targeted early intervention should include plans to improve the use of data for assessing early intervention and identifying families who could benefit from early intervention, at local and national level. The strategy should promote the value of data collection and analysis by drawing on case studies of local authorities or their partners using data to improve outcomes. It should also set out the general principles of good practice with data collection and analysis, such as collecting baseline data in preparation of assessing a new intervention and avoiding the use of self-reported measures.***

116. ***The new strategy should set out what local authorities should measure to assess their early intervention initiatives or to identify families who could benefit from receiving early intervention support, and give examples of specific data that would capture this. These measures should be identified in consultation with child development experts and local authorities themselves, and cover aspects such as social, emotional and language development from birth through to the start of school. Consideration should be given to the burden of collecting the data and the compatibility of its collection with existing practice. In identifying these measures, the Government should ensure that it seeks opportunities for local authorities to make use of data that they or their partners already collect.***

117. ***The new strategy should also address challenges in data-sharing between different organisations working with young children. It should include guidance to local authorities and their partners on data protection legislation and provide examples of best practice in data sharing, focusing specifically on childhood development, trauma and related early interventions. The Government should additionally consider what infrastructure and licences could facilitate efficient, interoperable data processing by local authorities and assess the cost-benefit of providing funding towards this.***

118. **Collection of the most important data at a national level would provide central Government with information on the national state of childhood adversity and early intervention, and drive local authorities to ensure the necessary data is collected. Children are not currently assessed with a national measure of child development until the Ages and Stages Questionnaire at age two to two-and-a-half. *In addition to ensuring full coverage of the health visits mandated by the Healthy Child Programme, the Government must ensure that the data collected during such visits is reported nationally. It should consult the Institute of Health Visiting and child development experts to determine if the Healthy Child Programme should include assessments of social and emotional development prior to the fifth mandated visit, and if so provide the resources necessary to allow for this.***

119. ***The new adversity-targeted early intervention strategy should also set out measurable objectives for progress on data collection, such as the proportion of local authorities supplying full data from the Healthy Child Programme mandated visits, or the proportion of local authorities identified by Ofsted as delivering sufficiently data-driven early intervention. If data collection and analysis does not consequently improve***

359 Qq250–255

within two years of the strategy's implementation, the Government should consider introducing statutory requirements for the reporting of data that can be used to monitor the delivery and impact of early intervention.

Training and assessing the early years workforce

120. Paragraphs 93 to 104 of this Report identified the need for increased awareness, across the early years workforce, of the importance of early years experiences in child development. The need for an improved ability to engage with scientific evidence and data was also flagged, in particular for those in leadership positions.

121. The obvious route to improved awareness and knowledge is through training. Dr Shirley Woods-Gallagher, Special Advisor on School Readiness for the Greater Manchester Combined Authority, flagged that a "twin-track approach" was needed to train those coming into the early years workforce, via pre-qualification training, as well as the existing workforce, through continuing professional development.[360] Martin Pratt told us that "there is a strong argument for having a national approach" to training, with "multidisciplinary training, so that different aspects of different professional disciplines are contributing".[361]

122. ***The Government's new national strategy for adversity-targeted early interventions must include steps to increase the knowledge that professionals across the early years workforce have of: the impact of childhood adversity or trauma and what can be done to remedy this; how to identify those families that could benefit from early intervention; how to access and use relevant, up-to-date scientific evidence; how to make best use of data in offering and delivering early intervention services, and in understanding and evaluating the effectiveness of those services; and child development and the importance of early years experiences. The strategy should identify and define the 'early intervention workforce', comprising the full range of professions that engage with young children or their families and that could either: help to identify those who would benefit from early intervention; or would play a role in delivering early intervention services. The Government should then review the pre-qualification training and continuing professional development offered to the different professions in the early intervention workforce and ensure that each covers the different elements outlined above, at a level appropriate to the profession in question.***

123. Dr Caroline White, Head of the Children and Parents Service in Manchester, told us that ongoing support was required in addition to training schemes:

> In commissioning a particular programme, there can be an expectation that it will just happen by training a workforce. It is so much more complex than that. For example, a workforce might be trained in an evidence-based programme, but people are just left to deliver it, rather than having the high-quality supervision and consultation that is required with most evidence-based programmes to get the outcomes.[362]

360 Q268
361 Q268
362 Q223

OXPIP, a voluntary sector parent-infant psychotherapy service, similarly advocated "specialist clinical supervision for statutory staff engaged in [early years service provision]".[363] The 2017 evaluation report of the Children's Social Care Innovation Programme also reported that "strengthening supervision was part of many of the more successful projects" involved in the programme.[364] Dr White cautioned that people across the whole workforce often confused line management for proper supervision covering case consultation and theoretical supervision of their practice, one reason why such supervision was still "hugely missing across the workforce".[365]

124. One approach to promoting the use of evidence in commissioning and managing early years practice has been to appoint 'champions' within a service, with a responsibility to advocate this. Dr White made clear that for this to work, the champions must have the necessary influence and budget required to achieve change.[366]

125. **Many evidence-based interventions require ongoing, accredited supervision from specialist supervisors with expertise in that particular model.** ***As part of a new national strategy for adversity-targeted early intervention, the Government must make clear that in commissioning evidence-based programmes, local authorities should ensure that there is sufficient accredited, ongoing, specialist supervision from qualified supervisors in that programme for the workforce, throughout the delivery of the programme. Local commissioners should aim to support the development of their own accredited supervisors, to enable cost-savings and deliver an experienced and expert workforce, leading to greater sustainability.***

The Apprenticeship Levy

126. Acknowledging the restricted budgets available for training, Dr Woods-Gallagher highlighted the resources made available by the Apprenticeship Levy,[367] noting that they could be used for continuing professional development as well as initial training.[368] Although the Greater Manchester Combined Authority was still exploring existing early years apprenticeship standards to determine their compatibility with the skills that the Authority wanted for its workforce,[369] Dr Woods-Gallagher told us that a similar initiative was already underway for health and social care adult degrees:

> We have lots of staff who might have come into practice and are really good family support workers, homelessness workers or home care workers. You almost reach a roadblock at the level 2 or level 3 qualification and have to jump the Rubicon to graduate a qualification on the other side and to accelerate your career through social mobility. That is the mechanism we want to create.[370]

363 OXPIP (EYI0068), para 2
364 Department for Education, 'Children's Social Care Innovation: Programme Final evaluation report' (2017), pp59–60
365 Q273
366 Q264
367 Q268
368 Qq230–231 and 295–296
369 Qq269–270
370 Q231

Dr Woods-Gallagher additionally noted that with organisations being able to transfer 10% of their annual apprenticeship funds to external organisations,[371] the funding opportunity of the Apprenticeship Levy was growing.[372] Engaging with philanthropists was raised as another avenue for funding to supplement the Apprenticeship Levy.[373]

