This briefing is intended to inform the Health and Sport Committee’s short inquiry on early years which is part of its themed work on health inequalities. It focuses on antenatal services, child health services and child development. It also provides examples of child health and wellbeing programmes from the rest of the UK and Europe. It does not focus on childcare and pre-school education as this is the subject of SPICe briefing 14/26 Early Learning and Childcare and 11/51 Early years – Subject Profile.
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EXECUTIVE SUMMARY

Despite continued improvement in health outcomes and increases in the average life expectancy and healthy life expectancy across Scotland, inequalities in health still persist. In 2011-12 men living in the most deprived areas of Scotland were estimated to live over 10 years longer in poor health than men living in the least deprived areas (Scottish Government 2013a).

The main causes of health inequalities lie outside the health service, with the social and economic conditions in which people live, such as housing, employment, nutrition, education and support networks, all playing an important role in determining health. Experience in early childhood is thought to be a key driver of future health as “giving every child the best start in life is crucial to reducing health inequalities across the life course” (The Marmot Review, 2010, p94). Addressing health inequalities at an early stage is also believed to result in significant future economic benefits (Wave Trust, 2013).

The Scottish Government has a number of policies and initiatives that aim to address inequalities in the early years, including the Early Years Collaborative (EYC). The EYC is a coalition of Community Planning Partnerships, including social services, health, education, police and third sector professionals. The objective of the EYC is “to accelerate the conversion of the high level principles set out in Getting it Right for Every Child and the Early Years Framework into practical action. This must:

- Deliver tangible improvement in outcomes and reduce inequalities for Scotland’s vulnerable children.
- Put Scotland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016.
- Sustain this change to 2018 and beyond.”

(Scottish Government online)
INTRODUCTION

The health of Scotland’s population has improved over the last 50 years but health inequalities still persist. Deprivation is a key determinant of health inequalities, although personal factors such as age, gender and ethnicity all play a part. Average life expectancy has increased over recent years but significant variations between the most and least deprived areas remain. In 2009-10 the life expectancy of men living in the most deprived areas of Scotland was 11 years lower than the life expectancy of men living in the least deprived areas (Audit Scotland, 2012). This variation is also evident in measures of healthy life expectancy. In 2011-2012 men in the most deprived areas of Scotland were estimated to spend 22.7 years in “not good” health compared to 11.9 years in the least deprived areas. Women in the most deprived areas were estimated to spend 26.1 years in “not good” health compared with 12.0 years in the least deprived areas (Scottish Government, 2013a).

It is widely believed that the causes of health inequalities lie outside the health service and in order to address these, policies should address the wider social determinants. In the report Review of the Social Determinants and Health Divide in the World Health Organisation: European Region: final report the World Health Organisation (WHO) outlined the key issues in understanding and promoting health equity. The WHO stated that “the highest priority is for countries to ensure a good start for every child. This requires as a minimum, adequate social and health protection for women, mothers-to-be and young families and making significant progress towards a universal, high-quality, affordable early years education and child care system” (WHO, 2013a, pxv).

The report Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities (Health Scotland, 2014 p. 6-7) provides an explanation of the causes of health inequalities which manifest as differences in wellbeing, healthy life expectancy, morbidity and mortality. Health inequalities are influenced by:

- Fundamental causes (such as political priorities and societal values that lead to an unequal distribution of power, money and resources)
- Wider environmental influences including economic (such as the availability of jobs) physical (such as air and housing quality), learning (the availability and quality of schools), accessibility of services and social and cultural (for example, community and social capital)
- Individual experiences including economic and work (such as employment status, job security) physical (exposure to noise, damp, pollutants), learning (early cognitive development and school readiness), services (such as quality of services) and social and cultural (for example, support, resonance and coping mechanisms).

Reducing health inequalities is a priority for many Governments. A wide range of policies and solutions for reducing health inequalities have been proposed. These have included the introduction of a living wage, focusing resources on childhood, the implementation of 20 mile per hour speed limits, taking a “health first” approach to health-related worklessness, the use of participatory budgeting to make decisions on public health priorities and interventions, using further and adult education, improving the employment conditions of public sector workers, improvements in the independence, participation, health and wellbeing of older people and evaluating the cost effectiveness of interventions (British Academy, 2014).

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1 Social Capital describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit. Definitions of social capital vary, but the main aspects include citizenship, ‘neighbourliness’, social networks and civic participation (ONS online).
Research by Dr Katherine Smith (2013) looked at the available evidence on health inequalities and explored whether there is a consensus about the remediation policies that are likely to be effective. Smith found that the research community tends to identify upstream policies (those which focus on the fundamental causes such as raising income of poorer groups or progressively distributing income) as likely to have the greatest impact on reducing health inequalities. However, Smith also found that when researchers were asked to assess policy proposals on the strength of the available evidence they were more likely to support proposals relating to lifestyle-behaviours and health services. This shows that there is a disparity between what people thinks works and what evidence to supports.

**EARLY YEARS**

There is evidence that childhood experiences are a major determinant of future health. In evidence to the Scottish Parliament Health and Sport Committee the then Chief Medical Officer for Scotland, Sir Harry Burns, stated that:

“…the basic problem lies in the early years. That is not the only explanation by any means, but we will not fix the problem without changing the conditions in which very young children are nurtured and grow…..Poverty is a consequence of much of what we are discussing, and we must tackle it. It is not for me to come up with the economic solutions to poverty. However, if we get young people attaining at school and involved in successful activity in the jobs market, we will ultimately deal with poverty and begin to break the cycle. However, the key first and foremost is the early years.” (Scottish Parliament, 2013).

The importance of early years is set out in the Marmot Review (2010) *Fair Society, Healthy Lives*, which outlines that a child’s physical, social and cognitive development during the early years strongly influences their school readiness and educational achievement, economic participation and health. It notes that inequalities in childhood play an important role in the development of emotional and social capabilities which enable people to sustain positive relationships in later life. The Wave Trust (2013) considers that up to the age of 2 is particularly important in terms of psychological and cognitive development, and that this in turn has implications for an individual’s emotional and physical health as well as their educational and economic achievement. Figure 1 overleaf illustrates the importance of the pre-school years and highlights the age at which particular skills are most readily acquired.
Whilst there is a large evidence base highlighting the importance of a child’s early experience in influencing their future health outcomes, most research focuses on individual risk factors. For example, maternal health (including stress, diet, drug, alcohol and tobacco use during pregnancy) has been found to play an important role in foetal and early brain development (The Marmot Review, 2010). After a child is born other risk factors exist. These include likelihood of breastfeeding, the mental health of the mother, level of parental attachment, exposure to tobacco smoke and parenting style (Scottish Government, 2014c). The following diagram illustrates how risk factors can combine to have a negative impact on the health and wellbeing of a young child.

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2 A number of reviews of the evidence in this area have been undertaken including Scottish Government (2008b), Scottish Government (2014c), NHS Health Scotland (2012), Scottish Collaboration for Public Health Research and Policy (2010).
Disadvantage in the early years can lead to a higher risk of injury and social, emotional and cognitive difficulties (NHS Scotland, 2012). Findings from the Growing up in Scotland study found that children living in the most deprived areas were more likely to have long term health problems, had two or more accidents by the age of 46 months, asthma or allergies, behaviour problems and language difficulties (Scottish Government, 2010b).

