HOUSE OF COMMONS

Science and Technology Committee

Oral evidence: Evidence-based early-years intervention, HC 506

Tuesday 20 March 2018

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Watch the meeting

Members present: Norman Lamb (Chair); Bill Grant; Stephen Metcalfe; Carol Monaghan; Damien Moore; Graham Stringer.

Questions 99 - 211

Witnesses

I: 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.

II: 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.

Written evidence from witnesses:

- Triple P UK
- EasyPeasy
- Early Intervention Foundation
- WAVE Trust

Examination of witnesses

Witnesses: Ailsa Swarbrick, Matt Buttery, Jen Lexmond and Professor Edward Melhuish.

Q99 **Chair:** Welcome, all of you. Thanks very much for attending this morning. May we start by getting you to introduce yourselves briefly, so that we have that on the record?

Professor Melhuish: I am Edward Melhuish, professor of human development at the University of Oxford.

Jen Lexmond: I am Jen Lexmond, CEO and founder of EasyPeasy.

Ailsa Swarbrick: I am Ailsa Swarbrick, the director of the Family Nurse Partnership National Unit, based at the Tavistock and Portman NHS Trust.

Matt Buttery: I am Matt Buttery, the chief executive of Triple P UK—Positive Parenting Program.

Q100 **Chair:** I will start with some questions. The first one does not relate to you, Professor Melhuish. Will the rest of you briefly describe the interventions that you provide? How many families does your organisation work with?

Jen Lexmond: EasyPeasy is a technology start-up driven by the desire to narrow early gaps in child development. Our starting point is the Michael Marmot review, which shows that by the time children arrive for their first day of school there is already a considerable gap in their development: their language and communication skills, their self-regulation, and their ability to focus attention, to persist with difficult tasks and to make choices independently.

I and our organisation are driven by a mission to improve social mobility. We realise that the early years are absolutely the best place to start to accomplish that goal. The brain is developing very quickly in the early years. If you intervene early, it creates a very promising place to get a return on investments.

That was our starting point. We also felt that there was a real opportunity to use digital technology as a way of achieving scale and cost-effectiveness in an early intervention service. Over the past three years, we have been on a journey of design, testing and development of a digital service that sends game ideas, activities and evidence-based information and advice to parents through mobile phone prompts and apps.

Q101 **Chair:** How do they get to know about it?

Jen Lexmond: It is delivered through schools, nurseries and children's centres across England. We are currently working with around 10,000 families, around 250 early-years settings and 12 local authority partnerships.

We have also taken a strong approach to testing and measuring the impact of EasyPeasy. So far, we have a randomised control trial published by Professor Kathy Sylva at the University of Oxford, which found positive impact on parents' behaviours—their self-efficacy with sticking to rules and boundaries—and on children's cognitive self-regulation. Those are the two areas where we have statistically significant impact.

The cost of EasyPeasy per child is now under £15, so we can deliver that impact, using digital technology and evidence at scale, for a remarkably low cost.

Q102 **Chair:** Do you have evidence on whether you reach the children and families who are most in need of the intervention?

Jen Lexmond: Yes. I would describe EasyPeasy as a targeted universal service. When working with a local authority, for example, we work first to target EasyPeasy at local settings in disadvantaged communities. Different data may be used to assess that. We may look at pupil premium data or other relevant data about disadvantage or lack of opportunity.

We start by geographically targeting disadvantaged spaces. Then, within the school, we recommend that EasyPeasy be delivered universally, because a big part of the design of EasyPeasy is building social cohesion, networking families together on the digital service, connecting them to one another and avoiding stigma. We tend to deliver across the entire community of the school.

Ailsa Swarbrick: The Family Nurse Partnership is a public health prevention early-years and early-intervention service. It was brought to the UK about 11 years ago from the US. It targets young first-time, usually teenage, mothers who have come from disadvantaged backgrounds. The young client receives, from early in pregnancy until her child is two, intensive, structured, very evidence-based home visits from a nurse with highly specialised training. 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.

We currently operate in over half of the local authorities; we are in over 80 local authorities across the country. Last year, we worked with over 11,000 young women, plus 8,500 of their partners—dads are very heavily involved in the programme, too—and over 10,000 babies. The programme reaches a large number of people. Since FNP has been in this country, we have worked with over 35,500 families in total.

One of the strong and important features of the programme is that it has a very strong, robust evidence base. It has had three randomised control trials in the US, which pointed to significant benefits in antenatal health, child health and development, and mothers' outcomes in both the short and the long term. It has also been evaluated in the Netherlands and in

this country. We carry that through, in a sense, in the way in which we deliver the programme. We monitor both the way in which the programme is delivered, so that we can be clearer that we are likely to get the kinds of outcomes that we have received previously, and things like short-term outcomes—what nurses are doing. We receive feedback from them.

Q103 **Chair:** Am I right in saying that there has been an evaluation in this country that was not so positive?

Ailsa Swarbrick: Yes. There was a randomised control trial, published two years ago, that looked at a number of short-term outcomes. It found benefits in child development, as well as some other benefits for the child, but it also found that there was no effect on primary outcomes—for example, quitting smoking.

Our response has been to learn, to seek to improve, where the trial showed that we needed to improve, and to build on the good things that were in the trial. We have introduced a significant and ambitious improvement programme that we are still in the process of running. We published an interim report on that last week.

Q104 **Chair:** What do you offer that the mandatory health visiting service does not offer?

Ailsa Swarbrick: There are a number of levels to the answer. In terms of the client's experience, she and other members of her family build a relationship with a trusted individual, who can role-model, in a sense, how a trusting, respectful relationship can continue over the course of the two years. That is then a kind of 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.

The service also offers evidence of long-term benefits from a number of very robust pieces of research across the country. It offers support for the mother not just to think about her own future and the future of her baby, but to engage with services more locally and to get in touch with other services of the kind you have just mentioned.

Matt Buttery: Triple P—Positive Parenting Program is a system of parenting interventions. It operates at different levels of intensity and has a variety of ways of delivering, but it is really a prevention-orientated early-intervention system. Specifically, it is designed to improve the health and wellbeing of communities by supporting the development of more resilient and nurturing families, improving parents' and children's mental health, reducing child abuse and neglect, and improving children's social mobility.

It is one of the most extensively researched systems of parenting interventions in the world. It has been subject to more than 151 randomised control trials. Nearly 300 evaluations have been published on

Triple P in 33 countries around the world. Fifty per cent of those have been published without the involvement of the developer, the University of Queensland, which owns the programme.

It is also one of the few programmes that has demonstrated the ability to address ACEs at a community level, particularly in the US. Public Health England picked up on that in a recent rapid review that it did, in which it talked about the strength of Triple P's evidence base for delivering that universal component of a population health approach to child maltreatment. More recently, we have developed an online version of the intervention, which is underpinned by evidence from six randomised control trials.

Q105 **Chair:** What does the evidence on the online version show?

Matt Buttery: It shows the same sort of evidence that you would get with group delivery. The evidence is comparable. There is some great evidence around early ADHD symptoms in children, as well as around emotional and behavioural problems, increasing parental confidence and increasing authoritative parenting. It is very similar—a self-directed intervention over eight weeks of delivery.

We argue that the digital component is a key part of a population approach to parenting. It 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. Recently there was some interesting work in Australia, where we have seen an overrepresentation of single parents, those with the highest level of benefits and those who speak English as a second language in the uptake of the online programme, compared with state averages. That suggests that it may have even more ability than face-to-face interventions to reach into some of those hard-to-reach groups.

May I give you an anecdotal example of Triple P? It is 22 programmes, so thinking about it can feel a bit complex. There was a family I was involved with a number of years ago. Life had gone well. They had a four-year-old, and everything was going well. Then they had a baby, and the four-year-old decided that he did not want to go to bed. He also decided that he would like to get up during the night quite a bit. Of course, that was starting to take its toll on the family's mental health and causing them stress.

Mum had engaged with the children's centre with the four-year-old. She went back to the children's centre and was given some great advice, but it did not work. She then returned to the children's centre, a bit more stressed this time, and said, "Can you help me?" She was offered a 10-week parenting programme. It is great that she was offered a parenting intervention, but she said to me that her heart sank at the thought of having to go through 10 weeks. At this point, the lack of sleep was affecting dad's work. Dad said, "I can't believe that it is going to take us this long to solve. I don't think that I can cope any longer."

As I got involved with the family, we sat down over one night with an evidence-based TipSheet and worked through it. They selected the strategies that they wanted to employ and managed to get the four-year-old to bed that night. We did another session when I checked in a couple of weeks later, and they were still using the strategies. From their point of view, things had resolved themselves six months later; it was much better.

What was interesting for me was that, when I turned up that evening for the first time, dad greeted me at the door and said, "I am going to go and shout in his face, because that is all I have got left." This is a really good example of how a parenting intervention of the right intensity, delivered at the right time, can prevent the sorts of ACEs for which we might otherwise be totally reliant on treatment later on. Hopefully, the example illustrates how early intervention at just the right time can work. The Triple P system of interventions gives that.

Q106 **Chair:** Matt, what data would you like national and local government to collect to facilitate the evaluation of intervention effectiveness? I am conscious of the fact that in local government commissioners may be faced with these competing programmes, and others. How do they make judgments about how best to deploy public money?

Matt Buttery: As I have already said, Triple P is one of the best-evaluated programmes in the world. As well as that robust evidence base, there are a number of in-the-field evaluations. Those are really important pieces of evaluation, where you can show replication in the real world—for example, in Santa Cruz and in Ireland. There is also a fantastic in-the-field evaluation of the parenting early intervention programme (PEIP) that was delivered by the DFE. You are right: commissioners are obviously keen to know about the evidence base.

There are two levels to the answer to your question. There is the sort of information that you get from the programme. It would be useful to think about how you standardise those measures. We have an implementation process that works with a site delivering Triple P to ask it which measures it uses locally and which measures from the basket of those available with Triple P would be useful locally, so that there can be some level of integration with the system locally. But it would pay to start to think about how we can standardise some of those measures.

If you are thinking at population level, in the US they have started to tie some of the outcomes of the Triple P population-level delivery system to outcomes from social workers, around child maltreatment, with hospitals, around reductions in emergency hospital admissions, and with foster care, around the number of children going into care. There is much more that we could do to link the outcome data from a programme, which are important, to those outcomes, which are really where the cost saving could be made.

Q107 **Chair:** Does either Ailsa or Jen want to say anything about the collection

of data, nationally or locally, and what we should be doing?

Ailsa Swarbrick: Yes. As I mentioned before, we collect a great deal of information and data through the Family Nurse Partnership. One of the challenges is being able to see how the data compare with local data for other children or mothers in the area. Those datasets are available, largely. At the moment, we are doing quite a bit of exploration of data linking, to see whether we are able automatically to assess outcomes of people on our programme against those of others.

Clearly, that would help us to improve, but it is not always straightforward. I know that 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 and the specific questions that are asked across the piece, so that you can get a much broader view of the many different forms of early intervention that there are, the way in which they work, the impacts that they have and what works for whom and in what circumstances. It is a matter of understanding how best to target and to assess that information.

Outcomes are critical, and we want to invest public money well. It is also necessary to think about what the experience of receiving interventions is. If I were thinking of something different, I would be very interested in thinking about how we can understand better the experience of the relationship that we believe drives many of the outcomes that we see on the part of both the clients, in particular, and the nurses. That is something we are looking at within FNP now.

Jen Lexmond: I agree with those points. One of the great challenges of the area in which we work is trying to pull funding and investment into the intervention life cycle earlier. You can do early intervention anywhere along the life cycle, but in the early years it is particularly effective right at the beginning. It is difficult to have those conversations under austerity and tight budgets, so whatever we can do better to connect prevention and early intervention programmes to cost savings, in the way my colleagues describe, is really important.