127. **The Apprenticeship Levy offers an important potential source of new funding for training of the early years workforce.** ***The new adversity-targeted national strategy should promote the opportunity presented by the Apprenticeship Levy as a source of funding for training early years practitioners. The Government should monitor the number of local authorities that make use of the Levy in this way, evaluate the impact where authorities have used it, and provide guidance to assist other local authorities in using the Levy funding if it proves to be successful.***

Implementation science

128. A variety of initiatives, such as the Children and Young People's Improving Access to Psychological Therapies programme and the Children and Adolescent Mental Health Services Outcomes Research Consortium, have previously aimed to improve the provision of early intervention in England through some of the measures advocated in this Report—an increased focus on early intervention, a commitment to use evidence-based interventions, the development of a trauma-informed workforce and better data collection and use of that data—without achieving as much as some hoped.[374] Newcastle University highlighted that the practical considerations of transforming early intervention services were as important as identifying the changes to be made:

> The relatively new discipline of 'implementation science' clearly demonstrates that to change behaviour we need to do more than simply communicate the evidence. Rather people's capabilities, motivations and opportunities to change must also be addressed. This field is a rapidly developing one and plans to promote evidence-based policy and practice need to take these additional implementation steps seriously.[375]

Dr Caroline White, Head of the Children and Parents Service in Manchester, similarly told us that "there are things that we know make implementation successful, and we are not applying that knowledge as effectively as we could be",[376] and outlined some of the main components comprising implementation science:

> It is things like being programme-driven rather than practitioner-driven; collecting good data […] and being able to report on that data and interpret it for people so that it is meaningful and not just number-crunching; it is about understanding policy, practice and need.[377]

371 'Transferring unused apprenticeship funds to other employers', Education and Skills Funding Agency, accessed 22 August 2018
372 Q229
373 Q246
374 Q250; Tamimi, 'Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same?', BJPsych Bulletin vol 39 (2015)
375 Newcastle University (EYI0007)
376 Q215
377 Q285

129. Many of the main components of implementation science—the collection and analysis of data to enable rigorous evaluation of the programmes being delivered, ongoing specialist supervision and consultation for practitioners, leadership and long-term planning—have already been discussed in this Report. The additional consideration of 'programme-driven' service transformation was identified by multiple contributors to our inquiry,[378] who usually referred to this as a need for 'model fidelity'—close adherence of an intervention's real-world delivery to its initial design. The Sheffield's Children & Young People's Public Health Team told us that fidelity extended to properly accredited training and supervision.[379] This focus on fidelity was also reported by Graham Allen in his 2011 report to Government:

> More or less every expert I talked to during the preparation of my review reminded me of the penalties of failure to implement these evidence-based early intervention programmes with fidelity to the design of their originators. This typically results in the loss of all their potential impact, economic gains as well as child well-being. The UK has a poor track record in fidelity of implementation.[380]

130. Professor Leon Feinstein, Director of Evidence at the Children's Commissioner's Office, has, however, warned that successful intervention is not guaranteed simply through rigorous application of a proven programme:

> The recently emerging field of implementation science has emphasised the difficulty […] that for human services interventions in part 'the practitioner is the intervention'. In practice, the child and family are also part of the intervention. This makes each local implementation subject to complex, individual level heterogeneity. The role of science and evidence in this approach is much more to support the quality of practice than to develop rigorous evaluations of gold standard products that can then be easily 'rolled out'.[381]

George Hosking, CEO of the WAVE Trust, suggested that plans to deliver early intervention should consider implementation, effectiveness and appropriateness equally.[382] The Early Intervention Foundation similarly told us that evidence-based interventions "are only likely to deliver results if delivered carefully according to the programme requirements and if effort is made to ensure they are integrated with wider local service arrangements".[383]

131. Related to the need to tailor intervention delivery to the local setting without compromising on following interventions faithfully, we heard of the importance of local authorities being given sufficient time to plan and develop early intervention strategies, as well as detect the results achieved.[384] For example, Dr Shirley Woods-Gallagher, Special

378 For example, see Children and Parents Service (EYI0004), Centre for Evidence Based Early Intervention (EYI0029), Centre for Mental Health (EYI0050), Roots of Empathy (EYI0077) and Professor Peter Fonagy (EYI0097)

379 Sheffield's Children & Young People's Public Health Team (EYI0064), para 3.11

380 Graham Allen, 'Early Intervention: The Next Steps' (2011), para 73

381 Feinstein *et al.*, 'On Estimating the Fiscal Benefits of Early Intervention', National Institute Economic Review, vol 240 (2017)

382 Q183

383 Early Intervention Foundation (EYI0061), para 23

384 For example, the Foundation Years Trust told us that "given the time that it can take to embed a programme within a community and to start to see an impact, there should be a long-term commitment to testing and evaluating what works"—Foundation Years Trust (EYI0060)

Advisor on School Readiness for the Greater Manchester Combined Authority, illustrated the level of planning that had been undertaken prior to delivering training in routine enquiry (see the footnote for a definition):[385]

> Over the last four months, we have taken great time and care, with two officers from my former team going out to spend detailed time with frontline police officers, health visitors, midwives, schools and so forth, saying, 'If you were to do a routine enquiry in your day-to-day practice, what would that look like? What do your existing questions look like? What would the uplift be to include some extra questions? What are the systems that you record them on, and how could we do that?' It is only now, at this stage, that we are considering what the actual training package would be like, because we have taken all that time to work out the implementation science, noting that it will be slightly different for one or another workforce, thinking, 'this is how we will record the data, this is how we will supervise it at place level'.[386]

However, noting that "early intervention pays off in the long term", the Children and Parents Service in Manchester warned us that "most policy makers, strategic leads and managers want results quickly".[387] This ties in with the short-term funding cycles described in paragraph 80 of this Report.