There are potential economic benefits in addressing health inequalities at an early stage. A number of studies suggest that early intervention can offer significantly better outcomes and value for money than later interventions (Department for Children, Schools and Families, 2010). One of the key messages of the Early Years Framework is that effective interventions in the early years can generate significant future financial savings\(^3\) (Scottish Government, 2011). Child development has also been found to influence an individual’s future wellbeing, obesity, mental health, heart disease, economic participation and social participation, all of which have economic implications (Irwin et al, 2007 as cited in Geddes et al, 2010).

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\(^3\) For more information see the Wave Trust report *The Economics of Early Years’ Investment*.
Table 1 outlines the key legislation in the area of early years. Scottish and UK legislation in relation to childcare is set out in SPICe Briefing *Early Learning and Childcare* (Kidner, 2014).

Table 1: Legislation related to the early years

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Health Service (Scotland) Act 1978</strong></td>
<td>General duties to provide a health service. Ministers must make arrangements for the care, including medical and dental care, of expectant mothers and nursing mothers and of young children (s.38).</td>
</tr>
<tr>
<td><strong>Children (Scotland) Act 1995</strong></td>
<td>Local authorities must produce “children’s services plans” (s.19), must provide day care for “children in need”, and can provide day care for other children (s.27).</td>
</tr>
<tr>
<td><strong>Education (Additional Support for Learning) (Scotland) Act 2004</strong></td>
<td>Made provision for the assessment and provision of support to children with additional support needs (ASN). A child with ASN includes any child who, for whatever reason, requires additional support for their education.</td>
</tr>
<tr>
<td><strong>Breastfeeding etc. (Scotland) Act 2005</strong></td>
<td>Made it an offence to stop or prevent a child under the age of 2 being breast-fed milk in a public place or licensed premises, where the child is otherwise lawfully permitted to be.</td>
</tr>
<tr>
<td><strong>Provision of school education for children under school age (prescribed children) (Scotland) Order 2007</strong> SSI 2007/396</td>
<td>Increased the required amount of free pre-school education from 412.5 to 475 hours per year.</td>
</tr>
<tr>
<td><strong>Children and Young People (Scotland) Act 2014</strong></td>
<td>Made provision about the rights of children and young people. This legislation aimed to encourage greater progress and achieve greater consistency in the implementation of Getting it Right for Every Child by creating statutory duties in relation to certain elements including:</td>
</tr>
<tr>
<td></td>
<td>- Amending existing duties to have children’s services plans (Part 3)</td>
</tr>
<tr>
<td></td>
<td>- A named person for every child (Part 4)</td>
</tr>
<tr>
<td></td>
<td>- A child’s plan where targeted intervention is required to assure wellbeing (Part 5)</td>
</tr>
<tr>
<td></td>
<td>- A statutory definition of wellbeing (s.73 and Part 13)</td>
</tr>
<tr>
<td></td>
<td>- Creating statutory duties to share information between agencies where there is a concern about wellbeing (s.26-29 and 38)</td>
</tr>
<tr>
<td></td>
<td>- Extending free pre-school education from 475 hours to 600 hours for all 3 and 4 year olds and two year olds who have been “looked after” or have a kinship care residence order from 2014 (Part 6) (Kidner, 2013)</td>
</tr>
</tbody>
</table>

(Adapted from Kidner, 2011).

At an international level the *United Nations Convention on the Rights of the Child* is a human rights treaty that grants all children and young people a comprehensive set of rights. Under Article 6 Governments must do all they can to ensure that children survive and grow up healthy and under Article 24 Governments must provide good quality health care, clean water, nutritious food and a clean environment so that children can stay healthy (UNICEF online).
POLICIES AND INITIATIVES AIMED AT REDUCING HEALTH INEQUALITIES

A number of policies have been introduced by the Scottish Government that aim to address health inequalities. This section highlights the relevant policies in this area. However, it is worth noting that there is some cross over between policies.

The Scottish Government launched three linked social policy frameworks for tackling inequality Equally Well, the Early Years Framework and Achieving our Potential\textsuperscript{4,5}.

EQUALLY WELL

The report of the Scottish Government Ministerial Task Force on Health Inequalities, Equally Well, was published in 2008 and outlined recommendations for tackling the underlying causes of health inequalities under a range of headings including early years. It noted that action in a number of areas was needed to address future inequalities in health. Including:

- High quality ante-natal care that identifies and addresses risks early
- Improving maternal nutrition during pregnancy
- Improving the quality of interaction between parents or carers and children in the very, early years, for example through high quality home visiting services and parenting programmes
- Targeted interventions and programmes for children at particularly high risk
- High quality centre-based pre-school provision and school education
- Alleviating poverty in families with young children
- Reducing environmental hazards

Members of the Task Force included relevant Scottish Government Ministers, the Scottish Government Director of Public Health and Wellbeing, the Chief Medical Officer for Scotland and representatives from Glasgow Centre for Population Health, Convention of Scottish Local Authorities (COSLA), NHS Boards and the Lloyds TSB Foundation for Scotland.

The Ministerial Task Force was reconvened in 2010 to review progress. The aim of the 2010 Review was to:

- Gauge how well key agencies, including the Scottish Government, had been able to respond to the recommendations in Equally Well
- Make additional recommendations
- Consider how to replicate the progress made by the Equally Well test sites
- Set out arrangements for future monitoring and governance

The main conclusion of the 2010 review was the need for a greater focus on prevention and preventative spending, as well as reinforcement of the general principle that poor health was not simply due to lifestyle choices. Poor health was seen to be linked to people’s aspirations, sense of control and other cultural factors. This was described in the review as a “sense of coherence”, in which the external environment is seen to be easily understood, meaningful and manageable. The 2010 review also re-emphasised that a more collaborative approach across different public services was required, and that Community Planning Partnerships working effectively together would be key. The Task Force agreed to reconvene in 2012 to assess progress.

\textsuperscript{4} Achieving our Potential is the Scottish Government’s framework to tackle poverty and income inequality in Scotland.

\textsuperscript{5} It is worth noting that Equally Well and Achieving our Potential were not aimed exclusively at children and young people.
In 2012/13 the focus of the review was to:

- Reflect on changes in the way that people and communities were being engaged in decisions that affect them
- Consider the implications of the Christie Commission report for how health inequalities might be tackled
- Look at how characteristics of "place" had an impact on health inequalities in Scotland

The Report of the Ministerial Task Force on Health Inequalities (2013) identified the development of social capital, support for Community Planning Partnerships and the community planning process, focus on the 15 to 44 age group and supporting the implementation of a Place Standard\(^6\) as priorities (Scottish Government, 2014d). In addition the Task Force considered its own input into the work to tackle health inequalities. It was clear to members that a regular two yearly review may not be the best way to monitor progress nor influence the current way of working and that alternative arrangements for coordination of work to tackle health inequalities, to monitor and to influence progress, should be considered. Ministers have agreed that the Health and Community Care Delivery Group which meets up to four times a year will consider priority actions for tackling health inequalities. The group includes representatives from local government, the NHS, the third sector and Government.