Sometimes the savings from investment in the early years are longer term. They can be shorter term, but it is a web to put together. From my perspective, as someone trying to build and scale a start-up, it sometimes feels like there are an awful lot of other jobs to be doing on the side to make those arguments and to knit together the data side. That feels like a real challenge. Cost-benefit—looking at the relative cost of different early-intervention services and the benefits that accrue from them—is a big part of that, too.

I want quickly to mention one example. EasyPeasy is currently being supported by the Education Endowment Foundation to run a larger-scale randomised control trial, reaching about 1,200 children and their families. One thing that excites me about that project is the way in which the

study is being run. We are going to take a short-term measurement of impact just after the length of our programme, which will run for about five months, but we will also connect into administrative data at school level. In the national pupil database, all the children who receive EasyPeasy will be tracked as they grow up, so that we can track the impact that EasyPeasy is having on their attainment right the way through school.

I would love to see the ability to do that not just within the confines of quite complex randomised control trials that are really difficult to run, but as part of delivering our service to the 10,000 or 18,000 we are going to serve this year. Having ways of connecting into longitudinal and administrative data that are already being collected as a matter of course, not just in education, but in health and other areas—in mental health, for example—could be really beneficial for proving what we are doing over the long term.

Q108 **Chair:** I go back to what you said earlier. As a general principle, do you think that there is a strong case for shifting resources into more investment in the early years that you are describing?

Jen Lexmond: Yes. I am sure that Edward can speak about this for a long time. There is a fantastic evidence base that shows that investing earlier in the human life cycle yields greater returns. One of the stats that I use a lot is from Professor James Heckman at the University of Chicago, who shows that there is a 13.7% return for every dollar invested in quality early-childhood programmes aimed at disadvantaged children.

If you compare that to anything—the stock market or whatever—it is a fantastic return. I know that that can feel a bit abstract, but that concept, which he has modelled out incredibly impressively, is really important. That is what led me to start my company in this space, because I felt that it was exactly the right place to get the best outcomes and returns.

Q109 **Chair:** Edward, you have been set up now. Your moment has come. First, do you have any comments on what you have heard so far? Secondly, I have a specific question for you. What did your review of the Sure Start programme reveal?

Professor Melhuish: First, all three of the programmes my colleagues on the bench are talking about work. There is evidence that they work to some degree. EasyPeasy is a very interesting innovation. I think that we are going to see more development of programmes in the IT area. I am working with some companies to develop programmes that can help parents to improve things like their activities with children and their communication with teachers and educators. All the programmes work.

With regard to the Family Nurse Partnership, the English RCT stands out as being the only RCT of the FNP that did not find positive results; it found null results. Basically, the reason for that was a fundamental mistake that was made at the Department of Health in choosing which

outcomes were critical in the randomised control trial. We see a similar study, but with different outcomes, in the Netherlands. It found entirely positive results.

Q110 **Chair:** In the Netherlands, they chose different outcomes to measure.

Professor Melhuish: Yes. The RCT was done immaculately. The Cardiff team did it brilliantly, but it was given the wrong outcomes to work with by the Department of Health.

It was also interesting that there was not a single child development specialist on any of the teams in the Department of Health and the FNP that were doing the evaluation. I find that absolutely incredible. However, these programmes work.

Twenty per cent of children in this country enter school inadequately prepared to benefit from it.

Q111 **Chair:** Presumably, there is a very clear socioeconomic factor.

Professor Melhuish: It is 20% across the whole population; it is 40% for what we would regard as the free school meals population.

As James Heckman, who was quoted by Jen, has said, mental and behavioural patterns, once established, are difficult to change by the time children enter school. We find that, for the vast majority of children, the trajectories children are on at the start of school are carried through to the end of school, so that the end-of-school results are primarily predicted by the start-of-school results. That means that, if we want economic development in this country, which will require a more highly developed and educated workforce than we currently have, we need to invest more in the early years. That investment needs to be in early education and in forms of parent support and parenting programmes from pregnancy onwards.

As has been said, cost-benefit analyses show positive results. There have been dozens of cost-benefit analyses of the long-term benefits of early intervention. They come up with very different results, from 3:1 to 20:1, and everywhere in between. What is interesting about all those cost-benefit analyses is that, even though they come up with different ratios, they are all positive—every single one. One issue that comes up with cost-benefit analyses is that the payoffs do not start to kick in until 10 years after you lay out the money. The problem in this country is that our election cycle is five years. Most politicians do not look further ahead than the next election, so that is a big problem.

Now I will move on to the Sure Start work. When we did the Sure Start work, we originally had a free-for-all. Basically, Government handed out money to the people who were working in disadvantaged areas to run programmes and they were allowed to do more or less what they liked with the money. We were looking not at one programme on 260 sites, but at 260 different programmes. We found that some of them had

positive results, many had null results and some even had negative results. We presented those results to Margaret Hodge, who looked at them. She also looked at our results from another study, the EPPE study, which showed that children's centres had very positive results. She then announced that she would make all Sure Start programmes children's centres. By 2006, that had been achieved. What we saw in 2006 was that the results from Sure Start evaluation became much more positive. We were starting to see some definite improvements.

Unfortunately, there were then three accidents, for want of a better word. Tony Blair said, "Children's centres are very popular. I want one in every community in the country." We went from 500 children's centres, as was the case at that time, to 3,500 children's centres by 2010.

Q112 **Chair:** Is that defined as an accident?

Professor Melhuish: I am trying to be generous in my terminology. That happened without adequate funding to do it, so you got watering down of the whole model and things like that.

Then, of course, we had the recession in 2008, with the cutbacks that came with it. Again, that led to watering down of the programme. Then we had a new election in 2010, with a Conservative-led Government. Sure Start was a child of Labour, so it was not looked on all that kindly. Funding was not cut, but there was not much support for it.

Graham Stuart produced a parliamentary report on Sure Start programmes in 2014. He recommended that the original children's centre model, for disadvantaged communities, be reinstated, because it had drifted off.

Q113 **Chair:** Before the big expansion.

Professor Melhuish: Yes. He recommended that we concentrate on disadvantaged areas and deliver the model as originally planned.

Some local authorities have maintained children's centres from their own funding. I am currently working on a project called ISOTIS, which is the Greek word for equality. It is looking at closing the gap for disadvantaged families and children across Europe; it is funded by the European Commission. In each country, one of the things that we are doing is selecting a case study of good practice. In England, we knew from the Sure Start work what the model of children's centres should be like for them to work, so we looked around the country to find a centre that was running a more or less pure children's centre model.

We found one in east London. We chose that centre purely because it fitted the model that our earlier research predicted would produce good results. The centre provides pregnancy care, via midwives; early infancy care, via health visitors; childcare, for those mothers who want it; early education; and a primary school. It provides care and support for families and children from pregnancy through to the end of primary school.

We did that study in 2017. In 2018, the national pupil database produced its results on the best schools in England. This school was the top-rated school in the whole country.

Q114 **Chair:** In terms of value added.

Professor Melhuish: In terms of value added. We did not know that when we set out, but it validated our approach.

The children's centre model can work, when it is done properly. Unfortunately, the whole approach has been left to wither on the vine, by and large, by central Government. Graham Stuart's report should be activated. It has just been sitting on the shelf somewhere. That report would be useful information for the Committee.

Chair: Thank you very much. That is really helpful.

Q115 **Bill Grant:** That is hard to follow, Professor Melhuish. Your enthusiasm is wonderful and most welcome.

Ailsa, the success of your system and process in the Netherlands and America has been touched on, yet there seems to have been a negative vibe. The professor seems to have covered that; he suggested that they were asking the wrong questions. You responded to that negative outcome. What changes did you introduce? As a side question, although the Netherlands and the USA are in the western world, do culture and lifestyle account for any of the variations?

Ailsa Swarbrick: We did respond. The trial was disappointing, obviously. FNP is a very complex programme. It works with mothers, children and other members of the wider family. It seeks to achieve a wide range of outcomes, from early in pregnancy until the babies are adults, so it seeks to do an awful lot. It does that through up to 64 home visits, covering quite a wide curriculum, over nearly two and a half years. 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.

Our view was that the trial had really important learning for us, and we wanted to act on that. We wanted to be open, honest and transparent about what was working and what was not, but we also wanted to recognise that there were many things that appeared to be working really well or that appeared promising, both on the basis of the other international evidence and on the basis of some of the findings that I have mentioned already, such as those around child development and maternal self-efficacy.

There was an interesting thing about the level of safeguarding awareness in mothers. We wanted to recognise the fact that the programme was bringing into services many disadvantaged families who often do not take them up, that it was operating at scale and that it was offering a very different way of working with the early years. We have talked a lot about

the benefits of very early intervention and prevention. My point is that it seemed as if you could not draw a very simple conclusion from that one trial, so we wanted to learn from it. That is what we did.

We do not have the luxury of many years of further development or of being able to run another trial very quickly. We therefore developed an approach with our partners at Dartington Service Design Lab that we called ADAPT—accelerated design and programme testing—which is a very handy acronym. Ten sites worked with us to co-design and then rapidly to test, to refine and to test again a number of changes that we felt went to the heart of how to improve the programme. We are still in the middle of that process.

The methodology draws from both very good evidence and research credentials. The changes that we developed were informed both by literature reviews and the best academic evidence that there is, and by improvement science and the kinds of healthcare improvement methodologies that are being used more and more around quality improvement.

Q116 **Bill Grant:** So you responded to the negative aspect.

Ailsa Swarbrick: Yes, we did.

Q117 **Bill Grant:** Although, as Professor Melhuish suggests, the negativity may not have been overly justified.

Ailsa Swarbrick: We thought that there were things that we could learn. We had brought the programme from the US to England. We felt that there were things that we could do to reflect the context.

Q118 **Bill Grant:** Was there no evidence of cultural lessons to be learned?

Ailsa Swarbrick: Yes. That was one of the things that we wanted to do. We wanted to flex the programme so that it met local needs. There is something about taking a programme from one country to another. We were also very aware that every local community might need a slightly different service because of its local circumstances.

Q119 **Bill Grant:** Tailored to the particular community.

Ailsa Swarbrick: Tailored to the local context—and tailored to individual clients as well, because they are all very different. We wanted to introduce much more flexibility and direct responsiveness to individual and local circumstances, while retaining the very good evidence base that we have.

Q120 **Bill Grant:** Unless Professor Melhuish wants to comment on that, may I take you to another sphere? It is suggested that health visitor visits are more frequent than your Family Nurse Partnership visits, yet they have similar outcomes. Would you like briefly to discuss the merits or demerits of these two parallel streams? Are they similar, or are there significant differences?

Ailsa Swarbrick: Health visiting is part of the universal service. It offers some home visits, but it is not targeted and is not structured in the same way. There is a clear continuum, I suppose. The Family Nurse Partnership is the more targeted end of health visiting, in some constructs.

Q121 **Chair:** It complements the general offer.

Ailsa Swarbrick: Yes. The general offer is the universal front door. The Family Nurse Partnership is for people who need additional support—people with particularly difficult backgrounds, who need to go further.

Q122 **Bill Grant:** So it is more focused and tailored.

Ailsa Swarbrick: It is much more focused and tailored, with evidence of long-term benefits.

The comparison between health visiting and the Family Nurse Partnership in the trial is one of the questions we are looking at. There are a number of views. One is that the trial did not take enough account of long-term outcomes, because it measured at age two. Secondly, one of the things that we are testing now is that perhaps we were not targeting in a sufficiently focused way, given that there is a universal healthcare system here. We are now focusing much more on greater needs and targeting much more directly. Those are the main things. There is the question of the outcomes chosen as well.

Q123 **Bill Grant:** Matt, I understand that your system, the Triple P, was developed and has been successful in Australia. We have seen that there was variation between the USA, Netherlands and the UK. If we take the same comparators and risks, do you think that your programme could be at risk because it was designed and tailored for Australia? This is quite an unkind word, but could it misfit, or not dovetail into, the jigsaw that is the complex UK?