132. **Implementation science is a developing field that can inform the delivery of service transformation programmes, to increase the chance of successful implementation and sustainability.** ***In addition to the focus on data-driven practice and the delivery of relevant training and ongoing expert supervision, the new national strategy for adversity-targeted early intervention should encompass the latest evidence from implementation science, incorporating elements such as a commitment to model fidelity and the adoption of realistic timeframes for service redesign and deadlines for results. The Government should consult academics and practitioners to achieve this, and ensure that lessons from services that have successfully implemented evidence-based early intervention with positive outcomes are also taken into account.***

Support for local authorities

133. As the What Works Centre for early intervention, the Early Intervention Foundation has a remit to:

- assess the evidence on which interventions work and their relative value for money;
- advise Government, local councils and agencies, charities and investors on what works for whom, when; and
- advocate for early intervention to key decision makers.[388]

385 Routine enquiry entails asking all people who access certain services, such as medical appointments, if they have experienced ACEs and if so if it has affected them (see paragraph 30 of this Report)
386 Q237
387 Children and Parents Service (CAPS) Early Intervention (EYI0004)
388 Cabinet Office, 'What Works? Evidence for decision makers' (2014)

Throughout the course of our inquiry, we have heard that the Foundation was performing an important role and had successfully established itself as an authoritative voice in this field.[389] For example, Martin Pratt told us that when he surveyed Directors of Children's Services across London:

> There was a pretty universal view that the Early Intervention Foundation was a good source of [evidence regarding early intervention], that it was accessible and it was able to mobilise that information quickly into service design.[390]

Ailsa Swarbrick, Director of the Family Nurse Partnership National Unit (whose programme has been highly-rated by the Early Intervention Foundation), told us that:

> It is helpful to have a well-respected organisation doing a thorough piece of work into what is available to advise commissioners, while being aware of the limits because some programmes are younger and have not been so well evaluated.[391]

134. Donna Molloy, Director of Policy and Practice at the Early Intervention Foundation, noted that "any assessment of our record in the five years since we have been going has to be made in the context of our current funding arrangements":

> We are one of the smallest of the What Works Centres. Our current turnover is £1.5 million a year and we are an organisation of 20 people, which is quite small in contrast to organisations such as the Education Endowment Foundation with a £100 million endowment, or even the newly created What Works Centre for children's social care funded with £3 million a year.[392]

Indeed, Ms Molloy told us that:

> One of our asks of this Committee is to put us on a sustainable and more secure financial footing so we are not wasting time in frequent funding negotiations with Government Departments that take a lot of energy and capacity in such a small organisation.[393]

Professor Melhuish, of the University of Oxford, independently recommended to us that the Early Intervention Foundation "be made permanent".[394] Donna Molloy added that there was scope for the Foundation to do much more if it had a bigger team,[395] highlighting opportunities such as:

- identifying core principles from successful intervention programmes to be incorporated into workforce practice;[396]

389 For example, see Q89, Q158, Q159, Q372, Q421
390 Q294
391 Q158
392 Q208
393 Q208; In supplementary evidence, the Early Intervention Foundation told us that as of 4 May 2018, the Foundation had still not been able to sign a grant agreement with the Department for Education for the 2018–19 period and were hence running on its charity reserves—Early Intervention Foundation (EYI0111)
394 Q168
395 Q208
396 Q197

- bringing local authorities and academic partners together to evaluate programmes;[397] and
- building upon the Foundation's work in engaging with local commissioners to stimulate adoption of evidence-based early intervention.[398]

135. The comparison between the Early Intervention Foundation and the Education Endowment Foundation, a different What Works Centre focusing on education, was made several times during our inquiry.[399] Tom McBride, Director of Evidence at the Early Intervention Foundation, told us:

> If you look at the model that the Education Endowment Foundation was set up with—a £100 million endowment—it has been able to fund and co-ordinate a lot of high-quality evaluation of school-based interventions and programmes to build the evidence in that space. The funding is not there in the early intervention and prevention space currently to have that centralised model that would allow us to build the evidence base and tackle the gaps in our knowledge.[400]

Professor Feinstein, Director of Evidence at the Children's Commissioner's Office, also noted the Early Intervention Foundation's funding constraints and described them as "a weakness in the system".[401] Nadhim Zahawi MP, Parliamentary Under-Secretary of State for Children and Families, highlighted the success of the Education Endowment Foundation, and told us that he wanted to see the Early Intervention Foundation "deliver similar things":[402]

> Where I would like us to get to with local authorities using data for early intervention is where we have got to now with schools, using evidence from the Education Endowment Foundation on what really works in a school setting […] If I could come here and tell you that we are at a place where local authorities are using [the Early Intervention Foundation] evidence resource to deliver widespread decision making on early intervention, we would have won, and we would have done something really good, but I do not think we are there yet.[403]

Michelle Dyson, Director of Early Years at the Department for Education, acknowledged, however, that "funding for the Education Endowment Foundation is huge by comparison with that for the Early Intervention Foundation".[404]

136. The Government has allocated £10m for the establishment of a new What Works Centre for Children's Social Care,[405] which is due to be fully operational by 2020.[406] The Department for Education's 2016 'vision for excellent children's social care' outlined the remit for the new centre:

397 Q195
398 Q199
399 For example, see Qq 89,195,208,421 and 448–451
400 Q195
401 Q89
402 Q451
403 Q421
404 Q448
405 Q417
406 'Setting up the Centre', What Works Centre for Children's Social Care, accessed 24 July 2018

> [It] will have a sharp focus on improving outcomes for our most vulnerable children and their families. It will identify best practice in supporting children suffering from, or at risk of, abuse and/or neglect from targeted early support all of the way through to permanence. By looking at both effective interventions and practice systems we expect that the Centre will be able to build a truly comprehensive picture of what excellence looks like.[407]

Although this is clearly related to adverse childhood experiences, Ms Dyson made clear that the new centre would "focus from the point of referral into the social care system" and therefore not share the same remit as the Early Intervention Foundation for early-stage intervention.[408]

137. Donna Molloy told us that "the questions local authorities and partners ask when they talk to us about getting help with evaluations are very common", and said that "it is very inefficient for individual local authorities to be grappling with these evaluation challenges separately":[409]

> People up and down the country are grappling with how to show whether their early intervention system is delivering anything that might ultimately reduce pressure on their children's social care system and so on. People want to evaluate their integrated systems rather than very narrow services or interventions. There is certainly a very strong case for central support and capacity to work with local authorities in combination on some of this.[410]

Indeed, one of Ms Molloy's main recommendations for improving the use of evidence-based programmes was for increased central support for local authorities:

> Funding and technical expertise should be available to those in local authorities and their partner agencies who are seeking to test the impact of some of the things they are doing locally [Government Departments] used to make available technical expertise to local areas to evaluate certain things. That does not seem to happen as much now and is much needed in terms of this agenda.[411]

Dr Jo Casebourne, Chief Executive of the Early Intervention Foundation, told us that:

> Much more needs to be done to properly support the early intervention agenda, and that as an organisation we are not currently resourced to do all of what is needed […] with more secure and sustainable funding, the Early Intervention Foundation could do much more.[412]

138. **As the What Works Centre established to review the evidence relating to early intervention and to help disseminate the latest findings to relevant stakeholders, the Early Intervention Foundation has a key role to play in improving the provision of evidence-based early intervention in England, and should be a key partner to**

407 Department for Education, 'Putting children first: Delivering our vision for excellent children's social care' (2016), para 87
408 Q442
409 Q195
410 Q195
411 Q210
412 Early Intervention Foundation (EYI0111)