This briefing will now outline Scottish Government policies that have an explicit focus on children and young people.

**GETTING IT RIGHT FOR EVERY CHILD**

Getting it Right for Every Child (GIRFEC) is the Scottish Government’s approach for working with children and young people. It seeks to create change in culture, systems and practice in children’s services. It is intended that the GIRFEC principles will be integrated into all policy, practice, strategy and legislation affecting children, young people and their families (Scottish Government online). GIRFEC is founded on ten core components:

1. A focus on improving outcomes for children, young people and their families based on a shared understanding of wellbeing
2. A common approach to gaining consent and to sharing information where appropriate
3. An integral role for children, young people and families in assessment, planning and intervention
4. A co-ordinated and unified approach to identifying concerns, assessing needs, and agreeing actions and outcomes, based on the wellbeing indicators
5. Streamlined planning, assessment and decision-making processes that lead to the right help at the right time
6. Consistent high standards of co-operation, joint working and communication where more than one agency needs to be involved, locally and across Scotland
7. A Named Person for every child and young person, and a Lead Professional (where necessary) to co-ordinate and monitor multi-agency activity
8. Maximising the skilled workforce within universal services to address needs and risks as early as possible
9. A confident and competent workforce across all services for children, young people and their families
10. The capacity to share demographic, assessment, and planning information, including electronically, within and across agency boundaries

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\(^6\) The Scottish Government has committed to developing a Place Standard in recognition on the impact the quality of the built environment has and the view that architecture and urban design should not only to meet practical needs but also improve the quality of life (Scottish Government, 2014d).
The Children and Young People (Scotland) Act 2014 puts some elements of GIRFEC into statute, while other elements remain as policy. From 2016 the Act will:

- Require local authorities and health boards to develop joint children’s services plans, in co-operation with a range of other service providers
- Require a “named person” for every child, including duties for public bodies listed in Schedule 2 to share information with the “named person”
- Require a “child’s plan” where targeted intervention is necessary
- Create a statutory definition of “wellbeing” (Kidner, 2013).

A key element of the GIRFEC approach is the national practice model, which creates a common language and approach to identifying and meeting concerns. This includes the “wellbeing wheel” (known as SHANARRI\(^7\)), the “my world triangle” and the “resilience matrix”\(^8\). These provide a shared approach to organising and recording information about a child and to discussing ways of addressing concerns about wellbeing. It is recommended that it is used by all agencies, including when recording routine information. GIRFEC therefore has an emphasis on the way that information is shared and recorded by different professions. The SHANARRI indicators and a concept of “wellbeing” are legislated for in the Children and Young People (Scotland) Act 2014. Other aspects of the national practice model remain as guidance and policy (Kidner, 2013).

THE EARLY YEARS FRAMEWORK

The \emph{Early Years Framework} built on GIRFEC and the Curriculum for Excellence and set out a framework of key principles. It covers the age range 0 to 8 years. The overarching themes are local implementation, integrated working, early intervention and re-focusing effort on prevention rather than crisis intervention (Kidner, 2011). It includes interventions aimed at supporting parenting, improving housing, opportunities for play, increasing the flexibility and integration of services, and a focus on the first three years of a child’s life. The work is on-going, but the Scottish Government reviewed progress in January 2011 in the report \emph{Early Years Framework - Progress So Far}. Key messages include that:

- It is important to move away from crisis management to prevention and early intervention
- Effective interventions in the early years can also generate significant financial savings at later stages

THE EARLY YEARS TASKFORCE AND CHANGE FUND

In November 2011, The Early Years Taskforce was established, alongside the Early Years Change Fund, by the Scottish Government, in partnership with local government, the NHS, the Police and the third sector. The Early Years Taskforce was established to develop the strategic direction for the early years change programme and co-ordinate policy across Government and the wider public sector to ensure that early years spending is prioritised by the whole public sector.

\(^7\) The GIRFEC approach uses eight areas of wellbeing (Safe, Healthy, Achieving, Nurtured, Active, Responsible, Respected and Included - SHANARRI) in which children and young people need to progress in order to do well now and in the future. These eight areas are set in the context of the four capacities (successful learner, confident individual, responsible citizen and effective contributor) used in the \emph{Curriculum for Excellence} (Scottish Government online).

\(^8\) For further information see the Scottish Government’s website.
The Early Years Change Fund was intended to support prevention and early intervention (Scottish Government, 2012b). In evidence to the Finance Committee the Minister for Children and Young People stated that “funding commitments for the Early Years Change Fund from health and local government will end in 2014-15, and the Scottish Government has committed £8.5 million to the early years change fund for 2015-16 to support the transition away from the change fund model” (Scottish Parliament, 2014, col 3532). The role of the taskforce has recently been reviewed and there is currently no timescale for when this group will come to an end. However, the role and existence of the taskforce will be kept under review (Scottish Government, 2014⁹).

HEALTH FOR ALL CHILDREN

In 2011 the Scottish Government published A New Look at Hall 4. The Early Years. Good Health for Every Child. This guidance sets out how the Health for All Children (Hall 4) can be delivered. Hall 4 was guidance to support the recommendations of the Royal College of Paediatric and Child Health’s fourth review of routine child health checks, screening and surveillance activity. The New Look at Hall 4 focused on:

- The allocation of the Health Plan Indicator - this was developed following the publication of the 2005 guidance for use by health practitioners to enable the allocation to a core, additional or intensive programme of support, depending on a child's need
- The 24-30 month review - the introduction of a 24-30 month review for all children to review the child's development and identifying and addressing areas where additional support is required
- The delivery of health improvement information and advice and that Public Health Nurses and Health Visitors should ensure that they promote the use of materials such as Ready Steady Baby! and Ready Steady Toddler! (Scottish Government, 2011d)

IMPROVING MATERNAL AND INFANT NUTRITION: A FRAMEWORK FOR ACTION

The Scottish Government’s Improving Maternal and Infant Nutrition: A Framework for Action, was also published in 2011. This is a framework which aims to improve the nutrition of pregnant women, babies and young children in Scotland. It highlights the need to focus on the early years and targeting those in need, to ensure that health outcomes for children are improved and health inequalities reduced (Scottish Government, 2011c).

FRAMEWORK FOR MATERNITY CARE

The Scottish Government’s Refreshed Framework for Maternity Care in Scotland, published in 2011, outlines the principles which govern maternity services from pre-conception, through pregnancy, childbirth and postnatal care and into parenthood. One of the key drivers for refreshing the framework was the need to reduce inequalities in maternal and infant health outcomes at birth and across the life course (Scottish Government, 2011b).

NATIONAL PARENTING STRATEGY

In 2012 the Scottish Government published its National Parenting Strategy which aims to “act as a vehicle for valuing, equipping and supporting parents to be the best that they can be so that they, in turn, can give the children and young people of Scotland the best start in life” (Scottish Government, 2012a). It brought together a range of policies aimed at helping parents

⁹ Personal correspondence 09 April 2014.
and provides a summary of commitments, some of which have been taken forward in the Children and Young People (Scotland) Act 2014.

**EARLY YEARS COLLABORATIVE**

The Scottish Government launched its Early Years Collaborative (EYC) in October 2012. This is a coalition of community planning partners including social services, health, education, police and third sector professionals. The objective of the EYC is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action.