Matt Buttery: Triple P was developed in Australia, as you say. It has been deployed with very little adaptation in 28 countries around the world, including the US, Ireland and places as far afield as Panama, Iran, Japan and Indonesia, some of which are quite culturally diverse. Studies have demonstrated the efficacy of the programme. A bit like the Family Nurse Partnership, Triple P has been in the UK for quite a long time now—for 15 years. While it came out of Australia, it is now owned as a global programme by the countries involved and by the research community across the 33 nations where research has been done and the 28 nations where there are practitioners.

The PEIP or parenting early intervention programme evaluation that was done in the UK, which I mentioned earlier, looked at five evidence-based programmes that were rolled out across the UK. It found that all of them were effective at reducing antisocial behaviour, improving parental confidence and efficacy, and reducing child conduct problems. The research said that Triple P was the most effective of those programmes—

statistically so, in some cases. That is a really helpful, in-the-field, real-world example from quite a large-scale roll-out of Triple P in the UK.

There is a really interesting paper, which I will be very happy to share with the Committee afterwards, from Frances Gardner at Oxford University. She looked at transporting evidence-based parenting programmes between countries. She found that those interventions were at least as effective in the country they were transported to. Actually, where the country was more culturally diverse, they were shown to be more effective—perhaps counter-intuitively. The data she looked at in the study say that they are at least as effective.

Q124 **Bill Grant:** Professor Melhuish, you made the comment that all the systems work. Have you anything to add to Matt's remarks? You were very enthusiastic and said that all the systems referred to work.

Professor Melhuish: All these programmes work, but it is still unclear which is the most cost-effective—which is the best, as it were. Further work can be done on that. The Early Intervention Foundation and the Education Endowment Foundation are good agencies to look at that in more detail.

I have had 40 years of Government funding to do some work in this area. One of the problems I have been faced with is the lack of competence within Government Departments in dealing with this topic. Both the Department of Health and the Department for Education spend quite a lot of money on research—not just in this area, but in a range of areas. A lot of that money is wasted because of lack of competence in the relevant Departments.

Q125 **Chair:** In designing the trials and so forth.

Professor Melhuish: It is a lack of competence both in understanding the nature of the area itself—the content area—and in research approaches.

Q126 **Chair:** What were the outcomes that you feel the trial should have focused on? Can you be clear about what they should have been looking at?

Professor Melhuish: In the case of the FNP, they should have had at least a clear, unambiguous language development outcome. They had a language development outcome, which was a parent report, but parent reports are notoriously unreliable. They cannot be relied on for planning policy on a large scale.

Q127 **Chair:** What sort of report?

Professor Melhuish: A parent report. That is, they just ask the parents, "Can your child do this? Can your child do that?" Parents are very positive about their own kid.

Q128 **Chair:** Sure. There should be something more substantial.

Professor Melhuish: Exactly. That was not planned. That would have been the first on my list of outcomes. There are a number of other outcomes that you could have included in the socioemotional domain, particularly self-regulation. 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. That requires adequate family support in the very early times of infancy, to make sure that the processes of mother-child attachment and so on go smoothly.

There is an ignorance among people in general about the importance of what they do for children's lives. Children's everyday experiences shape their lives, yet among many people there is a kind of fatalism. They think, "The child will be what it is going to be like anyway. It does not really matter what I do." When you have that kind of attitude, you do not try to help your child. To overcome that kind of philosophy, we need to change our culture with regard to how we view parenting. We need to realise that day-to-day activities with children make a real difference to children's long-term outcomes. Those long-term outcomes for children have consequences for the economic development of the country.

Chair: That is very interesting.

Q129 **Stephen Metcalfe:** I would like to explore that a bit further and to widen it. There have been two relatively recent projects. One was the effective pre-school, primary and secondary education project.

Professor Melhuish: I was one of the directors of that project.

Q130 **Stephen Metcalfe:** Absolutely. There was also a Government-sponsored project, the study of early education and development.

Professor Melhuish: I am a director of that project as well.

Q131 **Stephen Metcalfe:** Fabulous! You are therefore very well placed to summarise the findings of those two projects.

Professor Melhuish: Basically, the effective pre-school, primary and secondary education project showed that early experience in the home—the early home learning environment, a concept that was created in the project—has long-term consequences right through to the end of school. The patterns of early education and early childcare that a child receives in the early years also have long-term consequences right through to the end of school. Those findings led to the universal provision of pre-school education for every three-year-old, from 2004, and the provision of the two-year-old offer for the 40% most disadvantaged, from 2013. We also influenced the extension of maternity leave to 12 months and so on.

Those were the results of the EPPSE project, which finished in 2014. When the two-year-old offer was rolled out, we were asked to evaluate that. We won a bid to do that. We have been looking at just over 4,000 children around the country—a third in the 20% most disadvantaged, a

third in the 20% to 40% band and a third in the more affluent band. In that study, we are finding that the patterns of early experience affect children's results at age three. We have the four-year-old results coming out soon, and they mirror the three-year-old results very closely.

When we did the EPPSE study, there was no state funding for children under five, effectively, except if the children were at risk. As a result of the EPPSE funding, the whole pattern of early education changed in this country. It is now very difficult, for example, to find children who do not have pre-school education.

The quality of the early experiences offered to children has changed. In the EPPSE study, the range was very wide; there was some really terrible stuff and some really great stuff, with an awful lot in the middle. As a result of the changes that followed the EPPSE study, it has become a much narrower band. We cut out all the really bad stuff. That means that when we look at the effect of quality—

Q132 **Graham Stringer:** From your hands, have we cut out the really good stuff as well?

Professor Melhuish: We kept the good stuff, but we are operating on a much narrower band. When you have a very wide band, it is very easy to show quality effects, because the difference between the two ends is very big. When you have a narrow band, it is much more difficult to find quality effects, because you have a restricted range on the variable. That is what we are finding at the moment. The results of quality are not looking as strong as they did in the EPPSE. I think that that is because the whole system has changed so radically in the 20 years since we started the EPPSE project.

Q133 **Stephen Metcalfe:** Can you describe what high quality looks like?

Professor Melhuish: The critical aspect of high quality is the patterns of interactions and activities offered to the child. You should have warm, responsive interactions, with high levels of communication to the child, adjusted to the child's developmental level. You should have a range of activities for the child that stretch the child's capacity and are related to the developmental level, so that the child makes progress in a variety of activities in the socioemotional domain, the cognitive domain, the language domain and the understanding of numeracy and accuracy. It has to do with the patterns of interactions and activities offered to the child, adjusted to the child's level of development.

Q134 **Stephen Metcalfe:** Outside the home—in an educational setting.

Professor Melhuish: Yes, outside the home. Of course, parents in the home can offer a lot of these things themselves.

Q135 **Stephen Metcalfe:** Absolutely. Earlier you described the third-third-third model—

Professor Melhuish: We invented the concept of the home learning environment in the EPPSE. Basically, it is the pattern of activities offered in the home that help a child's development. That is a more powerful predictor of children's development at the start of school than income, parent education or social class.

Q136 **Stephen Metcalfe:** I am putting words in your mouth here, potentially, but the findings were that the outcomes for the lower third that you studied were remarkably different from what they would have been if you had not had that kind of intervention. Is that right, or were you taking the whole cohort?

Professor Melhuish: I am reporting results for the whole cohort.

Q137 **Stephen Metcalfe:** How do you know that those were not the ones who had it?

Professor Melhuish: We analysed the results for the different sections of the cohort separately. We found remarkably similar results for each section. One of the surprising findings of the SEED—the study of early education and development—is that the results so far of the early education offered, from two-year-olds upwards, are remarkably similar, regardless of which socioeconomic spectrum you look at. All children are benefiting.

We also find that a number of aspects of parenting are having much more powerful effects than early education. One is what we call limit setting in a home—to put it crudely, do the parents let the child run wild, or do they try to control their child's behaviour? The others are the home learning environment—the patterns of learning activities offered in a home—and the parent-child relationship. Those three things all have quite powerful effects on children's development across the socioemotional domain, the language domain and the cognitive domain.

Q138 **Stephen Metcalfe:** What is your view on the Government's early-years foundation stage?

Professor Melhuish: When it was introduced back in the early 2000s, I was a critic, but it has proved to be rather good. It has proved to be much more useful than I first thought it would be. It is currently being revised; a new version is about to be released by the Department for Education. The new version will have learned a lot of lessons from practice over the last 10 years.

There is a lot of accommodation within the structuring of the early-years foundation stage to the current limitations within the sector. We have an early-years sector that is comparatively unqualified, with a large proportion of unqualified staff, so you have to accommodate that within what you are asking it to deliver. The early-years foundation stage could be improved if the staff delivering it were more highly qualified.

Q139 **Stephen Metcalfe:** May I move on to your view on free childcare for all

two-year-olds?

Professor Melhuish: It is not for all two-year-olds.

Q140 **Stephen Metcalfe:** I was just going to qualify that. It is for 40%, isn't it?

Professor Melhuish: It is for 40% at the moment—the bottom 40%.

Q141 **Stephen Metcalfe:** I think that there is positive evidence—

Professor Melhuish: Yes—there are positive results.

Q142 **Stephen Metcalfe:** Therefore, would there be an economic benefit to the Government if they widened it to all two-year-olds?

Professor Melhuish: Let me put it this way. If all two-year-olds got it, there would be a benefit to the Government. The question is, can the top 60% pay for it themselves? By and large, they do.

Q143 **Stephen Metcalfe:** What would you say the gap is? What is the number of two-year-olds who are not receiving any form of early-years education?

Professor Melhuish: For two-year-olds, the number is probably around 30%. For three-year-olds, it is down to about 3%. We have almost 97% take-up by then.

Q144 **Stephen Metcalfe:** But there would be some economic benefit to the country from the 30% we are missing out at two.

Professor Melhuish: Yes. I should emphasise that the reason why it is 30% is that only 70% of the 40% who are currently offered it for free actually take it up. That figure has been increasing over the last couple of years. It was initially 50%. In the next year, it was 60%. It is now 70%-plus. It is going up.

Q145 **Stephen Metcalfe:** Some of the 30% is down to that. Finally, how are the Government responding to the findings of these various projects? What message would you like us to send to the Government in the report that will come out of this inquiry?

Professor Melhuish: I think that the Government are missing a trick with regard to the two-year-old offer. The two-year-old offer is targeting the 40% most disadvantaged families in the country. Of course, they are the families where you need to improve the outcomes for children in order to get long-term progress. You have a ready-made audience for a range of strategies for improving children's development.

At the moment, all that they 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. There is a very good opportunity here for targeting parent support programmes—not the Family Nurse Partnership, which is for children under two years, but

EasyPeasy, Triple P and a range of things like that—which could be offered to parents via that platform. They are missing a trick here.

Q146 **Carol Monaghan:** In 2016, there was an increase in free childcare to 30 hours a week for children in England.

Professor Melhuish: It was in 2017.

Q147 **Carol Monaghan:** It went through in 2016, so it was probably applied in 2017. This was for children in England where both parents were in work.

Professor Melhuish: Where they work 16 hours a week.

Q148 **Carol Monaghan:** Yes—where they work a certain number of hours. Is there a danger that we are missing out a group that we should tackle?

Professor Melhuish: The 16-hour-a-week rule is a mistake, because the families who most need the increase, in terms of child development outcomes, are usually the workless households, which will not qualify for any more. In the EPPSE study, for example, we found that children who had 15 hours a week were doing every bit as well as children who had 30 or 40 hours a week. There is some evidence that, for the most deprived families, the 30 hours or more could have additional benefits. That is not necessarily the case for the general population. Of course, the 16-hour-a-week rule rules out most of those most disadvantaged families. That is a mistake.

Carol Monaghan: Thank you for your thoughts.

Q149 **Chair:** The Minister was quite clear. It was designed as a work incentive, rather than as a child intervention.

Professor Melhuish: Oh yes. The 30 hours a week were brought in not because of any evidence, but purely as a political ploy. Having 15 hours a week was really popular, so Labour said, "We will increase it to 25 hours a week." Within a week, the Conservative Party said, "We will increase it to 30 hours a week." They were just bidding for the electorate's attention.