Government in developing and implementing the new national strategy. ***As part of the forthcoming Spending Review, the Government should review funding for the Early Intervention Foundation with a view to increasing and extending it, to ensure that the Foundation has greater long-term security, and so that it can meet the Children's Minister's aims of achieving for local authorities what the Education Endowment Foundation has achieved in schools.***

139. **In working to deliver on the new adversity-targeted early intervention strategy, local authorities would benefit from the support of a central specialist team with experience in effectively and sustainably implementing early intervention programmes, to help with planning and delivering evidence-based early intervention and to overcome the various challenges we have identified.** ***An expanded Early Intervention Foundation would be well-placed to host such a team, and the Government should invest in the Foundation to achieve this aim.***

Early Intervention Places

140. One of the key recommendations from the 2011 Allen review of early intervention was for the establishment of 'Early Intervention Places'.[413] These were envisaged as pioneering local authorities that would trial new approaches to early intervention:

> [The proposed Early Intervention Places] have strong political commitment [to early intervention], a good track record of innovation, an understanding of the need to improve the evidence […] and the willingness to share results of their work, whether successful or not.[414]

These Early Intervention Places were intended to "become focal points for the other 127 local authorities in the UK".[415] This proposal resembled a Canadian initiative recommended to us by Associate Professor David McDaid:

> Looking to Canada, there is something called the innovation fund, developed by Public Health Canada, which provides funding for testing and, if the testing works, for rolling out a bit more, and then a third level of funding for implementation. The Committee might want to look at that model.[416]

Unlike the Allen Review's recommendation for the establishment of the Early Intervention Foundation, the recommendation for Early Intervention Places was never taken up by the Government.

141. **We have heard strong arguments for the improved provision of evidence-based early intervention targeting childhood adversity and trauma in England. Nevertheless, we recognise that open research questions remain and further lessons about the real-world delivery of early intervention can be learnt.** ***The new national strategy should be targeted at, and acted upon by, all local authorities. In addition to this, the Early Intervention Foundation should identify local authorities willing to become 'Early Intervention Places', which would receive particular support from the central, specialist***

413 Graham Allen, 'Early Intervention: The Next Steps' (2011)
414 Graham Allen, 'Early Intervention: The Next Steps' (2011), p95
415 Graham Allen, 'Early Intervention: The Next Steps' (2011), p95
416 Q93

team we have recommended. Together with the central team, these local authorities would utilise implementation science to build sustainable implementations of evidence-based programmes, simultaneously generating new knowledge that can be rolled out to other local authorities at a pace consistent with the development of sustainable service transformation.

Funding

142. As outlined in paragraphs 76 to 82 of this Report, the spending on early intervention in England appears to be declining. Highlighting what they perceived to be a missed opportunity, the Royal College of Paediatrics and Child Health raised concern that this recent shift in funding away from early, and towards late, intervention was "in direct contradiction to the evidence on effectiveness and cost-effectiveness".[417]

143. Martin Pratt, Chair of the Association of London Directors of Children's Services, advocated adopting an approach that would lead to "an overall movement or shift in the centre of gravity in public investment towards prevention and early intervention", and stressed that this would have to be done in a co-ordinated way, rather than through individual programmes.[418] As an example of what such an approach could achieve, he told us that the proportion of children in care in Camden had reduced from 53 to 42 per 10,000 children in four years, which he attributed to a deliberate and co-ordinated shift in overall spending towards early intervention.[419]

144. The 2011 Allen Review acknowledged constraints in public funding and set out the opportunity for private investment in the sector.[420] The Early Intervention Foundation reviewed the case for social impact bonds in particular and noted their potential to cover the upfront costs of early intervention without diverting funding from other areas, but cautioned that the timescales and magnitude of the cost-savings typical of early intervention may not appeal to private investors.[421] Dr Woods-Gallagher, Special Advisor on School Readiness for the Greater Manchester Combined Authority, additionally told us that social impact bonds "can be complex to set up", and argued that local authorities should seek to invest in, and gain from, proven programmes themselves.[422] Professor Feinstein, Director of Evidence at the Children's Commissioner's Office, added that it might not be clear who would benefit directly from the cost-savings of early intervention, and argued that given the "collective economic benefit" of early intervention, the responsibility for investment in early intervention lay principally with the Government.[423] The Allen Review similarly concluded that even with private sector involvement, the Government should still manage "99% of the expenditure in the field".[424]

417 Royal College of Paediatrics and Child Health (EYI0054), para 5.2
418 Q218
419 Qq218–221
420 Graham Allen, 'Early Intervention: Smart Investment, Massive Savings' (2011)
421 Early Intervention Foundation, 'Introduction to Social Impact Bonds and Early Intervention' (2014)
422 Q245
423 Q79
424 Graham Allen, 'Early Intervention: Smart Investment, Massive Savings' (2011), p xv

Using technology to reduce costs

145. One particular avenue that was raised as a potential route to delivering early intervention programmes at low cost was through greater use of digital technology. Matt Buttery, Chief Executive of Triple P UK, told us that digital service delivery "provides the ability to take parenting to scale and, in a low-cost, effective way, to reach into parts of the community that face-to-face interventions do not always reach".[425] During our inquiry, we heard from EasyPeasy, a digital service that sends game ideas, tips, and advice to parents through short video clips. This service had been the subject of a randomised controlled trial, which reported "statistically significant differences between intervention and control groups on two of the seven measures" that were assessed (parents' self-efficacy regarding discipline and boundaries, and parent-reported child cognitive self-regulation).[426] Professor Melhuish, of the University of Oxford, told us:

> It is very early days to identify the relevant value of the digital approach versus a more traditional one, but my experience so far leads me to think that there is a lot more scope for taking advantage of digital technology. Private agencies are doing this and there is very little Government involvement in it. I think some Government involvement could be very beneficial.[427]

146. ***In adopting a new national adversity-targeted early intervention strategy, the Government should see effective early intervention as an opportunity to make long-term cost efficiencies—as well as improve people's lives—rather than a demand on resources. The Government should correspondingly make the necessary funding available where elements of the new strategy will require funding from central Government. The new strategy should also seek to drive a general shift in the focus of current expenditure on 'late interventions', required where problems have escalated, to earlier intervention. Although this may require an initial increase in expenditure, there is good reason to expect this to lead to long-term savings across diverse sectors. The new strategy should seek to identify ways in which the cost of early intervention can be brought down without compromising its effectiveness, for example by reviewing the evidence for digital early intervention services, as well as considering how local authorities can be incentivised—rather than penalised—for making long-term investments. Where local authorities cannot invest in early intervention initiatives that are expected to deliver long-term cost-benefits, the Government should be ready to provide additional funding to ensure the opportunity to improve lives and save public money is not missed.***

425 Q105

426 University of Oxford, 'EasyPeasy parenting app: Findings from an efficacy trial on parent engagement and school readiness skills' (2016)