The Scottish Government’s website states that this must:

- Deliver tangible improvement in outcomes and reduce inequalities for Scotland’s vulnerable children
- Put Scotland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016
- Sustain this change to 2018 and beyond

The EYC has four “stretch”\(^{10}\) aims:

1. To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015) and infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015)
2. To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review, by end-2016
3. To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017
4. To ensure that 90% of all children within each Community Planning Partnership area have reached all of the expected developmental milestones and learning outcomes by the end of Primary 4, by end-2021

Although focusing on reducing the rates of stillbirths and infant mortality the EYC hopes that improvements will be made at a population level in relation to reducing poverty, improved housing, reducing domestic violence and abuse. The EYC webpage states that the initiative is “not just about child deaths, but addresses many issues that span across multi-agencies in order to build better foundations for all children by supporting improved wellbeing for all pregnant women and babies”. The Scottish Government anticipates that this “will lead to babies being born with the building blocks already laid for good, positive development”, concluding that this “includes a wide range of factors with their roots in social, rather than clinical causes e.g. drug and alcohol misuse.” The success of the programme will be measured against 27 (not exhaustive)\(^{11}\) measures.

The work of the EYC is being delivered across four workstreams that relate to ages and stages in the early years. A number of key change areas, outlined overleaf, have been identified under each of these workstreams.

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\(^{10}\) A "stretch" aim is one to reach within a certain time (Institute for Healthcare Improvement online).

\(^{11}\) The 27 measures can be used by CPPs to determine whether the changes being tested locally are leading to an improvement, and contributing to the “stretch aims”. CPPs may decide that they need to capture different measures.
Early Years Collaborative Key Change Areas

**Meeting our aims/Cross cutting themes**

- Workforce development. Reliably delivering ways of working such as through the Solihull Approach\(^\text{12}\), that enable the whole team to ensure that children have a good emotional start in life
- Nutrition interventions across the age ranges, for children and families focusing on:
  - obesity (including inter pregnancy)
  - folic acid
  - healthy start vitamins
- Income maximisation for families that require it
- Stillbirth review process
- Sharing best practice - culture of learning and improvement
- Improved mental health of mother

**Conception to one year**

- Improving access to maternity services
- Attachment and child development. To include (not exhaustive)
  - breastfeeding/feeding
  - touch/contact
  - talking to baby
  - reference to Maternity Care Quality Improvement Collaborative interventions
- Point of contact checklist
  - Transfer of care to next service (or from the last one)
  - Continuity of care and carer
  - Workforce development – Solihull Approach
- Smoking cessation – reliably delivering interventions in pregnancy

**One year to 30 months**

- Improving and developing parenting skills
- Attachment and child development including (not exhaustive):
  - play at home
  - ready steady baby
  - play talk read
  - bookbug
- 27-30 month review implemented and pathway of intervention delivered

**30 months to primary school**

- Improving and developing parenting skills
- Attachment and child development
- Children eligible for pre-school hours are identified and receive 95% of their allocation

(Scottish Government, 2014a)

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\(^\text{12}\) The Solihull Approach an integrated model of working for care professionals working with families, babies, children and young people. It is used by a wide variety of practitioners including health visitors, school nurses, family centre workers, midwives, social workers, foster carers and parents (Solihull Approach website).
MATERNITY AND CHILDREN'S QUALITY IMPROVEMENT COLLABORATIVE

The Maternity and Children's Quality Improvement Collaborative (MCQIC) is part of the Scottish Patient Safety Programme. The Maternity Programme was launched in March 2013 and aims to support clinical teams in Scotland improve the quality and safety of maternity healthcare. The overall aim of the Maternity Workstream is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families. It has the following key objectives (Scottish Patient Safety Programme online):

- Increase the percentage of women satisfied with their experience of maternity care to more than 95% by 2015
- Reduce the number of avoidable adverse events in women and babies by 30% by 2015

The collaborative has six sub-aims which are to (NHS Greater Glasgow and Clyde, 2014):

- Reduce the avoidable proportion of stillbirths and neonatal mortality by 15%
- Reduce severe post partum haemorrhage by 30%
- Reduce the incident of non medically indicated elective deliveries prior to 39 weeks gestation by 30%
- Offer all women carbon monoxide (CO) monitoring at the booking appointment for antenatal care
- Refer 90% of women who have raised CO levels of who are smokers to smoking cessation services
- Provide a tailored package of care to all women who continue to smoke during pregnancy

National funding has also been provided for a Midwifery Champion in each of the territorial health boards to support MCQIC activities (Scottish Government, 2013c).

PLAY STRATEGY FOR SCOTLAND: OUR VISION

The Scottish Government’s policy, Play Strategy for Scotland: Our Vision (2013) aims to improve the play experience of all children and young people in Scotland. It is in line with the United Nations Convention on the Rights of the Child. The policy recognises the importance of building strengths and abilities that lie within communities. It notes that play is a right and fundamental part of children’s quality of life and central to how children learn, both in terms of cognitive skills and skills around relating to other people. The policy complements the Children and Young People (Scotland) Act 2014 and further supports other policy frameworks such as the Early Years Framework, Equally Well, Achieving our Potential and the Child Poverty Strategy for Scotland in tackling long term drivers of poverty and inequalities through early interventions and prevention (Doi, 2014).

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13 Play encompasses children’s behaviour which is freely chosen, personally directed and intrinsically motivated. It is performed for no external goal or reward, and is a fundamental and integral part of healthy development – not only for individual children but also for the society in which they live.
THE CHILD POVERTY STRATEGY

The *Child Poverty Strategy for Scotland* was published in March 2011. The Scottish Parliament Health and Sport Committee focused on child poverty at its meeting of the 19 November when a roundtable session was held with representatives from the Child Poverty Action Group in Scotland, Commission on Social Mobility and Child Poverty, Scotland’s Commissioner for Children and Young People, One Parent Families Scotland, Joseph Rowntree Foundation, NHS Greater Glasgow and Clyde, COSLA, Save the Children and Scottish Business in the Community. At its meeting on the 12 December 2013 the Health and Sport Committee heard from the Minister for Children and Young People and the Minister for Housing and Welfare.

A revised *Child Poverty Strategy* for 2014-2017 was published by the Scottish Government in March 2014. This focuses on three outcomes maximising household resources, improving children's wellbeing and life chances (with the aim of breaking inter-generational cycles of poverty, inequality and deprivation) and addressing area based factors ensuring that children from low income households live in well-designed, sustainable places (Scottish Government, 2014e).

**Case Study**14 - Healthier Wealthier Children

Healthier Wealthier Children is a collaboration between NHS Greater Glasgow and Clyde, local authorities, Glasgow Centre for Population Health and voluntary sector money advice services. The project aims to reduce child poverty by helping families with financial concerns. The pilot project was funded by the Scottish Government.

The project works closely with antenatal and community child health services to target pregnant women and families with young children experiencing, or at risk of, child poverty, as costs increase and employment patterns change around the birth of a child. The project offers income maximisation advice for families experiencing child poverty and aims to prevent families from falling into poverty by working with health and early years services to identify families at risk at an early stage (NHS Greater Glasgow and Clyde, 2013).