Q150 **Damien Moore:** One of our earlier witnesses said that there is a growing early-intervention industry. Would you describe yourselves in that way? What can private or charity providers do better than public bodies in this field?

Jen Lexmond: That is a really interesting question. My background is in public policy. I used to work in think-tanks; I worked for Government Digital Service for a while as well. When I worked at a think-tank called Demos, I worked on social mobility policy. My job was better to understand where inequalities stem from and what kinds of recommendations we could come up with to influence Government. Through that, I became involved in the all-party parliamentary group on social mobility. I produced a report for the group about some of that work.

I remember a speaker at one of the events—it was Alan Milburn, actually—saying, "We see the evidence about the importance of parenting and understand the importance of early years and early intervention, but Government is not always in the best place to respond to parents. The household is a bit of a black box. How do we provide support in the right way without the obvious accusations of paternalism and trying to reach in where we shouldn't be?"

That really stuck with me at the time. It was one of the moments that set the kernel of EasyPeasy in motion. I thought, "Through the third sector or from outside Government, I might be able to do more to solve this problem." I went on my own journey out of Government and public policy towards the world of social innovation and user-centred design, to try to come up with a solution that would be better placed. I remember him saying, "If you come up with something, we will help you to get it out and to distribute it, because we see the evidence and believe it." I guess that I decided to do that and to put something together.

Speaking from my personal experience, I feel that it has come from a very mission-driven desire to close gaps in early development and to support more social mobility. I do not know whether that speaks to what other folks are doing in the sector, but I feel that there is an opportunity for social innovators and social enterprise to work with Government, public services and the early-years workforce to provide more innovative solutions that start with the lived experience of real parents.

We designed EasyPeasy by sitting down with a couple of hundred parents in south London and asking them, "What is your life like? Where are the barriers for you? Where are the challenges to engaging in exactly the ways Ted has outlined, by being warm and responsive and by being able to set rules and boundaries clearly and decently with your children? Where are the gaps and difficulties in that?"

Then we asked, "What are the different channels that we could use to reach and support you?" On a pathway of design and testing, we found that getting to their mobile phones was great, because everyone in our focus groups was sitting with their kid on one knee and their phone on the other. At EasyPeasy, we started by emailing stuff out, but no one in the groups that we were particularly targeting knew their email address. They were all sitting there with their phones, so we pivoted and decided to channel what we were doing there.

The question that you asked Bill about localisation and local factors made me think about the challenges that we have faced in figuring out not just what works from an evaluation point of view but what works for local communities from an engagement point of view. Email might be a great way to reach some groups, because they are on desktop computers in the office all day, but if that is not the kind of job that people have, and they do not have a laptop, a smartphone might be a more effective way of reaching them.

In the same way, we have moved from copy into video. We use video clips, because they are more engaging. They get over language and literacy barriers for some parents as well.

I wanted to take the liberty to throw that in. That is my story. I am sure that these guys will have more thoughts on the industry point.

Ailsa Swarbrick: As Jen started to point to, I would not say there is an early intervention industry but there is a really strong, growing and well-informed community. We talk together; we have the same mission and support the same long-term outcomes. I believe that early intervention and prevention are critical for producing long-term outcomes and cost-benefits, but it is not owned by one sector and I do not think it should be.

Family nurses are highly trained NHS nurses. A lot of the value of what they do comes from their clinical background. However, in the changes that we have been making to FNP we have certainly wanted to draw on some of the things Jen has just been talking about: youth-centred design, the most interesting thinking about innovation and academia. I would characterise it as a rich, diverse and I hope innovative community, which is seeking long-term benefits for the most disadvantaged in our society.

Matt Buttery: The previous two speakers have said a lot of what I would want to say. I do not think it is any secret that we are largely commissioned by local or central Government, but within that parents are also actors—often, willing actors we need to think about and respect. We have shown that in a population approach to parenting, allowing parents to choose what level and intensity of intervention they want to access, is one of the most powerful ways of getting it out there.

To pick up one of Ted's earlier points about which of these works best and which should be funded, I do not think it is quite as simple as that. All of us have good evidence that we work and early intervention and prevention needs to be better resourced—full stop. It is about how much of the public purse is spent on this rather than which of us should get the most of the pie that is currently spent on it in the first place.

What we are advocating is a community-wide and population approach to parenting, the idea of bringing digital into the mix and allowing parents a choice—that high-tech and high-touch approach. As Ailsa said, we are a community. All of us have different strengths and weaknesses in what we bring, but we are learning from each other.

Q151 **Damien Moore:** To touch again on funding, who pays for your programmes, and has that been affected by the decrease in Government ring-fenced funding for early years?

Matt Buttery: I have already said that in our case it is largely local authorities or central Government themselves that would pay. In some

cases it is CCGs or CAMHS services. It is no secret that we live in a challenging funding environment, but, as I think we have already touched upon previously, what is important here is cost-benefit, and what we focus on is the value of our programme. That is really where we need to try to focus the conversation going forward.

The Social Mobility Commission published an interesting report last year that talked about the fact that, when it comes to parenting programmes, many local authorities, because of budget cuts, had chosen low-cost programmes that have not been shown to work. We do not need to think about the funding of programmes in terms of what is cheapest but what is the best value for money. That report recommended ring-fenced funding for evidence-based-parenting programmes being restored and made available, maybe even with central funding mechanisms. I believe the Government are looking at some sort of public service framework in the Green Paper and some of the work the DWP is doing.

Ailsa Swarbrick: FNP is commissioned by local authorities mainly through its public health funding. Of course, the current economic environment has an effect. Part of the work we are trying to do is to make it as cost-effective as possible and we are looking at things like digital for the longer term. I would absolutely agree with Matt about the need to have long-term sustainable funding. Often, particularly with early intervention, you do not see the benefits until quite a long way down the track and the benefits do not necessarily accrue to the organisation that funds them, so it is important to think about what the long-term funding model is and how that is dispersed across sectors.

Jen Lexmond: EasyPeasy is funded from a few different sources. Our initial funding came from the innovation fund of Guy's and St Thomas's Charity, the hospital foundation trust. We have also been supported through foundations such as the Sutton Trust and the Education Endowment Foundation. We also have social impact angel investment through a group called Clearly Social Angels, and we have revenues from local authorities and individual independent schools and nurseries, as well as maintained schools and nurseries.

As a quick follow-up to that, when we were in the early design stage of EasyPeasy in 2014-15 we had a lot of questions. We did not have a business model and were wondering how we should approach this: should we go direct to parents themselves, or should we try to work through local public services, schools and nurseries? We were led down what we call a B2B to B2C model. Initially, we have a partner that is a local authority or school, and that is for a number of reasons. The main thing is to reduce barriers to engagement from the hardest-to-reach groups, disadvantaged families, so having a price point on it is going to be a considerable natural barrier. We wanted to remove that and put the price point somewhere else.

Equally importantly, we wanted to see how we could work with the local early years workforce and infrastructure of schools and nurseries to use their staff and their own incentives around the pupil premium, or what have you, to reach out themselves. That is why parents are invited to join EasyPeasy through a text message via the teacher at school. Therefore, where it exists in communities, you are trying to use the expertise and local knowledge of practitioners to help push EasyPeasy out into local areas, and I think that is really relevant to the business model we have ended up with.

Chair: Matt, I am conscious that we are tight on time.

Matt Buttery: Maybe I will send some follow-up to the Committee Office. In terms of cost-benefit, there are some long-term outcomes, but there are some very short-term ones that some of these programmes can deliver. In less than two years in the US Triple P showed a 33% reduction in cases of child maltreatment; a 21% reduction in kids going into care; and a 13% reduction in emergency hospital admissions due to child maltreatment.

Those are cashable savings in the short term and obviously have a big impact on the lives of the children involved. There is some long-term cost-benefit stuff but also some very short-term cost-benefit stuff, and there are some great studies on things like the Triple P system that show cost benefits of 9:1 from Washington State and 13:1 from Access Economics in Australia. It is important for us to tease out some of the early benefits, but, as Ailsa says, some of those do not accrue to people that commission the programme.

Q152 **Damien Moore:** Do families come to you of their own accord, or are they referred? On that point, do you think that some of the interventions that are needed for children are resisted potentially because parents do not feel as though they need it?

Jen Lexmond: The way a parent would join EasyPeasy is to receive an invitation from the teacher or carer at their child's nursery or school. I should have mentioned earlier that EasyPeasy is currently providing support to parents with children between two and a half and five years, so these are the early years just before school. We work through nursery and reception classes.

What happens is that they will see a bit of awareness-raising posters and so on within the setting, and at some point they receive a text message on their phone that is authored by the teacher. It will say, "Hello. Hey, can you come and join the EasyPeasy pod with other parents from the class? We're going to be learning and playing together with EasyPeasy games." Then they click a link and they get started.

Q153 **Chair:** Which parent receives that message? Is it every parent, or parents teachers are worried about?

Jen Lexmond: The way we tend to target disadvantage is at the setting level.

Q154 **Chair:** It is universal within that setting.

Jen Lexmond: In some cases we have teachers who prefer to target a particular group. I think we are learning right now about the impact of that.

Q155 **Chair:** There is a danger that the parent says, "They think I'm a bad parent."

Jen Lexmond: That is why we suggest going universal within disadvantaged settings and areas.

Q156 **Damien Moore:** Public services are often licensed or regulated. As providers, would regulation or licensing help or hinder what you do?

Ailsa Swarbrick: The Family Nurse Partnership is a licensed programme, which I think is a benefit.

Q157 **Chair:** In that the intellectual property is owned by someone.

Ailsa Swarbrick: The intellectual property is owned by the University of Colorado, but that then sets out the parameters of the programme, so to speak—the kinds of things that are done or not done. We have found that that helps to protect, particularly when times are tight, the integrity of the programme so it can be delivered in a way that should be effective.

We have also found recently in particular that we are able to flex within that. We have been operating at the boundaries of the licence, I think, but with the full agreement and support of the licensor. There is flex, but generally it has been a helpful thing just in terms of knowing what you are doing.

On the "voluntary point," within FNP clients are referred usually through maternity services, but they take up the programme voluntarily on the basis that, if you really want to change behaviour, you want to do it and not be coerced into doing so.

Matt Buttery: I would echo the very last sentence. As Ailsa said, in terms of uptake, Triple P as a system is offered in very different ways in very different places even within the UK, but we would advocate that in a population approach parents choose. We think that that parent choice and parent information is critical. As I have already illustrated, when you put both digital high-tech with a high-touch offer—some parents from hard-to-reach groups might migrate to the digital in the first instance, so we feel that the digital first offer is important.

We have a licence in place. The University of Queensland owns the Triple P programme. That is a real strength because we as the licence holder have to adhere to strict quality standards in how we deliver the programme. Triple P is a manualised programme. We train practitioners.

We also have an implementation framework. For us, a lot of the learning from around the world has been that we need to support the implementation of the programme.

Chair: I am going to ask all of you to be really disciplined. We are over time and still have questions to put to this panel, so we need to keep it tight.

Q158 **Damien Moore:** Ailsa, how valuable to you is the Early Intervention Foundation guidebook rating?

Ailsa Swarbrick: We have had a very good rating. Clearly, it is valuable. That is a bit tongue in cheek. It is more than 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. I think they pay attention to that, but it is important to explain, disseminate and have a clear basis on which to make decisions.

Matt Buttery: To be clear in what we say here, the Early Intervention Foundation is sitting behind us. Triple P has some of the best evidence in the world and the strongest outcomes for the child, parent and at community level. We are pleased that Triple P features not only in the Early Intervention Foundation's What Works Centre but Triple P and Stepping Stones Triple P for parents of children with disabilities feature in NICE guidelines. That is a really important thing.