427 Q167

Conclusions and recommendations

The evidence behind early intervention

1. Research into adverse childhood experiences (ACEs) has usefully raised awareness of the importance of early years experiences on child development, and of the potential consequences associated with childhood adversity or trauma. The ACE framework helps to provide a common language for early years practitioners working in different sectors. However, the simplicity of this framework and the non-deterministic impact of ACEs mean that it should not be used to guide the support offered to specific individuals. (Paragraph 17)

2. There is now a body of evidence that clearly demonstrates a correlation between adversity suffered during childhood and an increased prevalence of health and social problems in later life. Despite a variety of proposed explanations for this correlation, the causal pathways linking childhood adversity or trauma to subsequent problems are less certain. Nevertheless, when delivered effectively, there is strong evidence that early intervention can dramatically improve people's lives and reduce long-term costs to the Government. *The Government should ensure that it is making the most of the opportunity for early intervention to effectively and cost-effectively address childhood adversity and trauma, and the long-term problems associated with such experiences.* (Paragraph 25)

3. Important research questions regarding childhood adversity and early intervention remain. Progress on this front would benefit from a more co-ordinated approach across different academic fields, as well as greater access to relevant administrative data held by the Government. *As it starts working towards its goal of improved interdisciplinary collaboration, UK Research and Innovation should co-ordinate research into child development and early intervention methods for addressing childhood adversity, across different academic disciplines. Particular focus should be on developing interventions to address adverse childhood experiences for which no effective intervention has been demonstrated, including sexual abuse, parental substance misuse or parental incarceration and crime.* (Paragraph 31)

4. *Further, we recommend that the Government should ensure that academic researchers can access Government administrative data relevant to childhood adversity, long-term outcomes and the impact of early intervention, while ensuring appropriate privacy and safeguarding mechanisms are in place. UKRI should consult the relevant academic community to determine which data would be beneficial, and work with Government departments to ensure researchers can access that data as appropriate.* (Paragraph 32)

The current state of early intervention in England

5. Whilst there is evidence of good practice in some local authority areas in England, there is no clear, overarching national strategy from the UK Government targeting childhood adversity and early intervention as an effective approach to address it. Nor does there seem to be effective oversight mechanisms for the Government or others to monitor what local authorities are doing. This has led to a fragmented and

highly variable approach to early intervention across England, with evidence of a significant gap between what the latest evidence suggests constitutes best practice and what is actually delivered by many authorities. Where local authorities are not providing early intervention based on the best available evidence, vulnerable children are being failed. (Paragraph 45)

6. *There is now a pressing need for a fundamental shift in the Government's approach to early intervention targeting childhood adversity and trauma. The Government should match the ambition of the Scottish and Welsh Governments, and build on the example set by certain English councils, to make early intervention and childhood adversity a priority, and set out a clear, new national strategy by the end of this Parliamentary session to empower and encourage local authorities to deliver effective, sustainable, evidence-based early intervention*. (Paragraph 46)

7. *The Government should ensure that it has better oversight of the provision of early intervention around the country, so that it can identify approaches that are working well, detect local authorities in need of support and hold local authorities to account. It should determine what information is needed to be able to assess the local provision of early intervention and set out a framework as part of the new national strategy that ensures that all local authorities will provide such information, with as little disruption to their working practice as possible*. (Paragraph 47)

8. Co-ordination between the different Government departments whose areas of responsibility relate to childhood adversity or problems associated with this could be improved. We welcome the formation of the new ministerial group working to improve family support for those with young children. *This group should: make tackling childhood adversity a focus of its work; improve cross-Government co-ordination on this issue; and ensure that there is clear accountability for driving this agenda across all Government departments*. (Paragraph 48)

9. The Healthy Child Programme is the only mechanism in place through which all children in England should receive early years practitioner support before the age of five. Its coverage is therefore critical for identifying ACEs and other child development issues early. *The Government should review the current provision of the Healthy Child Programme across England and set out, as part of the new national strategy, a date for achieving complete coverage in the number of children who receive all five mandated health visits. Given existing workforce pressures, the Government must ensure that this required increase in coverage does not negatively impact the quality of health visits. It should consult the Institute of Health Visiting on how this can be managed, and be ready to recruit additional health visitors as required*. (Paragraph 54)

10. There appears to be significant concern within the early years community at the outcomes for assessment chosen by the then Department of Health for the major study it commissioned of the Family Nurse Partnership. We therefore do not encourage national or local Government to act upon the study's overall recommendation to discontinue provision of the Family Nurse Partnership. Nevertheless, the study's findings should be considered, and where they can be used to improve the impact of the Family Nurse Partnership programme such action should be pursued. We

commend the Family Nurse Partnership National Unit for implementing its 'ADAPT' initiative to learn from the study's findings, and we urge local commissioners and providers to act upon the conclusions reached by this initiative. (Paragraph 59)

11. Although we commend the Government on its willingness to commission a significant study of the effectiveness of the Family Nurse Partnership, such studies are only of value if their findings are widely supported and acted upon. The provision of evidence-based early interventions will clearly benefit from studies that can provide a strong evidence base. *If the Government commissions future major studies of significant early intervention programmes—which we would welcome—it must ensure that the outcomes it decides are to be assessed, and other elements of the design of such studies, are supported by the early years practitioner community. The Government must then act upon the evidence generated by those studies.* (Paragraph 60)

12. The delay in launching a consultation on the future of Sure Start Centres is regrettable and has meant that Ofsted has not inspected children's centres since 2015. Local authorities have been left unsure of the status of children's centres in future policy. *The Government should clarify its position on Sure Start centres. In response to this Report, it should specify if—and when—it intends to hold a consultation. If it intends to proceed with a consultation, this should be held within three months. The Government should also set out the focus and purpose of such a consultation. If a consultation is not going to be held, the Government must urgently reinstate Ofsted inspections of children's centres and make clear its thinking on the role and value of children's centres.* (Paragraph 64)

13. We welcome Minister Doyle-Price's ambition to do more in this area. However, there was a disappointing level of ambition and focus on pre-school aged children in the Government's 2017 Green Paper on 'transforming children and young people's mental health provision'. *As it develops its action on children and young people's mental health, the Government should recognise the importance of child development and the impact of adversity in the early years, and ensure that it adopts 'transformative' ambitions and policies for pre-school aged children alongside its work targeting schools and colleges.* (Paragraph 68)

14. Prevention of mental health problems can start before signs of low mental wellbeing start to appear, through promotion of healthy mental wellbeing to all children. *The Government should set a policy for primary and secondary schools that seeks to promote wellbeing as well as improving the early identification of, and support for, emerging problems.* (Paragraph 70)