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14 The case studies used in this briefing are intended to highlight some of the work that is being undertaken in a particular area. No inference should be made by the inclusion or exclusion of a project/initiative,
PROGRAMMES AND INTERVENTIONS

Many commentators have highlighted the importance of the early years in the future development, health and wellbeing of children. To address inequalities in the early years a myriad of programmes and interventions have been established, which cover all aspects of childhood from preconception and pregnancy to infancy and early childhood through to later childhood, including in relation to childcare and education. This section intends to highlight some recent reviews in this area and outline some of the interventions and programmes in existence in Scotland that aim to improve the health of babies and young children and reduce health inequalities.

The Marmot Review (2010) notes “to have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundation” (p94). The review made a number of recommendations in relation to the policy objective of giving every child the best start in life. Including:

- Increasing the proportion of overall expenditure allocated to the early years and ensuring that expenditure on early years is focused progressively across the social gradient
- Supporting families to achieve progressive improvements in early years development, including:
  - Giving priority to pre and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
  - Providing paid parental leave in the first year of life with a minimum income for healthy living
  - Providing routine support to families through parenting programmes, children’s centres and key workers, delivered to meet social need via outreach to families.
  - Developing programmes for the transition to school
- Providing good quality early years education and childcare. This provision should be:
  - Combined with outreach to increase the take-up by children from disadvantaged families
  - Provided on the basis of evaluated models and meet quality standards

The Scottish Collaboration for Public Health Research and Policy (2010) reviewed interventions for promoting early child development for health. It reported that successful interventions used a combination of centre and home-based child and parenting programmes, that the economic returns can be three to seven times greater than the investment, and that the greatest effects were seen from programmes targeting people at the highest social risk. Although IQ and developmental improvements were found to generally diminish with age, academic improvements persisted and lead to better outcomes. It also looked at preschool education and highlighted the importance of the home learning environment.

In its report Review of social determinants and the health divide in the WHO European Region: final report the World Health Organization examined the social determinants of health. In relation to early years development, education and health it states that inequalities in the conditions for good child development are potentially remediable through family support, maternal care, child care and education. It notes that the health system is often an important entry point for families who need support and offers an opportunity to make progress in the early years through programmes such as nurse-led support for families and mothers throughout pregnancy and the early years of the child’s life (WHO, 2013a).

The Wave Trust (2013) in its report Conception to age of 2 – the age of opportunity, recommended that policies should reflect the importance of the relationship between a child and their primary care giver and parental mental health. Policy debate should also emphasise the
impact of multiple risk factors. The report highlights the importance of a healthy pregnancy in a child's development and nutrition (including breastfeeding) in the first few months of life. It notes that good hygiene, home safety and immunisation are important in promoting health. The report commented that the most effective interventions are often preventative rather than reactive and that preventative interventions can be less stigmatising.

NHS Health Scotland (2012) published an evidence review that looked at the effectiveness of interventions to support parents, infants and children in the early years. It looked at health-led parenting interventions in pregnancy and the early years, postnatal parental education for optimising infant general health and parent-infant relationships, interventions for promoting early childhood development for health, group based parenting training programmes for improving emotional and behavioural development in children from birth to 3 years old, the factors relating to the risk of children experiencing social and emotional and cognitive difficulties, and promoting the social and emotional wellbeing of vulnerable preschool children.

This briefing will now go on to look at some of these areas in more detail.

**PREGNANCY AND MATERNITY SERVICES**

Poor and unequal access to health services is believed to contribute to prenatal and antenatal health inequalities. Complex social factors can impact on a woman’s ability to access and make optimal use of prenatal and antenatal care (Health Scotland, 2010). The Health and Sport Committee considered the issue of access to healthcare at its evidence sessions on the 25 March and 1 April 2014.

Maternity services are seen as being well placed to provide health promotion and advice to women and are potentially very important in tacking health inequalities (House of Commons Health Committee, 2009). NHS maternity care services provide a universal service for women and their babies during pregnancy and the early period of an infant's life. They are also seen to have an important role to play in signposting people to wider early years services including social care services, housing services, welfare services and the third sector. In 2012 there were 2,835 midwifery staff in Scotland (ISD Scotland, 2013a) with 58,027 live births (GRO, online). This represents approximately 20 live births per whole time equivalent (WTE) midwife per annum and this has remained fairly constant over the past 5 years.

Maternal and parental circumstances and behaviour during pregnancy have been found to impact on children's outcomes. Alcohol and drug misuse, domestic abuse, smoking as well as diet and maternal nutrition impact on health outcomes at birth, in infancy, and across the whole of a person's life (Scottish Government, 2011b). Health inequalities have been found in terms of low birth weight with more low birth rate babies being born in the most deprived areas (7.1%) compared to the least deprived areas (3.6%) (Scottish Government, 2013).

The Scottish Government’s Refreshed Framework for Maternity Care in Scotland notes that inequalities in access to, and or, the quality of antenatal healthcare received continues to contribute to health inequalities. It states that there is a clear correlation between poorer pregnancy outcomes, including higher rates of maternal and infant deaths and morbidity, in women who book later for antenatal care, attended infrequently or never attend for care. The framework goes on to note that women and babies who are at the greatest risk of poor health outcomes are the least likely to access and/or benefit from the antenatal health care that they need. The framework notes that improving access to antenatal care is insufficient and needs to be accompanied by a focus on continuous, effective, assessment of health and social need in order to identify any prevention and early intervention actions needed before babies are born and in early childhood (Scottish Government, 2011b).
The Scottish Government has established a HEAT\textsuperscript{15} target that at least 80\% of pregnant women in each deprivation group (Scottish Index of Multiple Deprivation (SMID) quintile\textsuperscript{16}) will have booked for antenatal care by the 12th week of pregnancy (gestation) by March 2015 to ensure improvements in breast-feeding rates and other important health behaviours. The Scottish Government’s website notes that there is evidence that women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have a poorer experience of that care. Figure 3 shows the number of women booking for antenatal care by gestation. It is possible to see from this graph that a proportion of women living in most deprived areas book for antenatal care later than those in the other areas. Table 2 shows that 65.2\% women in the most deprived areas had booked antenatal care by 12 weeks gestation compared to 73.7\% of women in the least deprived areas. Barriers for access include women’s perceptions and fears of how they will be treated, fears that their baby may be taken away if they disclose risky behaviour e.g. substance misuse, treatment by and attitudes of staff, poor continuity of care and lack of integrated care, lack of staff knowledge and sensitivity about the impact of social inequities on women’s lives and poor communication between staff and women (Scottish Government, 2011e).

Figure 3: Number of women booking for antenatal care by gestation showing deprivation group for year ending 31 March 2012.

\begin{figure}
\includegraphics[width=\textwidth]{figure3}
\caption{Number of women booking for antenatal care by gestation showing deprivation group for year ending 31 March 2012.}
\end{figure}

\begin{table}
\centering
\begin{tabular}{|c|c|}
\hline
Deprivation Group & No of Women Booking Antenatal Care by 12 Weeks Gestation \% \\
\hline
1 - Most Deprived & 65.2 \\
2 & 70.4 \\
3 & 72.3 \\
4 & 74.5 \\
5 - Least Deprived & 73.7 \\
\hline
\end{tabular}
\caption{Number of women booking for antenatal care by 12 weeks gestation by deprivation group for year ending 31 March 2012.}
\end{table}

Source: ISD Scotland (2013b)

\textsuperscript{15} HEAT stands for Health Improvement, Efficiency, Access to Services and Treatment. It is an internal NHS performance management system that includes targets that support National Outcomes (Scottish Government online).