It is important to have evidence-based lists. What we would love to see in terms of development and where the EIF goes next as a still reasonably young What Works Centre is that it starts to take into account meta analyses and think about some population-level trials. Therefore, rather than just single interventions, it starts to think about how they combine, particularly in relation to population-level data that prevent ACEs. In addition, service-level evaluations such as the PEIP and the work I described in Ireland are important, but, above all, we agree it is critically important that there is a strong and robust external evaluation framework.

Q159 **Damien Moore:** Jen, conversely what have you encountered as not being part of the guidebook? What would you do to try to get your evidence in there?

Jen Lexmond: We have just heard about the important role the Early Intervention Foundation plays in convening conversations and sharing with the local authority commissioning sector what is evidence based and what is worth paying attention to. Therefore, it has always been an organisation of which I have been supportive.

EasyPeasy had a frustrating experience. The Early Intervention Foundation conducts evidence reviews within windows of opportunity—it will look at a particular area of early intervention, as I understand it—so if your evaluation misses that window you are unable to be considered by

the group. This happened to us with our study led by Professor Kathy Sylva. Our work was published a couple of weeks after a thematic review of what works in parent-child interaction in the early years, so we unfortunately missed that window.

I think we need to hear more from the EIF about how it feels it is doing in shaping local authority decision making. I understand that is quite a complicated thing to do. I have to point out that, when local authorities are so tight and can spend only on statutory stuff, that is a relevant part of why we struggle and where our challenge is in scaling our product, although I think we have done really well over the past couple of years to be with 12 local authorities and 10,000 families.

All the fantastic work of EIF in promoting stuff that is evidence-based, taking roadshows around the country and sharing that evidence, making commissioning toolkits and convening conversations are things we would love to benefit from. I understand it has pressures and challenges in being able to do more reviews, which I think you will hear about in due course.

Q160 **Carol Monaghan:** Matt, Glasgow City Council adopted Triple P wholesale and it was delivered universally. I am not sure what the current situation is. I was one of the cohort of parents who experienced the Triple P seminar. My children go to a school that has a huge range of backgrounds. Some parents would have benefited; some definitely did not need this intervention. Is there a danger with a universal approach that funds are diverted from the most needy, who need the highest intervention?

Matt Buttery: Triple P is still delivered in Glasgow. Thinking about how this universal approach works, I guess the idea is that as water rises in a harbour all boats rise. What people like Professor Ron Prinz have said—there is a reference to some of his work in my submission—is that parenting does not happen in a vacuum: both negative parenting and pro-social parenting happen within a community of parents.

There is an ability for parents to impact each other in a social contagion effect that can be generated. Targeting the whole population means in a sense you are trying to shift the culture as a whole as to how we do parenting. As the cost-benefits show, the population approach is quite an economic way of taking that sort of approach.

Q161 **Graham Stringer:** Professor Melhuish, in this country as children progress through the education system we spend more and more on them, particularly if they are successful. Can we draw the implication from what you are telling us about the effectiveness of early-years intervention that the shape of that expenditure is fundamentally wrong in helping those individual children and the country's economy?

Professor Melhuish: I think early intervention should be delivered as part of a process of progressive universalism; that is, you need a

universal service base on which to launch intervention strategies. Another alternative strategy is to target intervention to populations that are deemed most appropriate. In the medical field and educational field it has been found that targeting reaches only 50% of those people who need it, whereas if you have a universal platform you reach everybody and can assess the relevant need. You then get appropriate targeting, which was why I mentioned earlier that the two-year-old offer is an ideal platform for targeting a whole range of interventions, because you have staff in contact with the relevant people.

There is a range of things outside the remit of this Committee and most Departments that affect the need for early intervention. One of these is employment. Workless households are a toxic environment for children, so if you reduce unemployment you reduce the need for intervention as one of the consequences.

Social housing policy in this country produces clusters of disadvantaged families all living together where they learn maladaptive parenting techniques from each other because parenting is a learned skill. Children learn maladaptive techniques from each other because they are clustered together.

Social housing policy in this country needs to be revised to reduce the clustering of disadvantage. We need the disadvantaged population to be more spread out among the general population. Those two factors, which I understand are outside the remit of this Committee, in the longer term would have a bigger effect on the need for early intervention than anything you are actually discussing now.

Q162 **Graham Stringer:** That is very interesting.

Professor Melhuish: Let me give you another example—I have some evidence on this. In our EPPSE study we found that a disadvantaged child who attended a centre where all the other children at the centre were disadvantaged would do considerably less well than a similarly disadvantaged child who was in a more mixed centre. That has a considerable long-term impact on children at the start of school and later as well.

Q163 **Graham Stringer:** How important is it that the protocols of the programmes we are talking about are strictly adhered to, and how do we know they are being adhered to?

Professor Melhuish: Basically, we are talking about situations where often staff delivering these interventions are relatively poorly qualified. Therefore, a highly specified programme is needed because they do not have the professional capacity to make judgments. One difference here is the Family Nurse Partnership, where you have highly trained nurses delivering it, but even in that case the Family Nurse Partnership works only when it is properly implemented.

Further work could be done on extracting the principles from the wide range of parenting programmes out there. What is the common core of them, because they do have a common core? That common core could be delivered in a variety of ways. At the moment, we need to deliver it in a highly structured way because the staff who work in this area mostly could not cope with judgmental issues that require a lot of experience and training. Further work in that area around extracting the common core from the range of parenting programmes out there and how it could be made general practice with all who work with children and families would be a good strategy.

Health visitors work with families in this partnership. I think the whole training of health visitors should be completely overhauled to include more emphasis on what parents need to do with children in order to facilitate their development. A considerable revision of midwives' training could take place. Training of staff we have working in the early child care centres and early education should be improved for them fully to understand how the consequences of what they do and the parents do on a day-to-day basis actually affect their children's development. This is part of the common core I am talking about.

Q164 **Graham Stringer:** The question is: how do we know, and how is it monitored? Do the licensing regimes stop or prohibit what you are saying because they are too prescriptive?

Professor Melhuish: An unfortunate consequence of the licensing procedure is that you have to follow what the licensee tells you.

Graham Stringer: You cannot respond to individual families.

Professor Melhuish: In the short term I think we need to use licensed programmes because they are often the best available, but work should be taking place in developing a module of training across professions about the basic principles underlying these interventions.

Q165 **Graham Stringer:** Within that, is it possible to disaggregate what parts of the programmes are of particular benefit? It comes back to monitoring the evidence if you do disaggregate.

Professor Melhuish: It goes back to what I said earlier about the nature of quality. Interactions drive development, and that is true from birth onwards. You see it in the attachment literature in early infancy; you see it in language development literature. Interactions drive development. It is part of the nature of human evolution that we have evolved as a social species to learn much of what we need to function in society through interactional procedures. The core of what these programmes are doing is trying to improve those interactions between the parent and child.

The same applies to people in childcare and early education settings. The learning that takes place is through the interactions between the educators and childcare givers and the child. It is true in the parenting

situation as well, because the home learning environment is about the interactions that provide learning opportunities for the child in the home.

If we can get this message across about how interactions drive development, and how certain kinds of interactions are positive for children's development and certain kinds of interactions are negative for children's development, we can improve the situation generally.

Q166 **Graham Stringer:** Are the clients in these digital programmes self-selecting? Is there a digital divide here?

Professor Melhuish: There is a bit of self-selection in these programmes, because, looking at it from the outside, you would say, "That parent really needs this programme." Often that parent will opt out of that programme, so there is a certain amount of self-selection. This is where progressive universalism helps, because if the intervention is offered as part of a universal platform it is not seen as stigmatising. One of the problems with targeting is that it stigmatises parents, and that is one of the fundamental drivers of self-selection.

Q167 **Graham Stringer:** My final question is on the evidence about the effectiveness of digital online programmes compared with other interventions. What is the evidence and the comparison?

Professor Melhuish: This is a very new area and we are still accumulating evidence on it. I am currently working with some centres and have been struck by how all these very poor and disadvantaged families have smartphones and are capable of doing things with them that I cannot do. For example, we have introduced communication platforms on smartphones so a parent can share information about their child with the educator, and they love it. I am amazed how quickly these things take off.

One thing I have learned about these digital platforms—I have developed a couple of pieces of software—is that in order for it to work it has to be enjoyable. If it is enjoyable, they will use it. If you make it useful as well as enjoyable, that is the trick, and there is a lot of scope here.

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.

Matt Buttery: There are a number of points here, but, to stick to the main one about progressive universalism and breaking down evidence-based programmes, that is what the Triple P system does. You have the very light-touch interventions Carol talked about, which are targeting everybody at school level. I do not know how many were in the seminar that you attended.

Carol Monaghan: Two hundred to 300.

Matt Buttery: Maybe it is one or two practitioners delivering to 200 to 300 people. That is a very light-touch intervention.

Moving on from there, earlier in my submission I described something that might be an intervention on an individual problem that a parent is facing. Most people think of parenting programmes as multi-parent programmes of, say, eight or 10 weeks with eight to 10 parents in a room. That is in a way describing some of the elements of the Triple P system.

The idea is that you are breaking it down and giving parents the choice about what level of intervention they want to engage with. What was shown in Ireland was that of the number of parents who went on to engage with the highest level of intensity I have just described—which, as Ted would say, on the clinical scale they needed—about a third of them went through one of the lighter-touch interventions in the first place. The idea of normalisation and destigmatisation, with someone just trying it to see how it feels and saying, "It's okay. More than that; my friends are doing it too," creates cover for those people maybe to move on and engage in a longer intervention, which might be what they need.

Equally, sometimes complex problems are solved by very simple solutions. The reason I gave the example of sleep is that, if you are presented with a family where the mother is suffering from post-natal depression, the child is not sleeping and there seems to be the potential for a domestic violent relationship, or the couple's relationship is stressed, what is the primary problem? What are the secondary sequelae? If everyone got a good night's sleep, might the secondary problems be manageable?

Q168 **Chair:** Before we bring this panel to a close, do you have any final recommendations you want to make to us? As we shape our recommendations, are there any things that you think Government or anyone else should be doing? What is your 30-second message to us? I use "30-second" advisedly.

Professor Melhuish: Currently, we have the Early Intervention Foundation and the Education Endowment Foundation working in this area. Their work at the moment is temporary. I think the work of both organisations should be made permanent.

Jen Lexmond: I would think of digital as a new way to deliver increased positive parent-child interactions of the sort that, as Ted explained, will drive child development at a much lower cost, giving us greater and quicker scale and fidelity of implementation—the same thing going out to all those people with the evidence base behind it. I would think of digital as a real opportunity to support more scalable and cost-effective early intervention in this country.

Q169 **Chair:** We have heard that Ted is working on some software, so you have some competition there.

Ailsa Swarbrick: I mention three things: first, a mechanism for long-term sustainable funding across sectors; secondly, investment in evidence and research is really important, but that is about development and innovation as well as about pass or fail; and, thirdly, well-informed, cross-sectoral local and national leadership is very important.

Q170 **Chair:** It has been an absolutely fascinating session.

Professor Melhuish: I can get money tomorrow to evaluate anything. What I cannot get money for is developing anything. This is a really big fault in current Government funding.

Jen Lexmond: I could not agree more.

Chair: Thank you very much indeed. I am going to stop you there before you say any more. We appreciate the time all of you have given us.

Examination of witnesses

Witnesses: Tom McBride, Donna Molloy and George Hosking.

Q171 **Chair:** Welcome, all of you. Perhaps we could start with very brief introductions. Donna, do you want to start?

Donna Molloy: I am Donna Molloy, director of policy and practice at the Early Intervention Foundation.

Q172 **Chair:** Which we have been hearing all about.

Tom McBride: I am Tom McBride, director of evidence in the Early Intervention Foundation.

George Hosking: I am George Hosking, chief executive and research director of WAVE Trust. I am also a clinical criminologist with particular experience in working with victims and perpetrators of violence and physical, emotional and sexual abuse and neglect, and with the perpetrators and victims of domestic violence.

Q173 **Chair:** I make a plea to all of you to keep your answers succinct. I am sorry you have had to wait before your session starts. Will you first explain the roles of your organisations? We have heard something about the Early Intervention Foundation, but may we have a very succinct description from one of you and from George about the WAVE Trust?