15. There are a variety of programmes beyond the Healthy Child Programme, the Family Nurse Partnership and the Sure Start initiative that reach children who are experiencing or have experienced adversity and trauma. However, none of these programmes specifically target these children and they do not prioritise preventing ACEs or mitigating their effect. This reinforces the need for the Government to develop a new national strategy specifically focusing on childhood adversity and trauma, and on evidence-based early intervention initiatives that can address these issues. (Paragraph 73)

16. There is an opportunity for the Government to increase the provision of evidence-based early years programmes, without increased cost, by setting more prescriptive specifications on the content of childcare eligible for Government funding. *The Government should work with researchers and practitioners to examine how new specifications on the free childcare it funds could increase the use of evidence-based programmes, and what the impact would be on the families affected. Such specifications could rapidly increase the number of families receiving evidence-based programmes and we call on the Government to review this by the end of this Parliamentary session, although local providers should be given a period of time to adjust to any new specifications.* (Paragraph 74)

Key Challenges to Delivering Early Intervention

17. Despite the long-term savings associated with effective early intervention, the amount of funding available to local authorities that is nominally destined for early intervention is declining. This can result in early intervention activity being sacrificed in favour of statutory duties, in addition to the commissioning of cheaper, unproven interventions as well as a reluctance to properly evaluate interventions that are being delivered. Nevertheless, funding constraints should not be used by local commissioners and others as an excuse to avoid acting upon the latest evidence regarding childhood adversity and early intervention—especially given the savings that some programmes can deliver for local authorities, particularly in the long-term, and given the positive impact on the life chances of children. (Paragraph 82)

18. The collection and analysis of appropriate data is vital to monitoring the impact of early intervention initiatives to ensure that they are achieving the desired effect and to inform further improvements. It can also help to identify families that may benefit from early intervention. Despite these critical uses, the local collection and analysis of data is not conducted as widely or as thoroughly as it should be around the country. Collation of relevant data at a national level is also insufficient, with fewer than half of local authorities submitting data on the five mandated visits of the Healthy Child Programme to NHS Digital. Public Health England's public health indicator data does not appear to include any measures sufficiently focused on childhood adversity or early intervention. The early years are a critical period for child development so it is unacceptable that there is no national system of data collection assessing such development before the age of two. Two years on from the publication of the Government's 'vision' for children's social care, it is clear that there is still significant work to be done to achieve its aim of making full use of data in the early years system. (Paragraph 88)

19. Local authorities and their partners face a combination of challenges in collecting, sharing and interpreting data relevant to childhood adversity and early intervention. These include a lack of capability or capacity, as well as problems with sharing data between different services and systems. However, robust data collection and analysis is critical to the delivery of effective evidence-based early intervention. Although data collection can be time-consuming, it can improve frontline practice and—implemented properly—lead to efficiencies elsewhere. (Paragraph 92)

20. The establishment of Social Work England constitutes an important opportunity to review the training given to children's social workers. *The Government should ensure that the accreditation criteria for social workers include knowledge of child development science, the impact of adversity and methods for addressing this, as well as good practice in collecting and using data. The knowledge required should be tailored to the different roles and responsibilities of practitioners, supervisors and leaders. The Government must further ensure that training is available to allow social workers to meet these criteria.* (Paragraph 99)

21. There is scope for improved awareness of the importance of early years experiences on child development, and knowledge of the latest science in this domain, across the early years workforce. The capacity and motivation to engage with evidence should also be improved, in particular for those in leadership positions. The establishment of Social Work England constitutes an important opportunity to review the training given to children's social workers, but the early years workforce encompasses a much broader range of professions than social workers alone. (Paragraph 104)

22. Although many organisations report that intervention outcomes benefit from families receiving support from the same practitioner throughout their interaction with a particular service, constraints in capacity are a major contributory factor resulting in many services not consistently achieving such continuity of care. (Paragraph 107)

A new national strategy

23. *The Government's new strategy for adversity-targeted early intervention should include plans to improve the use of data for assessing early intervention and identifying families who could benefit from early intervention, at local and national level. The strategy should promote the value of data collection and analysis by drawing on case studies of local authorities or their partners using data to improve outcomes. It should also set out the general principles of good practice with data collection and analysis, such as collecting baseline data in preparation of assessing a new intervention and avoiding the use of self-reported measures.* (Paragraph 115)

24. *The new strategy should set out what local authorities should measure to assess their early intervention initiatives or to identify families who could benefit from receiving early intervention support, and give examples of specific data that would capture this. These measures should be identified in consultation with child development experts and local authorities themselves, and cover aspects such as social, emotional and language development from birth through to the start of school. Consideration should be given to the burden of collecting the data and the compatibility of its collection with existing practice. In identifying these measures, the Government should ensure that it seeks opportunities for local authorities to make use of data that they or their partners already collect.* (Paragraph 116)

25. *The new strategy should also address challenges in data-sharing between different organisations working with young children. It should include guidance to local authorities and their partners on data protection legislation and provide examples of best practice in data sharing, focusing specifically on childhood development, trauma and related early interventions. The Government should additionally consider what*

infrastructure and licences could facilitate efficient, interoperable data processing by local authorities and assess the cost-benefit of providing funding towards this. (Paragraph 117)

26. Collection of the most important data at a national level would provide central Government with information on the national state of childhood adversity and early intervention, and drive local authorities to ensure the necessary data is collected. Children are not currently assessed with a national measure of child development until the Ages and Stages Questionnaire at age two to two-and-a-half. *In addition to ensuring full coverage of the health visits mandated by the Healthy Child Programme, the Government must ensure that the data collected during such visits is reported nationally. It should consult the Institute of Health Visiting and child development experts to determine if the Healthy Child Programme should include assessments of social and emotional development prior to the fifth mandated visit, and if so provide the resources necessary to allow for this.* (Paragraph 118)

27. *The new adversity-targeted early intervention strategy should also set out measurable objectives for progress on data collection, such as the proportion of local authorities supplying full data from the Healthy Child Programme mandated visits, or the proportion of local authorities identified by Ofsted as delivering sufficiently data-driven early intervention. If data collection and analysis does not consequently improve within two years of the strategy's implementation, the Government should consider introducing statutory requirements for the reporting of data that can be used to monitor the delivery and impact of early intervention.* (Paragraph 119)

28. *The Government's new national strategy for adversity-targeted early interventions must include steps to increase the knowledge that professionals across the early years workforce have of: the impact of childhood adversity or trauma and what can be done to remedy this; how to identify those families that could benefit from early intervention; how to access and use relevant, up-to-date scientific evidence; how to make best use of data in offering and delivering early intervention services, and in understanding and evaluating the effectiveness of those services; and child development and the importance of early years experiences. The strategy should identify and define the 'early intervention workforce', comprising the full range of professions that engage with young children or their families and that could either: help to identify those who would benefit from early intervention; or would play a role in delivering early intervention services. The Government should then review the pre-qualification training and continuing professional development offered to the different professions in the early intervention workforce and ensure that each covers the different elements outlined above, at a level appropriate to the profession in question.* (Paragraph 122)