\textsuperscript{16} The SIMD is a key tool for identifying the ongoing problem of area concentrations of deprivation and the specific issues and challenges that these areas face (Scottish Government online).
Table 2: Percentage of women that have booked antenatal care by 12 weeks gestation by deprivation group for year ending 31 March 2012.

<table>
<thead>
<tr>
<th>Deprivation group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Most Deprived</td>
<td>65.2</td>
</tr>
<tr>
<td>2</td>
<td>71.8</td>
</tr>
<tr>
<td>3</td>
<td>73.9</td>
</tr>
<tr>
<td>4</td>
<td>74.8</td>
</tr>
<tr>
<td>5 - Least Deprived</td>
<td>73.7</td>
</tr>
<tr>
<td>Not Known</td>
<td>71.2</td>
</tr>
<tr>
<td>Total</td>
<td>71.3</td>
</tr>
</tbody>
</table>

Source: ISD Scotland (2013b)

The Scottish Government’s report *Having a baby in Scotland 2013: Women’s Experiences of Maternity Care* presents the national findings of the 2013 Scottish Maternity Care Survey. The results will be used to identify areas for improvement in maternity services in Scotland and to inform future service developments at local and national levels (Scottish Government, 2014b).

More detailed information on the evidence for interventions delivered in the antenatal period such as antenatal classes, smoking cessation, preparation for parenthood, antenatal depression and supporting pregnant women at risk can be found in *Evidence summary: Interventions to support parents, their infants and children in the early years (pregnancy to 5 years)* (NHS Health Scotland, 2012).

Case Study- Bump Start

Bump Start is a project operating in North and North East Edinburgh that provides support for women with higher support needs. It was developed on a health assets model and aims to link health literacy, social capital and personal empowerment to achieve a holistic approach. The core of the approach is one to one outreach work, it recognises that social and community connections are a vital resource, provides links to local services that can provide long term help, liaises with health professionals and embeds the process in a health literacy programme. Part of the project is the development of Pregnancy Cafes which aim to provide parent education for people who traditionally have avoided midwife led parent education classes. The sessions follow a broad curriculum to support pregnancy and parenting led by the parents own interests and the Bump Start health agenda which looks at pregnancy and birth, healthy lifestyle during pregnancy and early childhood, feeding breastfeeding and other choices including healthy baby foods, practical preparations including equipment and home safety, child development and things to do with babies – community opportunities, reading, rhyme and toys (Bump Start, 2012).

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17 Asset models recognise and build on a combination of the human, social and physical capital that exists within local communities (Glasgow Centre for Population Health, 2012).
EARLY CHILDHOOD

Breastfeeding and Nutrition
The World Health Organisation recommends exclusive breastfeeding for the first six months. At six months solid foods, such as mashed fruits and vegetables, should be introduced to a baby’s diet to complement breastfeeding. Breast milk gives babies all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses. Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer, and helps with weight loss. The benefit of breastfeeding continues into adolescence and adulthood, people who were breastfed are less likely to be overweight or obese and are less likely to have type-2 diabetes (WHO, 2014).

The Scottish Government’s policy Improving Maternal and Infant Nutrition: A Framework for Action aims to improve the nutrition of pregnant women, babies and young children in Scotland. It notes that mothers living in areas of deprivation are less likely to take the recommended nutritional supplements prior to pregnancy and have a good diet during pregnancy; they are also less likely to breastfeed and more likely to introduce complementary foods earlier than recommended (Scottish Government, 2011c).

ISD Scotland figures show that there is a clear association between breastfeeding and deprivation. In 2012/13, 41.3% of mothers in the least deprived areas were exclusively breastfeeding at the 6-8 week review, compared with 14.2% of mothers in the most deprived areas. This means mothers in the least deprived areas were nearly three times as likely to exclusively breastfeed at 6-8 weeks compared with mothers in the most deprived areas. A similar pattern is seen in the overall breastfeeding rate (ISD Scotland, 2013). In Sweden the breastfeeding rates are much higher. Of the babies born in 2010 97% were breastfed in the first week, 87% at 2 months and 63% at 6 months (WHO, 2013b).

Health Scotland (2013) has produced national peer support guidance for NHS Boards which is intended to inform professionals in health boards and voluntary sector agencies about the most up-to-date policies and evidence related to breastfeeding peer support.

Case Studies

Best Buddies
Best Buddies is a peer support scheme for new mothers in Edinburgh. The initiative began in order to support people in areas of the city where breastfeeding rates were lowest. Volunteers, who are trained by infant feeding advisors, give encouragement and support to women (NHS Lothian).

Community Mothers
Community mothers is an evaluated breastfeeding support programme in Lanarkshire. It involves local women who volunteer to provide support and encouragement to breastfeeding mothers within their own communities. The volunteers are recruited, trained and supported by midwives who co-ordinate the programme. NHS Lanarkshire has one of the lowest breastfeeding rates in Scotland and Community Mothers is one of initiatives aimed at increasing rates of breastfeeding (NHS Lanarkshire online).

Fun Fit Dundee
A new programme in Dundee for families with children aged 2-4 who are overweight. Includes learning about nutrition, eating on a budget and games and exercises (NHS Tayside online).
Audit Scotland (2010) identified health inequalities in terms of dental health and obesity between children living in the least and most deprived areas of Scotland. With an increasing prevalence of obesity and tooth decay evident in children living in the most deprived areas. Obesity in childhood can lead to physical and mental health problems in later life, such as heart disease, diabetes, osteoarthritis, back pain, increased risk of certain cancers, low self-esteem and depression (ISD 2013d). In 2008 the Scottish Government introduced a HEAT target for NHS Boards to deliver a prescribed number of child healthy weight interventions to eligible children, aged between 5 and 15, in their Board area by March 2011. In 2011 a successor HEAT target was introduced: to achieve 14,910 completed child healthy weight interventions over the three years ending March 2014. The target has also been extended to include pre-school aged children and now covers children aged between 2 and 15. Guidance from the Scottish Government requires that at least 40% of interventions completed should be delivered to children/families from the two most deprived local SMID quintiles (ISD, 2013d).

NHS Health Scotland (2012) provides information on the evidence on interventions delivered in the postnatal period including debriefing following childbirth, breastfeeding promotion, the promotion of bonding, parenting programmes, promoting early cognitive development, preventing early infant problems, promoting the mental health of children and families and supporting families at risk.