Donna Molloy: The Early Intervention Foundation is one of the Government's What Works Centres. Our mission is to ensure that effective—by which we mean evidence-based—early intervention is available and used to improve the lives of children and young people at risk of poor outcomes.

We have three functions at EIF: we make the case for early intervention; we seek to engage policymakers, local commissioners, service managers and so on in the economic, social and moral case for early intervention; we generate evidence, which is the What Works side of the house Tom heads up; and we use a range of methods to make sure this evidence is able to influence both local and national policy and practice.

Q174 **Chair:** You are funded by a grant from Government.

Donna Molloy: That is right.

George Hosking: WAVE Trust was set up by Strategy Consultants some 22 years ago to bring a business strategy approach to questions of how to prevent damage, particularly to children. Our initial focus was on abuse and neglect and looking at their impact on violence in society, but with the growth of the understanding of ACE research across the world we have also looked at a wider range of other impacts, including, for example, mental health problems, educational performance, career outcomes and income inequality.

Q175 **Chair:** The Early Intervention Foundation has identified interventions with proven effectiveness for seven of the 10 adverse childhood experiences that you identify. How widely used are these proven interventions across the country? Are there any good reasons for any local authorities or commissioning groups not to be delivering those proven interventions?

Donna Molloy: The first thing to say is 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. We do not have data on that. We know through our work of 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. We know from the national evaluation of children centres that the average number of families who receive an evidence-based intervention per year is about 20, which is obviously very small in scale.

Recently, we did work to look at the use of evidence in the child protection system, where we reviewed the evidence about which interventions had been shown to reduce maltreatment, and then looked in detail at what was being commissioned and delivered in five local authority areas. Again, there was a significant gap between what we know from evidence and what gets delivered in local systems.

Q176 **Chair:** It is very haphazard around the country, is it?

Donna Molloy: It is very variable. A lot depends on local leadership and the extent to which evidence is prioritised by local lead members, senior officers and so on. 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.

One of the biggest reasons in our experience of why evidence is not a higher priority in how decisions are made is lack of capacity in local government and public services to engage with evidence. Engaging with evidence is not straightforward. Evidence will not tell you what to do; all it will tell you is how far things have worked in a particular context or set of circumstances, or for a particular population; it will not tell you whether that intervention will work in your area. Making decisions about what to invest in and deliver is skilled work, which involves carefully weighing up the strength of evidence against considerations such as cost, its fit with the local context, workforce and so on. Capacity for that sort of skilled reflection in local areas is in short supply.

Q177 **Chair:** The result of that is that, unless you undertake an audit of the country, we really have no idea across the country about what is being delivered where and the effectiveness of it.

Donna Molloy: We do not have an overall picture. We have anecdotes and certain studies that shine a light on particular areas. There is some evidence about the extent to which well-evidenced programmes that develop children's social and emotional skills are being delivered in schools and the extent to which this has reduced in recent years, but we certainly do not have an overall perspective.

Q178 **Chair:** In our previous evidence session Professor Feinstein told us that we know early intervention can work but that "we do not know enough about what works for whom and when." Would you agree that we are in that position? How much of an obstacle is that uncertainty about the evidence, and to what extent can interventions be delivered when we do not know which interventions to deliver to whom and when?

Donna Molloy: We would absolutely agree with that perspective. To some extent the term "what works," while a helpful label, is an oversimplification because nothing works everywhere and for all families, and what works in one context might not work in another. Our view is that we need to increase significantly the availability of evidence about what works for certain types of family needs in different contexts, and do more to increase the clarity of messages about what works for whom and when to many of the local audiences that seek to develop and test services in this space.

Q179 **Chair:** Presumably, the consequence of this lack of knowledge and understanding and lack of capacity in local government is that public money is often not being spent most effectively.

Donna Molloy: That is sometimes the case. To give an example, one of our most substantial pieces of work was reviewing the evidence for interventions in the early years. These are interventions that seek to improve parent-child interactions in the period from conception to age five. We reviewed 75 interventions. About one quarter of those had good evidence of improving child outcomes, but a large number have yet to demonstrate evidence of that sort of impact. Taking from that very clear

messages for local areas, which have particular families they want to help, and apply that and decide what to do is skilled work and a challenge.

Q180 **Chair:** From that study, was the conclusion that the majority of these interventions do not work, or that we just do not have the evidence yet, or is it a mixture of both?

Donna Molloy: It is a mixture. A proportion had good evidence of improving child outcomes, so there is some choice for commissioners. That is a good position to be in, but there is a large amount of activity where we do not yet know enough. A lot of that is because many of those interventions have not had the capacity and resource to evaluate their own impact, which takes us back to the point about lack of capacity for evaluation across the sector.

Q181 **Chair:** Is there also an issue about whether studies are evaluated independently of the organisation that is providing the service?

Tom McBride: We encourage independent evaluation, but most evaluation at least initially is conducted by developers of programmes. We see no problem with that in principle. To get the highest rating available in our guidebook, you would have to have an evaluation that is independent of the developer. Looking across the piece, evaluations tend to show less positive effects when they are independent of the programme developer, and there are a number of theories as to why that might be.

Q182 **Chair:** What should local authorities and commissioning groups do for those adversities for which effective interventions or screening tools have not yet been developed? I noted in particular that three ACEs where the Early Intervention Foundation had not found evidence-based interventions were sexual abuse, parental substance abuse and parental incarceration or household crime. It is a bit disturbing. We know that sexual abuse is a significant issue and yet, on the face of it, we do not have interventions that we know work. Is that what you are saying?

Tom McBride: We have not identified any programmes in those areas that have good-quality empirical evidence of improving outcomes for children. That is the basis for that, but it is not correct to put the onus necessarily on local authorities to address that. Clearly, they need to be providing services to these populations and trying to monitor the impact of those services as they can, but we need a much wider and more ambitious research strategy that will start to address the many gaps we have around what works to tackle early childhood adversity. Certainly, one of the recommendations we would like to see this Committee make is a much longer-term ambitious strategy that starts to fill some of these gaps.

Q183 **Chair:** Do you want to add anything, George?

George Hosking: Only in the general sense that we take a slightly different approach to focus on programmes and their evaluation. We very much favour research evaluation of programmes and it does make a difference when you see measures of effectiveness, although effectiveness is only one of the measures by which programmes might be judged. The appropriateness of programmes is at least as important as their effectiveness, and the feasibility of implementation of programmes is a third important dimension. Studies have looked at these three dimensions and found that very often the focus on effectiveness may lead one into the wrong solutions because it ignores the importance of the other two areas.

In terms of what needs to happen to transform outcomes for children, we think that far more important than the individual selection of programmes is the general approach that has been taken by both national and local policymakers. For example, if one local authority decided that it would implement really meaningful measures to improve prevention of harm before it takes place—an area in which there is a dearth of research—I would expect it to produce far better outcomes than a neighbouring authority that decided to put in all the very best, top RCT-evaluated intervention programmes but was ignoring the dimension of prevention in what it is doing.

The way in which local authorities or health boards work together is critical. The Highland region of Scotland is a glowing example and has created extremely effective multiagency working. It intervenes the very first time a child shows up on the radar; it brings all the agencies to bear on the problem, including bringing the child into the solution, if the child is old enough, and always the parents as well; and it creates action plans and follows them up very effectively. That is an extremely effective system, which is not looking particularly at evidence-based programmes; it is simply an approach that says it is important to get things right first time. That is an important principle from business with which I am very familiar.

Let us talk about programmes, but there are things that are more important than programmes, and in my view the principle of the overall system and approach that is taken is significantly more important.

Q184 **Chair:** Do we know whether Highland's approach is bearing results?

George Hosking: Yes, it is bearing results.

Q185 **Chair:** Are they published?

George Hosking: It has shared data with me showing that, but it led to the adoption in Scotland of what is called the GIRFEC principle—getting it right for every child—which has been adopted across Scotland with, I think, very positive results. If I pick up that theme, I think that in 2009 or 2010 the Finance Committee of the Scottish Parliament carried out a six-month study of the value of prevention.

At the end of those six months I was in the Scottish Parliament when the Convenor, the former Finance and Health Minister of Scotland, Tom McCabe, summarised the six months' evidence. I will never forget his words: "We have seen evidence stacked from the floor to the sky that this is the right thing to do." As a result of that, the Scottish Government made a commitment in 2011 to make prevention a fundamental principle of their policies. I happen to think it has been very slow in putting that into practice, but the fundamental principle is accepted across Scotland without question. I think that is a fundamentally valuable commitment that is bearing and will bear fruit in Scotland, but which is very much absent currently in England.

Q186 **Bill Grant:** That follows neatly from the shared experience in the highlands. My question is about the relative effectiveness of measures to prevent adversity cases in the first place, compared with intervening after the event. I think you have touched on that, George. I understand that the WAVE Trust is active in Northern Ireland. Do you have any positive, or possibly negative, outcomes of the work you have done there so far? I would like you to compare it with what has been done in the highlands. It seems to be very positive. Is there any read-across?

George Hosking: The study in Northern Ireland, which is a comprehensive, community-wide prevention project, is still in the set-up phase and is moving much more slowly than I would wish, partly for funding reasons and partly because local areas tend to work in a certain way. I spent most of my life working in a multinational business and am used to faster decision making and follow-through than I have discovered in the social sphere.

Things are not happening as quickly as we would like, but they are moving in a very positive direction, in the course of which we have come across some very interesting evidence of interventions that we think have great promise attached to them, but it is too early for us to say, based on what we are doing in Northern Ireland, what the results would be.

Tom McBride: To build on what George said, we should not think of prevention and treatment after the event as an either/or question. Clearly, prevention is a good thing. Stopping children being the victims of serious sexual, emotional or physical abuse is the right thing to do and is almost certainly likely to be very effective.

It is perfectly possible with the right will to evaluate prevention strategies and see whether they are improving outcomes for children—we would want to see that—but we also have to accept that in the near future we are probably not going to prevent all instances of ACEs and that we need evidence-based programmes for those who have been the victims of serious abuse and neglect.

Q187 **Bill Grant:** There is growing awareness of ACEs. Are they helpful or problematic in delivering the right interventions to the right people? Where does the value lie in knowledge of an adverse childhood

experience? Can it be valuable in some instances and negative in others?

George Hosking: I read with some frustration the previous session of this Committee when it talked about ACEs. I firmly believe that ACEs are an extremely valuable tool of public policy. We are working with police forces, probation services, youth justice agencies and education. Every six months we host a conference of senior civil servants looking at ACEs, which initially encompassed three countries, Scotland, Wales and Northern Ireland, each of which has made a major commitment to make prevention and response to ACEs a top public policy priority. I am happy to say that at our very next six-monthly session, which takes place in May, both England and the Republic of Ireland have asked to join in, so hopefully that will spread more widely.

Based on the evidence we have seen particularly in the United States, where Washington state has been implementing approaches to ACEs across its various services for over 10 years now, where the governor of Wisconsin has made a commitment to make it a completely ACE-informed state and cities such as Philadelphia have made a similar commitment, I see significant positive outcomes from these approaches. I think that some of the doubts expressed about ACEs in previous evidence are simply not based on an understanding of what is happening in practice with them.

Q188 **Bill Grant:** To clarify it for myself, having knowledge of adverse childhood experiences is a valuable asset and piece of data, and you do not see any problem honing and using the data wisely.

George Hosking: Not if it is used properly. One of the distinctions that came across to me in the previous evidence was the difference between ACEs as a public health or policy tool, where I think it is entirely positive, and whether you use it in working with individuals who have suffered it. As a clinical criminologist, I have never sat down and measured the number of ACEs somebody I have been working with has suffered in their childhood. I am much more interested in hearing the life story of the individual. As the point was made in previous evidence, some forms of abuse may have been more damaging than others and they are not necessarily the same for different people.