29. Many evidence-based interventions require ongoing, accredited supervision from specialist supervisors with expertise in that particular model. *As part of a new national strategy for adversity-targeted early intervention, the Government must make clear that in commissioning evidence-based programmes, local authorities should ensure that there is sufficient accredited, ongoing, specialist supervision from qualified supervisors in that programme for the workforce, throughout the delivery of the programme. Local commissioners should aim to support the development of their own accredited supervisors, to enable cost-savings and deliver an experienced and expert workforce, leading to greater sustainability.* (Paragraph 125)

30. The Apprenticeship Levy offers an important potential source of new funding for training of the early years workforce. *The new adversity-targeted national strategy should promote the opportunity presented by the Apprenticeship Levy as a source of funding for training early years practitioners. The Government should monitor the number of local authorities that make use of the Levy in this way, evaluate the impact where authorities have used it, and provide guidance to assist other local authorities in using the Levy funding if it proves to be successful.* (Paragraph 127)

31. Implementation science is a developing field that can inform the delivery of service transformation programmes, to increase the chance of successful implementation and sustainability. *In addition to the focus on data-driven practice and the delivery of relevant training and ongoing expert supervision, the new national strategy for adversity-targeted early intervention should encompass the latest evidence from implementation science, incorporating elements such as a commitment to model fidelity and the adoption of realistic timeframes for service redesign and deadlines for results. The Government should consult academics and practitioners to achieve this, and ensure that lessons from services that have successfully implemented evidence-based early intervention with positive outcomes are also taken into account.* (Paragraph 132)

32. As the What Works Centre established to review the evidence relating to early intervention and to help disseminate the latest findings to relevant stakeholders, the Early Intervention Foundation has a key role to play in improving the provision of evidence-based early intervention in England, and should be a key partner to Government in developing and implementing the new national strategy. *As part of the forthcoming Spending Review, the Government should review funding for the Early Intervention Foundation with a view to increasing and extending it, to ensure that the Foundation has greater long-term security, and so that it can meet the Children's Minister's aims of achieving for local authorities what the Education Endowment Foundation has achieved in schools.* (Paragraph 138)

33. In working to deliver on the new adversity-targeted early intervention strategy, local authorities would benefit from the support of a central specialist team with experience in effectively and sustainably implementing early intervention programmes, to help with planning and delivering evidence-based early intervention and to overcome the various challenges we have identified. *An expanded Early Intervention Foundation would be well-placed to host such a team, and the Government should invest in the Foundation to achieve this aim.* (Paragraph 139)

34. We have heard strong arguments for the improved provision of evidence-based early intervention targeting childhood adversity and trauma in England. Nevertheless, we recognise that open research questions remain and further lessons about the real-world delivery of early intervention can be learnt. *The new national strategy should be targeted at, and acted upon by, all local authorities. In addition to this, the Early Intervention Foundation should identify local authorities willing to become 'Early Intervention Places', which would receive particular support from the central, specialist team we have recommended. Together with the central team, these local authorities would utilise implementation science to build sustainable implementations*

of evidence-based programmes, simultaneously generating new knowledge that can be rolled out to other local authorities at a pace consistent with the development of sustainable service transformation. (Paragraph 141)

35. *In adopting a new national adversity-targeted early intervention strategy, the Government should see effective early intervention as an opportunity to make long-term cost efficiencies—as well as improve people's lives—rather than a demand on resources. The Government should correspondingly make the necessary funding available where elements of the new strategy will require funding from central Government. The new strategy should also seek to drive a general shift in the focus of current expenditure on 'late interventions', required where problems have escalated, to earlier intervention. Although this may require an initial increase in expenditure, there is good reason to expect this to lead to long-term savings across diverse sectors. The new strategy should seek to identify ways in which the cost of early intervention can be brought down without compromising its effectiveness, for example by reviewing the evidence for digital early intervention services, as well as considering how local authorities can be incentivised—rather than penalised—for making long-term investments. Where local authorities cannot invest in early intervention initiatives that are expected to deliver long-term cost-benefits, the Government should be ready to provide additional funding to ensure the opportunity to improve lives and save public money is not missed.* (Paragraph 146)

Formal Minutes

Tuesday 30 October 2018

Members present:

Norman Lamb, in the Chair

Vicky Ford	Stephen Metcalfe
Bill Grant	Carol Monaghan
Darren Jones	Graham Stringer

Draft Report (*Evidence-based early years intervention*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 146 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Tuesday 6 November at 9.00 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 20 February 2018

Professor Mark Bellis, Bangor University and Public Health Wales; **Professor Eamon McCrory**, University College London; **Professor Rosalind Edwards**, University of Southampton; and **Professor Sue White**, University of Sheffield — Q1–49

Dr Marc Bush, Chief Policy Adviser, YoungMinds; **Kate Stanley**, Director of Strategy, Policy and Evidence, NSPCC; **Associate Professor David McDaid**, London School of Economics and Political Science; and **Professor Leon Feinstein**, Director of Evidence, Office of the Children's Commissioner — Q50–98

Tuesday 20 March 2018

Ailsa Swarbrick, Director, Family Nurse Partnership National Unit; **Matt Buttery**, Chief Executive, Triple P UK; **Jen Lexmond**, Chief Executive Officer, EasyPeasy; and **Professor Edward Melhuish**, University of Oxford — Q99–170

Tom McBride, Director of Evidence, Early Intervention Foundation; **Donna Molloy**, Director of Policy and Practice, Early Intervention Foundation; and **George Hosking**, Chief Executive Officer, WAVE Trust — Q171–211

Tuesday 17 April 2018

Dr Shirley Woods-Gallagher, Special Adviser on School Readiness, Greater Manchester Combined Authority; **Professor Alan Harding**, Chief Economic Adviser, Greater Manchester Combined Authority; **Dr Caroline White**, Head, Children and Parents Service Early Intervention; and **Martin Pratt**, Chair, Association of London Directors of Children's Services — Q212–302

Professor Viv Bennett, Chief Nurse, Public Health England; **Dr Jeanelle de Gruchy**, President, Association of Directors of Public Health; and **Katy Hetherington**, Organisational Lead - Child and Adolescent Public Health, NHS Health Scotland — Q303–375

Tuesday 1 May 2018

Nadhim Zahawi MP, Parliamentary Under-Secretary of State for Children and Families, Department for Education; **Michelle Dyson**, Director of Early Years, Department for Education; **Jackie Doyle-Price MP**, Parliamentary Under-Secretary of State for Mental Health and Inequalities, Department of Health and Social Care; and **Mark Davies**, Director of Population Health, Department of Health and Social Care — Q376–470

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

EYI numbers are generated by the evidence processing system and so may not be complete.