Health Visiting and Child Health Reviews

Health visitors are considered to be well placed to contribute to tackling health inequalities (House of Commons Health Committee, 2009). Health visitors:

- Provide support during the antenatal period
- Teach parents about nutrition and healthy lifestyles
- Help parents develop parenting skills and confidence
- Monitor and assess the development, health and wellbeing of babies and young children
  Act as the named professional and first point of contact for all health and wellbeing and child protection issues for children under five
- Are key professionals who support children in the transition to school
- Work with community groups and social services colleagues to promote health in the early years (RCN, 2013)

Part 4 of the Children and Young People (Scotland) Act 2014 provided for a named person for every child. The named person is a single point of contact to provide advice and support to families and to raise and deal with concerns about a child’s wellbeing. Although not set out in legislation it is expected that in practice the “named person” will be a midwife, health visitor, Head, Deputy Head or guidance teacher depending on the age of the child (Kidner, 2013).

As at 30 September 2013 there were 1,316.4 WTE\textsuperscript{18} health visiting staff in Scotland (ISD Scotland, 2013a). Figure 4 shows the number of WTE health visitors between 31 September 2003 and 31 September 2013 (data is not available for 2006).

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\textsuperscript{18} Whole time equivalent
Public Health Nurses, along with health visitors, play a role in contributing to the health and wellbeing of children, young people and families. The focus of professional practice is early intervention, prevention and health promotion for children and families, promoting social inclusion and reducing inequalities in health, addressing key public health priorities and supporting the capacity of families to parent within their local communities through the provision of universal services (Scottish Government, 2011d).

In Scotland there is a programme of child health reviews and screening activities. These are set out in the Scottish Government’s policy documents *Health for all children 4: guidance on implementation in Scotland* (Hall 4), *A new look at Hall 4. The early years: good health for every child* and *The Scottish Child Health Programme: Guidance on the 27-30 month child health review*. The universal programme of reviews currently includes contacts within the first 24 hours and the first 10 days, at 6-8 weeks, at 3, 4 and 13 months, at 27-30 months, on entry to primary school, in Primary 7 and in secondary school. The issues covered include neonatal hearing screening, child development, parental concerns, family relationships and home learning environment (Scottish Government, 2014c).

The inverse care law has been found to operate in relation to child health reviews. Research carried out by NHS Scotland, in 2012, on child health reviews found that the inverse care law continues to operate in relation to universal child health reviews. It reported that coverage is lower in the most deprived groups for all reviews, and the discrepancy progressively increases for reviews at older ages (Wood et al, 2012).

**Family Nurse Partnership**

The *Family Nurse Partnership* is a voluntary programme for young, first time mothers. It offers intensive and structured home visiting delivered by specially trained family nurses from early pregnancy, before 28 weeks, until the child is 2 years old. It aims to improve pregnancy outcomes, child health and development and the mother’s economic self-sufficiency (Scottish Parliament Health and Sport Committee, 2013). The Health and Sport Committee heard evidence on the Family Nurse Partnership programme in its *Inquiry into Teenage Pregnancy*.

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19 The inverse care law was first described by Tudor Hart, in 1971, to describe the relationship whereby the availability of good medical care tends to vary conversely with the need for it in the population served (Watt, 2002).
CHILD DEVELOPMENT AND EARLY EDUCATION

The development of secure emotional attachment has been found to play an important role in a child’s development (Bowlby, 1958; Ainsworth, 1989). In 1951 Bowlby wrote:

“Just as children are absolutely dependent on their parents for sustenance... parents, especially... mothers, (are) dependent on a greater society for economic provision. If a community values its children it must cherish their parents” (as cited in Bretherton, 1992)

The Growing up in Scotland survey reported that children who experienced low levels of attachment, warmth or joint activities were twice as likely to have poor health at the age of five compared to children who had received optimal parenting (Scottish Government, 2014).

There are a number of organisations that work with parents and carers to enhance children’s learning and development. For example, the Parents Early Education Partnership (PEEP) is a charity which aims to:

- Promote parents' and carers’ awareness of children’s very early learning and development through making the most of everyday activities and interactions
- Support parents/carers in their relationships with their children, so that the children’s self-esteem will be enhanced
- Affirm the crucial role of parents/carers as children’s first educators
- Support parents/carers in the development of their children’s literacy and numeracy
- Support parents/carers so that they can encourage the development of positive learning dispositions
- Promote and support parents' and carers’ lifelong learning

Over 150 PEEP groups take place each week across Scotland (PEEP online).

There are also a number of nationwide initiatives available to all parents, including:

- The Scottish Book Trust's 0 to 5 programme which includes 'Bookbug' and provides books to all children in Scotland in the first year, between 1 and 2 years, at 3 years and primary one (Scottish Book Trust online)
- PlayTalkRead, is a Scottish Government marketing campaign that was launched in 2009 it combines Bookbug, advertising and roadshows to encourage positive parenting

Early child education and care has been an area of much commentary and is the subject on recent policy debate. Melhuish (2014) cites evidence that highlights the benefits of early child education and care. He notes that stimulating high quality care can benefit all children but can particularly help children from poorer backgrounds and can also help reduce poverty through enabling parental employment. He notes that “the universal provision of early education centres that integrate education, childcare, parental support and health services…..will reduce inequality, increase wellbeing and enhance economic productivity”. Detailed information on pre-school education and childcare can be found in SPICe briefing 11/51 Early Years – Subject Profile (Kidner, 2011) and 11/51 Early years – Subject Profile. (Kidner, 2014).
SUPPORT FOR PARENTS AND PARENTING EDUCATION

There are a wide range of projects in Scotland which aim to provide integrated support to vulnerable families. No comprehensive national overview is available. However, some examples are provided below.

Family Centres

In 2012 there were 140 family centres in Scotland (Care Inspectorate, 2013). These tend to combine childcare, pre-school education and various types of parental support and support services for families which can be adapted to meet local needs. They are usually managed by voluntary organisations or by the local authority’s social work or education department (Scottish Government, 2010a). In the report Joining the Dots, Susan Deacon recommended increasing this type of provision.

“Where children and family centres work well, and offer a range of childcare, activities, services and support - as well as valuable opportunities for parents to volunteer and to support one another – they can have a major beneficial impact on the wellbeing and development of young children, the family and the wider community. When coupled with effective outreach work they can often engage with parents and children who might otherwise not seek - or be offered - support from which they could greatly benefit.” (Deacon 2011).

Parenting Skills Courses

The Marmot Review (2010) cites evidence that parenting courses can benefit parents and children by improving maternal psychosocial health, improving behaviour and emotional adjustment of children under 3 years old, contributing to safer home environments and reducing unintentional injuries. The review goes on to note that the quality and consistency of delivery are critical to the effectiveness of such programmes.

A number of different parenting courses are available in Scotland, these include:

- The **Triple P positive parenting programme** which is a multilevel parenting and family support strategy aimed at preventing behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents (Triple P online).

- **Mellow Parenting** which is a Scottish based charity. It has developed a family of programmes to support parents and children in making good relationships. The foundation of the programmes is attachment theory with particular emphasis on the transmission of attachment and relationship styles across generations (Mellow Parenting online).