I would not use it as a tool in individual work, but as a public policy tool it is enormously valuable for one crucial reason. Part of my background before I became a clinical criminologist was as a corporate turn-around specialist. I have turned around about 30 international loss-making companies successfully. One of the reasons I was able to do so was that, with the help of a very brilliant Dutchman, I developed a methodology that created a common language allowing production, distribution, marketing, sales, finance, research and so on in a company to talk together in the same language. Whereas previously they had tended to operate as silos, suddenly they were able to talk in this common language. That common language as a tool enabled us to turn around loss-making businesses.

ACEs are a common language that can be used in health, social services, education, police, probation and youth justice, and I am already finding, particularly in Northern Ireland and Scotland—we are also doing work in Wales—that it is being grasped with enthusiasm by people from all these services. They are working much more collaboratively with one another. Suddenly, they have a common language they can speak, because the issues as to why a child is misbehaving in school, or is being considered for expulsion from school, are exactly the same issues—the number of ACEs the child has suffered—as are taking it into the criminal justice system, or explaining why a child is likely to become an offender, or why it is going to become a serious offender, as opposed to a very mild offender, or why it will suffer from cancer, liver or lung disease or especially mental health problems.

There is a common language, and if we set out to prevent these common causes for these multiple societal problems society will reap huge benefits.

Bill Grant: Thank you for that clarity.

Donna Molloy: To add to that, our view is that the adverse childhood experiences data are a powerful way of making the case for early intervention. As George said, it can lead to common understanding among diverse different groups of professionals about the core factor that early adversity has consequences. In sectors such as policing this is quite radical. The police tend to see people in black and white terms, and the idea that offending and antisocial behaviour is rooted in early adversity is quite a powerful way to think about how we change practice.

The downside is that the clarity and power of the ACEs data can lead to people rushing to apply it to their work sometimes in ways that might not be justified by the evidence. As other people have commented, the ACEs data do not allow you to predict at individual level who needs early intervention; it does not tell you anything about the severity or frequency of experiences and so on; it is not an assessment tool or way of judging what types of interventions people might need. Certainly, in our work we have seen some areas using the ACEs score as a way of prioritising who might need early help services.

Q189 **Chair:** What you are saying is that one should caution against misapplication of the evidence.

Donna Molloy: And clear messages about what it is for and what it is not for and how it might be used feels important.

Q190 **Bill Grant:** Is there any evidence regarding the impact of providing routine inquiries as part of children and young people services? How widespread is its use and which services, if any, should be using routine inquiries as part of evidence or information gathering?

Donna Molloy: We have not done any serious work on this whole area. We are aware of the routine inquiry pilots that have now been tested in a

number of services aimed at vulnerable people. Blackburn with Darwen was one of the pioneering places that EIF partnered with back in 2013 when we launched. Warren Larkin led a lot of the work that was presented at our national conference recently. It is very compelling. We are watching with interest as that work is evaluated and are interested in seeing its potential.

Q191 **Bill Grant:** It is ongoing and there are no known recorded benefits or values as of today.

Donna Molloy: Not that we are aware of, but this is not an area in which we have done substantial work.

George Hosking: I agree with what Donna is saying, but I am rather more optimistic about the potential use of this as a tool that can be informative. An interesting piece of research I have in front of me, carried out in San Francisco, looked at learning and behaviour problems in school children. It found that in school children with zero ACEs, which in the original ACE study was about half the population, 3% had learning and behaviour problems. When children do not have ACEs, it seems that learning and behaviour problems are extremely unusual.

In children with four or more ACEs, which in the original ACE study was about 12% to 15% of the problem, over 50% had learning and behaviour problems at school. In the intermediate group of children with one to three ACEs, over 20% had learning and behaviour problems at school.

Therefore, one could say to a very significant extent that when children have learning and behaviour problems at school the cause is likely to be prior ACEs in those children's lives. I will not take up the Committee's time, but I could explain why. Yet, traditionally schools have not looked at ACEs as something that might be relevant to school behaviour.

I grew up in the Scottish system at a time when something called the Lochgelly belt was used, with some pain—I can still feel some of the pain in my hands today—for anyone who stepped out of line or misbehaved. Many schools still have the attitude that there are standards of behaviour, which by the way I always think there should be, and when people step outside them punishment is applied. I think you have already heard the difference between the questions that might be asked under an ACE-informed approach. You ask, "What happened to you?" If members have the time to talk to their colleague Julie Cooper, she has a wonderful story of her experience in school asking that question and getting very different answers to why children might be behaving differently.

If you start to ask that question, as the example of Lincoln high school in Walla Walla in Washington state has shown, you get dramatically changed behaviour from children. Trauma-informed schooling, which has been applied without that title in Bridgend in south Wales and in Washington state, has been shown to improve behaviour, greatly reduce

school exclusion and simultaneously greatly improve academic results in schools.

Q192 **Bill Grant:** In noting ACEs, is there a possibility that that individual, male or female, on their journey through life can meet a supportive teacher, employer or friend who changes that?

George Hosking: Absolutely. Mark Bellis's research shows that not everybody who has ACEs ends up becoming a violent criminal or having other negative impacts. If you look at and understand what makes the essential distinction, it is whether that person has experienced warmth, love and understanding, usually from a consistently available adult during their life. That could be another family member; it could be a school teacher; it could be a youth worker; it could be almost anybody, but when that is provided in somebody's life it makes a difference.

I have worked with criminals who committed violent offences but were able to turn their lives round. One of the key things is to discover someone like a grandmother or a particular person who provided that person with love, even though his father beat something out of him every day with belts, fists and feet. The love of that grandmother was a kernel on which one could build in turning around that person's life and turning them into a pro-social human being.

Q193 **Stephen Metcalfe:** If I may direct my questions to the Early Intervention Foundation, in your evidence you said that local systems underused or undervalued evidence-based programmes. In your opening remarks you said that that was possibly due to a lack of capacity. Are there any other reasons why evidence-based systems are not chosen and those that do not necessarily have proven track records are chosen instead? What are the drivers to direct or push local authorities towards making evidence-based decisions?

Donna Molloy: The issue of capacity is crucial—capacity to engage with the evidence and think about how it could be applied to specific contexts, and capacity to generate evidence locally. Many local authorities and partners do not have good data on the extent to which their existing suite of programmes and services is delivering improvements for children and families. 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. That has certainly been one of the consistent challenges in many of the areas we have worked with.

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.

In addition, local leadership makes a big difference. There is a noticeable difference in those areas where local leaders value evidence and prioritise it and consistently ask officers quite challenging questions about what the

basis for particular decisions might be, and those areas where leaders might behave in a slightly different way, perhaps valuing particular projects their constituents or local population might like, despite the fact that the evidence for those things might be less strong. The culture of a local area and evidence's place within it is very important.

The last factor is about funding for evidence work locally. Tom might want to come in on this. We know that a vast amount of services being delivered in many local areas are not well evaluated because it is expensive to evaluate interventions, and most people would prefer to deliver a service rather than invest in a research project.

Q194 **Stephen Metcalfe:** Even if that service is not effective.

Donna Molloy: They will not know if they have not evaluated it, but there is a drive to prioritise getting services to people, which is completely understandable, but that 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.

Tom McBride: I would agree with all that. I just add very briefly that there are also weak incentives on local authorities and other agencies to take prevention and early intervention seriously. We are talking about services that can be quite costly at times. They might make sense in economic terms—we heard in the earlier session that there are often large pay-outs—but those benefits accrue over many years to different parts of the system that spent the money.

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.

George Hosking: We were commissioned by the Department for Education to carry out a study of what should be public policy priorities for children under the age of two. In 2013 that was produced in a document jointly published with the Department for Education, "Conception to age two — the age of opportunity." It stressed the value of prevention and early intervention as critical in that period.

The following year we were commissioned by the Department of Health to explore why local authorities were or were not implementing the recommendations in that report. We found that the prime reason given by people for not implementing it was that they did not have enough money. The second reason was a lack of leadership in the local area.

We did not believe that the first 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 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.

Q195 **Stephen Metcalfe:** That is a very useful connection to my next question. You talked about the capacity to use evidence to make evaluations. Must this be done on a council-by-council, or local authority area, basis or is there a role for a central body that can provide councils with evaluation of the evidence so you can demonstrate that Essex is doing it well, has implemented it and is saving money and show that evidence to an authority that is not doing that and might be saying it is to do with money, leadership or capacity? How would one go about establishing that system?

Donna Molloy: Tom might want to come in, but it is very inefficient for individual local authorities to be grappling with these evaluation challenges separately. Often, the questions local authorities and partners ask when they talk to us about getting help with evaluations are very common. 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.

We have done some of this work. Early on we tried to match local authorities struggling with evaluation challenges with partners in local universities or research institutes that had a specialism in the area they were interested in evaluating. It can be quite difficult for a local authority to put its head above the parapet and identify who in the vast field of academia might be appropriate. We were able to do some matching and draw in ESRC funding to get some evaluation projects off the ground. We would like to do much more of that. It feels as though there is a lot that could be done, because, as Tom says, this is not something local authorities should be grappling with on their own.

Tom McBride: To build on that, I draw a distinction between monitoring and evaluation. We think local authorities should be using routine admin data to monitor the effectiveness of their services. It is not effective or feasible for every local authority in this country to be running high-quality randomised control trials to evaluate the impact of services. That needs to be co-ordinated centrally. 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.

Q196 **Stephen Metcalfe:** So the challenge is funding.

Tom McBride: It is certainly one of the challenges. There is not the same level of funding compared with what is available in schools, for example.

George Hosking: Again, I would add my note of caution. I think the keys to success are not necessarily in the selection of programmes but rather in the fundamentals of the approach that are adopted. If an agency—a local authority or health board—embraces the principles of prevention and early intervention and starts to go down that pathway, it begins to do the things that make a difference. Usually, it then starts to look for evidence-based programmes within that umbrella. If they exist, it is wonderful, but in many cases they do not because the research has not yet been carried out. They may, however, still be doing the right things that make a difference.

Q197 **Chair:** You get the culture right first where there is a commitment and then apply the evidence.

George Hosking: Yes. The culture, philosophy and principles are more important than the selection of programmes. I am not saying it is not better to choose programmes with a strong evidence base versus those with no evidence base, but I would rather have a local authority that has committed itself to the right culture and is banned from studying anything on evidence base than work with one that has the wrong culture and all the manuals in the world on evidence base.

Donna Molloy: I do not think we are disagreeing here. We have focused on clearing the ground in terms of the evidence for some of the most common programmes in this space in our first five years and built our guidebook, which now has 80 interventions in it. We recognise that manualised programmes are only a small part of the landscape in early intervention activity. We have just agreed a new five-year strategy with our trustees.

One of the commitments in that strategy is to think about how we use the evidence from a manualised programme to extract some of the messages and common principles that might be incorporated more widely in workforce practices and so on—the point Ted Melhuish made at the end of the previous session. We call it sweating the programmes. That really needs to happen. A wide body of evidence is currently being used in quite a narrow field, and we feel it has a lot of potential to be applied more widely. That is work we are really keen to do.

Q198 **Carol Monaghan:** I mentioned to the previous panel the Triple P programme in Glasgow. We are talking about evaluation and evidence. That programme was evaluated. A study was commissioned by the Scottish Government. An evaluation done by Glasgow University reported little impact within Glasgow, but we still see it being used. Proven programmes have not been used, not just in Glasgow but elsewhere. You have said there is an issue about proven programmes not being taken up and unproven programmes being used. Do you not have a role to prevent

this situation from arising?

Donna Molloy: Absolutely. EIF and a number of What Works bodies have a role in making available very clear messages about what through our work has been found to improve child outcomes and what has not. One of the arguments we have made consistently to Government and some of our other funders, because we are not exclusively funded by Government, is that, as well as funding evidence work, the evidence in the system and the work that Tom's team does, we need to fund high-quality dissemination and communication activities, because evidence that just sits on websites is very unlikely to get used and influence decisions made locally—commissioning and so on. We have had a strong focus in the EIF from the outset in making sure our work reaches those who need it, but certainly there is a long way to go in all that activity.