1 Adoption UK (EYI0072)

2 ALDCS (EYI0105)

3 Association for Child and Adolescent Mental Health (ACAMAH) (EYI0070)

4 Association of Child Psychotherapists (ACP) (EYI0042)

5 Association of Directors of Public Health (EYI0031)

6 Barnardo's (EYI0037)

7 Best Beginnings (EYI0073)

8 Better Start Bradford (EYI0113)

9 Big Lottery Fund (EYI0091)

10 Bonin et al, PSSRU, LSE (EYI0081)

11 British Association for Counselling and Psychotherapy (EYI0085)

12 Bulwell Community Toy Library Limited (EYI0016)

13 Cardiff University (EYI0014)

14 Centre for Evidence Based EArly Intervention (EYI0029)

15 Centre for Longitudinal Studies, University College London (EYI0075)

16 Centre for Mental Health (EYI0050)

17 Children And Parents Service (CAPS) Early Intervention (EYI0004)

18 Children First (EYI0102)

19 Children's Commissioner's Office (EYI0063)

20 CLOSER (EYI0020)

21 CSJ (EYI0059)

22 Department for Education (EYI0053)

23 Department of Health and Social Care and Department for Education (EYI0109)

24 Dr Adam Burley (EYI0017)

25 Dr Elizabeth Gregory (EYI0024)

26 Dr Gill Main (EYI0049)

27 Dr Michelle Kelly-Irving (EYI0008)

28 Dr Sarah Starkey (EYI0062)

29 Dr Sebastian Kraemer (EYI0089)

30 Dr Sue Gerhardt (EYI0065)

31 Dr Warren Larkin (EYI0015)

32 Early Intervention Foundation (EYI0061), (EYI0111), (EYI0112)

33 EasyPeasy (EYI0046), (EYI0100)

34 Emerita professor Hilary Rose (EYI0095)
35 Family Drug & Alcohol Court National Unit (EYI0003)
36 First Step, Tavistock and Portman NHS Foundation Trust (EYI0023)
37 Foundation Years Trust (EYI0060)
38 George Smith, Kathy Sylva, Teresa Smith, Pam Sammons and James Hall, University of Oxford (EYI0110)
39 Greater Manchester Combined Authority (EYI0047)
40 Home Start Kirklees (EYI0019)
41 Home-Start UK (EYI0036)
42 Institute of Health Visiting (EYI0107)
43 International Centre for Lifecourse Studies in Society and Health (EYI0043)
44 Kidstime Foundation and The Children's Society (EYI0082)
45 Kingston University London (EYI0044)
46 Knapp et al, PSSRU, LSE (EYI0079)
47 Louise Arseneault (EYI0083)
48 Manchester City Council (EYI0011)
49 Mark Wheeler (EYI0088)
50 Marriage Foundation (EYI0052)
51 Mental Health Foundation (EYI0087)
52 Mersey Care NHS Foundation Trust (EYI0074)
53 Mr Graham Allen (EYI0090)
54 MRC/CSO Social and Public Health Sciences Unit (EYI0021)
55 Mrs Barbara Bryant (EYI0010)
56 Mrs Lynne MacKinnon (EYI0045)
57 Mrs Margaret Ellis (EYI0080)
58 Mrs Susan Korda (EYI0067)
59 Ms Ann Murdoch (EYI0001)
60 National Association for Therapeutic Education (EYI0094), (EYI0101)
61 Newcastle University (EYI0007)
62 NHS Health Scotland (EYI0035)
63 NSPCC (EYI0034)
64 OXPIP (EYI0068)
65 Paul Milton (EYI0098)
66 Penelope Leach (EYI0027)
67 PIP UK (EYI0005)
68 Professor Christine Power (EYI0056)
69 Professor Peter Fonagy (EYI0097)
70 Professor Sarah L Halligan, Dr Catherine Hamilton-Giachritsis, and Dr Rachel M Hiller (EYI0057)

71 Public Health England (EYI0033), (EYI0104), (EYI0108)
72 Public Health Institute, Liverpool John Moores University (EYI0032)
73 Public Health Wales (EYI0051)
74 Roots of Empathy (EYI0077)
75 Royal College of Paediatrics and Child Health (EYI0054)
76 Rt Hon Frank Field MP (EYI0106)
77 Safe Families for Children (EYI0066)
78 Sheffield's Children & Young People's Public Health Team (EYI0064)
79 Sheila Croney (EYI0099)
80 Sue Gerrard (EYI0025)
81 TACTYC (EYI0103)
82 Tavistock Relationships (EYI0012)
83 The Academy of Medical Sciences (EYI0028)
84 The Bowlby Centre (EYI0002)
85 The British Psychological Society (EYI0069)
86 The Challenging Behaviour Foundation (EYI0030)
87 The Communication Trust (EYI0071)
88 The Nurture Group Network (EYI0018)
89 The Open University (EYI0022)
90 The Stefanou Foundation (EYI0076)
91 The Wensum Trust (EYI0096)
92 ThinkForward (EYI0048)
93 Thrive FTC (EYI0040)
94 Transforming Lives for Good (EYI0038), (EYI0092)
95 Trauma Recovery Centre (EYI0026)
96 Triple P (EYI0093)
97 Understanding Society, Institute for Social and Economic Research (EYI0055)
98 Universities of Kent, Southampton, Sheffield, Westminster and Nottingham (EYI0039)
99 University of Bristol (EYI0086)
100 University of Reading (EYI0058)
101 University of Southampton (EYI0041)
102 Victim Focus Jessica Eaton (EYI0006)
103 WAVE Trust (EYI0078)
104 Young Adults Matter (EYI0114), (EYI0115)
105 YoungMinds (EYI0013)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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Third Report	Genomics and genome editing in the NHS	HC 349
Fourth Report	Algorithms in decision-making	HC 351
Fifth Report	Biometrics strategy and forensic services	HC 800
Sixth Report	Research integrity	HC 350
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Ninth Report	Flu vaccination programme in England	HC 853
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Third Special Report	Industrial Strategy: science and STEM skills: Government Response to the Committee's Thirteenth Report of Session 2016–17	HC 335
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Sixth Special Report	Algorithms in decision-making: Government Response to the Committee's Fourth Report	HC 1544
Seventh Special Report	Research integrity: Government and UK Research and Innovation Responses to the Committee's Sixth Report	HC 1562
Eighth Special Report	Biometrics strategy and forensic services: Government's Response to the Committee's Fifth Report	HC 1613

Ninth Special Report	An immigration system that works for science and innovation: Government's Response to the Committee's Eighth Report	HC 1661