Q199 **Carol Monaghan:** In terms of your impact with local commissioners, how widely do you feel your evidence is being used by local commissioning bodies?

Donna Molloy: Since the start, EIF's founding trustees were very keen that we did not just produce things that sat on our website. We have always had a very strong focus within the organisation on making our work accessible and taking it out there and engaging those we want to use it. We regularly run master classes, speak at national conferences, run evidence seminars and so on.

We know lots about the reach and take-up of those events and hits on our website, which are about 110,000 a year. We know that 70% of our users are not based in London, which says something about our reach and so on, but questions about how you know whether people receiving that information actually leads to behaviour change and making different decisions is obviously a challenge. We are working closely on that with some of the other What Works centres, such as EEF. We have a project funded by the ESRC at the moment.

We have begun to try to test and measure this. I mentioned our work on early years interventions. That was a good example, as well as a really comprehensive piece of work reviewing 75 interventions in the period from conception to age five. We were funded by Public Health England to run a significant dissemination programme to make sure those messages reached local commissioners. We ran a national conference and a number of regional evidence seminars. We reached 500 delegates from three quarters of English top-tier authorities, and for the first time commissioned independent evaluators to follow up with people who attended those events on whether it had made any difference to their work and what they actually did.

We know that the vast majority of those delegates left the events intending to make changes to their work and local commissioning decisions. When they were followed up four to six months after attending the work, 65% reported that they had used EIF evidence in the past four

to six months; 93% had discussed that evidence with their colleagues. We found it quite reassuring that people were creating that dialogue about the evidence we would want to see, and 90% had reflected on their own practice. People were using that in developing and commissioning new programmes and so on. We want to do much more of this. We need to know beyond hits on the website and so on whether the evidence we have is changing what we can do.

Chair: We are now very tight on time, so will you try to keep your answers as succinct as possible?

Q200 **Carol Monaghan:** I will try to keep my questions succinct as well.

Do you have the capacity within the EIF to be both the gatekeeper of evidence on early intervention and allow growth in new interventions? How do you decide what you are going to include in your guidebook?

Chair: It also might be worth addressing the EasyPeasy point we heard about in the previous session. If they miss out on a round and do not get endorsement, even if the evidence is there, does it distort the market, as it were?

Tom McBride: Our funding to date has meant that the route on to our guidebook has been via thematic reviews. We have done three big thematic reviews: one on early years; one on social and emotional learning; and one on inter-parental relationships. That is a question of funding. The funding arrangement we are currently finalising with Government for the next two years will allow us to add about 20 to 30 programmes to the guidebook, and we will not do that exclusively in a thematic way. We will offer an open call to evidence for programmes that wish to be on the guidebook that have outcomes for children.

I cannot give any public commitments today as to which programmes those will be, but clearly programmes that are being delivered in the UK and have UK evaluation evidence will be a priority. This is really a question of funding. We have been able to add only about 80 programmes to our guidebook over the first few years of our existence.

Q201 **Carol Monaghan:** What proportion or percentage of early interventions have been evaluated? You have 80. How many are there?

Tom McBride: That is really an unknowable question because there are so many programmes out there which are not visible to us. There are new ones being developed and delivered all the time in local authorities right across England and the rest of the UK and globally. It is not possible to answer that question directly. We deliberately targeted some of the programmes that are most commonly delivered in UK settings and those that have high-quality evidence.

Q202 **Carol Monaghan:** The Department of Health and Social Care has commissioned a review looking at the impact of ACEs. Has it co-ordinated with you, and does this overlap with the work you are doing?

Tom McBride: As I understand this work—we need to follow up with NIHR on this—it is a systematic or literature review of the work in this area. It would not consider in the same level of detail the evidence underpinning individual programmes. For a programme to go on to our guidebook, there is a very rigorous evaluation of the evidence in excruciating detail of what underpins it. I do not think this will cover it in anywhere near the same depth, so we see it as very positive and complementary to our work, but definitely not a replication of what we do.

Q203 **Carol Monaghan:** You see this as being a more superficial overview rather than the detail you provide.

Tom McBride: I do not want to describe it as superficial, but, as I understand it, it will not go into the same depth as we do, which scrutinises individual evaluations and the statistical and measurement techniques that go under it so that we have a very clear and robust view of the evidence underpinning that. I do not think this is the same thing, but I need to follow it up with NIHR.

Q204 **Carol Monaghan:** You are not entirely sure what this commission is going to look at.

Tom McBride: I have not spoken to them about this since it was identified by the Department for Education's submission to this Committee.

Q205 **Carol Monaghan:** The Family Nurse Partnership has been given the highest evidence rating when the only major UK study concluded that continuation of the programme "is not justified on the basis of available evidence." Surely, that is contradictory.

Tom McBride: What we try to do with our guidebook is provide an accessible overview of the evidence to commissioners, policymakers and so on, and we give all programmes a rating on a four-point scale. Clearly, what we are trying to do with that is collapse or condense quite complex and nuanced evidence into a single score. There are challenges around that.

The highest rating in our guidebook is reserved for programmes that have multiple high-quality evaluations proving improvements in outcomes for children; evidence of long-term outcomes, by which we mean that at least 12 months after the intervention stopped we still see a difference in those who received the service; and at least one evaluation that has been conducted independently of the evaluator. Family Nurse Partnership has all those things, as you heard this morning from the evidence in the US and the Netherlands.

The UK evaluation was disappointing in comparison with those trials, although they did find some positive results, and we reflect that in our write-up on the guidebook. That is why we are very clear that people should not commission programmes simply on the basis of the evidence

rating. They should engage with the rich materials on the guidebook, which includes evidence about what outcomes have been achieved, the skills of the workforce needed to deliver the programme to those it is targeted at and what results are being delivered in the UK versus elsewhere. All that information is available in our guidebook.

That said, there are some programmes with equivocal evidence. In the coming weeks we will be introducing a new category in our guidebook that reflects the equivocal nature of it, or where there is just contradictory information.

George Hosking: On FNP, I would like to reinforce what Ted Melhuish said. The measures used in the English study of FNP were simply not the appropriate ones for the programme. They measured birth weight, smoking in pregnancy, emergency child hospital visits and gap to second pregnancy. They are basically medical measures. The Dutch evaluation found that it had beneficial effects in preventing child maltreatment.

Chair: George, I am conscious that this evidence was largely covered in the first session. We need to finish by 12, so I would prefer that we do not go over that ground, which I think was largely covered in the first session.

Q206 **Damien Moore:** What do you think central Government's role should be when it comes to identifying ACEs and promoting and funding early intervention? What is it doing well? What more should it be doing, and what could it be doing differently?

Tom McBride: What it is doing well is funding the What Works Centres. That is a positive thing. It is a commitment to high-quality empirical research. The Department for Education and others are funding a number of RCTs currently. There is a growing commitment in the UK Government to evidence-based policy, and that is a positive thing.

One of the things we would definitely like to see this Committee recommend is a joining up across Whitehall of policy around early intervention, children and vulnerability. We are currently funded by four Departments: the Departments for Work and Pensions, Communities and Local Government, Education and Public Health England. We also work with the MOJ, Home Office and the Department of Health. 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. That might involve an inter-ministerial group; it could involve a strategy on vulnerability and early intervention that starts to join up this disparate agenda.

George Hosking: What has been done well, I think, are specific things such as the Healthy Child programme in the Department of Health, and the work that has been done in recent years in improving support to children from about age two onwards.

What is sadly lacking overall is a focus on prevention, in part because not enough attention is being paid to the very earliest years. The "Building Great Britons" report published in 2015 recommended that Government—this would cost them nothing—should require every local authority to produce a 1,001-day strategy, which Wales is focusing on, and an action plan to go with that strategy. If one made attention to prevention an important part of that, very significant progress would be made without it costing central Government anything.

It would be even better if they funded prevention in local areas, drawing the money from the Departments that benefit from it. One of the great problems we have in the system is that the benefits of early intervention and prevention flow largely to Departments such as the Home Office, the Ministry of Justice, DWP and so on, but they do not provide the funding. All the funding is required to be produced principally by the Department of Health.

Q207 **Chair:** The trouble is that the MOJ would benefit in 2035, or something like that.

George Hosking: But it would benefit by a policy. For example, the Scottish Violence Reduction unit has done great work in Scotland in pushing the message for prevention, because it is recognised by police officers that the way to prevent crime in Scotland is by prevention and early intervention. They played a major role in pushing through that agenda in Scotland. There are many people in the Met police who have the same perspective. It could be done with funding on a cross-departmental basis in such a way that you get sufficient money put into prevention, and those are the Departments that would benefit from it further down the line.

Donna Molloy: Part of the reason why cross-Government leadership or a forum is really important is that at the moment there is no space for discussion about what matters most in children's development and outcomes. 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. Many of the Departments we work with have a common interest in those things, but currently there is not a cross-Government place where that is debated and decisions are made.

Q208 **Damien Moore:** The current system seems fragmented, with many organisations working in the field. First, does that matter? Secondly, to what extent could the Early Intervention Foundation or a similar body provide a strategic leadership to that?

Donna Molloy: One of the points we would like to make is 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.

Many of the things we have talked about today and you have heard about so far in this Committee in terms of investment in high-quality evidence, building evidence capacity in the sector, and supporting those who are delivering interventions and have not yet had opportunity to develop their evidence, are all things we are trying to do with 20 people and would like to do much more of. 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.

Q209 **Damien Moore:** Are the Government doing enough to make more data available for research on ACEs and interventions perhaps by linking up data from children's services, schools and nurseries, the police and others?

Tom McBride: There is a lot of opportunity in this area and we are involved in a number of initiatives around data linking. There is complex legislation around this; there are complex ethical issues about linking together datasets.

Clearly, Government hold a lot of data from the criminal justice system, benefits, tax and education system, which could facilitate much deeper and higher-quality research in this space. The Digital Economy Act allowed for that. The onus has to be on central Government now to start linking those datasets and make them available in an anonymised and secure way to researchers who can do high-quality work on that subject.

Q210 **Damien Moore:** What would you recommend to improve the use of evidence among local authorities and commissioning groups delivering early intervention programmes?

Donna Molloy: I think it is the things we have talked about already. 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. In my previous career I spent many years in Government Departments. We 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.

George Hosking: WAVE has just completed a three-year study into what causes children to slide into lives of severe and multiple disadvantage, by which we mean some combination of unemployment, mental health problems, drug and alcohol abuse, criminality and so on. We see a very clear pathway. It begins with ACEs, usually early in life. It leads to behavioural and learning problems at school. That in turn leads to disruptive behaviour. That leads to school exclusion, and from school exclusion they are on a very fast track to entry into the criminal justice system.

Q211 **Chair:** At enormous cost to the state.

George Hosking: Yes, as Leon Feinstein said, but it is probably underestimated.

There are solutions. The solutions begin with prevention of ACEs, which we do almost nothing about in this country. Even after the ACEs have been suffered there are significant things we can do. I would like to put in a particular word for nurture groups in schools. Nurture groups are a method of taking at entry to primary school, or particularly transition to secondary school, those children in the high at-risk category and providing them with the kind of intensive support that can greatly transform their outcomes.

Sir Harry Burns, former Chief Medical Officer for Scotland, has said to me that the two great success stories of Scotland are Family Nurse Partnership and nurture groups, and Northern Ireland has also been implementing nurture groups and achieving great results with them. I would certainly like to leave the Committee with the message that we should be doing a great deal more on nurture groups.

The other matter is the whole issue of how you handle ACEs through trauma-informed care and trauma-informed schooling. I am a particular believer in trauma-informed schooling, where again there is a growing evidence base and very good results are being produced. It is a fundamental change in the whole way we set about schools and education. I think it offers huge benefits academically and behaviourally in our schools.

Chair: We have had some very compelling evidence today. Thank you all very much indeed for your time and patience in waiting for your session to start, with apologies for the late finish, but we appreciate it.