- The **Incredible Years** which is a research-based programme for reducing children's aggression and behaviour problems and increasing social competence at home and at school. The programme encompasses parent training, teacher training and child social skills training approaches (Education Scotland online).
Third Sector Organisations
There is a wide range of charities operating in Scotland that provide support to vulnerable children and families.20

- **Barnardo’s Scotland** works across Scotland and aims to reach out to the most disadvantaged children, young people, families and communities to help ensure that every child has the best possible start in life. Barnardo’s currently operates more than 122 community-based services ([Barnardo’s online](#)).
- **Children 1st** provides a range of services which promote the safety and wellbeing of children and young people. This includes a phone help line, parentline, which has been operating since 1999. They also run a number of Supporting Children and Families services across Scotland ([Children 1st Online](#)).
- **Homestart** is a UK wide charity that supports families that have a child under the age of 5. It operates a volunteer home visiting programme. Homestart supports many families who are facing difficult life circumstances such as drug or alcohol dependency, domestic violence and social care involvement in the family ([Homestart online](#)).
- **NSPCC** is a UK wide charity which aims to end cruelty to children in the UK. The NSPCC creates and delivers services to protect children, provides advice and support for adults and professionals worried about a child, works with organisations to ensure they effectively protect children, and challenge those who do not, and campaigns for changes to legislation, policy and practice in order to keep children safe ([NSPCC online](#)).

Case Study - **3D Drumchapel**

3D Drumchapel is a charity based in Drumchapel in the West of Glasgow which works with children and families providing a range of activities and support. Services include parent and child sessions, family time, learning and development workshops, issue-based workshops, home visits and volunteer development ([3D Drumchapel online](#)).

**RESILIENCE21 OF CHILDREN**

Children are not passive they also influence the environment they grow up in and individual children will respond to it in different ways. Melhuish (2014) notes that many children from disadvantaged backgrounds go on to develop into healthy adults but this may be due to their own personal agency or protective factors within their family and/or community. The Growing Up in Scotland report *Health Inequalities in the Early Years* focused on health inequalities and the factors associated with avoiding negative outcomes among disadvantaged children. It reported that a number of factors such as consumption of fruit and vegetables and higher levels of physical activity are associated with the avoidance of negative outcomes. Possible associations were also suggested with measures relating to housing tenure stability, major life events, parental feelings about household income and the home learning environment. Neighbourhoods were also identified as providing an important source of resilience for families. The extent of social support (such as attending parent and child groups) also appeared to be associated with avoiding negative outcomes (Scottish Government, 2010b).

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20 This list highlights some of the work currently being undertaken and should not be seen as a comprehensive overview.

21 Resilience is related to the ability to overcome adversity, doing well against the odds, coping and recovering ([Action for Children, 2007](#))
EXAMPLES OF CHILD HEALTH AND WELLBEING DEVELOPMENT PROGRAMMES

Table 3 shows that higher levels of equality in child wellbeing, measured in terms of maternal, educational and health, have been found in Denmark, Finland, the Netherlands and Switzerland compared to 20 other OECD\textsuperscript{22} countries. Fourteen of the 24 countries were rated higher than the UK in terms of equality in child wellbeing. In terms of maternal wellbeing the UK\textsuperscript{23} was found to have higher levels of inequity than the OECD average (UNICEF Innocenti Research Centre, 2010).

Table 3: Inequality in child well-being in 24 OECD countries

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country\textsuperscript{24}</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 – More equality</td>
<td>Denmark&lt;br&gt;Finland&lt;br&gt;Netherlands&lt;br&gt;Switzerland</td>
</tr>
<tr>
<td>7</td>
<td>Iceland&lt;br&gt;Ireland&lt;br&gt;Norway&lt;br&gt;Sweden</td>
</tr>
<tr>
<td>6</td>
<td>Austria&lt;br&gt;Canada&lt;br&gt;France&lt;br&gt;Germany&lt;br&gt;Poland&lt;br&gt;Portugal</td>
</tr>
<tr>
<td>5</td>
<td>Belgium&lt;br&gt;Czech Republic&lt;br&gt;Hungary&lt;br&gt;Luxembourg&lt;br&gt;Slovakia&lt;br&gt;Spain&lt;br&gt;United Kingdom</td>
</tr>
<tr>
<td>3 – Less Equality</td>
<td>Greece&lt;br&gt;Italy&lt;br&gt;United States</td>
</tr>
</tbody>
</table>

Source: UNICEF Innocenti Research Centre (2010)

The following section provides some examples of child health and wellbeing development programmes from the UK and further afield. It is not intended to provide a comprehensive guide to what is available in each country but rather highlight some of the programmes that are currently operating.

\textsuperscript{22} The Organisation for Economic Co-operation and Development

\textsuperscript{23} Information for Scotland is not available

\textsuperscript{24} (displayed alphabetically with groups)
**ENGLAND AND WALES**

Sure Start

The Childcare Act (2006) defined a Sure Start children’s centre as a place or a group of places:

- Which is managed by or on behalf of, or under arrangements with, the local authority with a view to securing that early childhood services in the local authority’s area are made available in an integrated way
- Through which early childhood services are made available (either by providing the services on site, or by providing advice and assistance on gaining access to services elsewhere)
- At which activities for young children are provided

In England there is a network of over 3500 Sure Start children’s centres which provide family support, interventions to improve parenting and the home learning environment, advice on employment and benefits, health advice and social facilities which allows parents to meet in a child-friendly setting. Funding comes mainly from central government and is weighted according to poverty levels (WHO, 2013). The core purpose of children’s centres is to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in terms of child development and school readiness, parenting aspirations and parenting skills and child and family health and life chances (Department for Education, 2013). Sure Start programmes have been found to be effective in improving some outcomes among nine month (directly) and three year old children (indirectly) in relation to social and emotional development and in the cognitive development of pre-school children (including positive behaviour, independence, better parenting and home learning environment) (NHS Health Scotland, 2012).

Sure Start Scotland was introduced in 1999/00 and had the same basic principles as Sure Start in England and Wales although it was generally left to local authorities to develop and funding was not ring-fenced. Following the publication of the Scottish Government’s Early Years Framework in 2009 national policy no longer referred to Sure Start although the framework promoted similar kinds of provision (Kidner, 2011).

**THE NETHERLANDS**

**Baby and Toddler Health Centres**

In the Netherlands Baby and Toddler Health Centres are responsible for vaccination, health and development screening and educating young parents on nutrition, hygiene and family health care. The centres are accessible and located in neighbourhoods and can be accessed free of charge. A child visits the centre eight times in their first year, a 14 and 18 months and then each year until just before their fourth birthday (when they start primary school). The centres also have a home visiting programme consisting of two home visits when the child is first born and within two weeks (WHO, 2013b).

**Maternity Care**

Mothers in the Netherlands are provided with 40-50 hours of maternity care by licensed maternity nurses within the first eight days of their child’s birth. This service includes supporting and educating the mother about topics such as breastfeeding, caring for the baby, modelling care behaviour, performing light household chores, caring for other children in the family and monitoring the health of the mother and the baby. This service is organised and financed by health insurance companies and it is part of the standard insurance policy that is compulsory for everyone in the Netherlands (WHO, 2013b).
SWEDEN

Programmes for Pregnancy and Early Infancy
In Sweden parents are offered support during pregnancy and early infancy within the maternity care services and child healthcare services at open pre-schools and family welfare centres. Parent education, delivered in group sessions, is offered to 98% of first time parents and 60% of repeat parents. Parents normally meet six times and each session lasts around 2 hours and has around 13 participants. The aim of the sessions is to offer knowledge and to provide an opportunity to meet others. Special groups exist for young mother, single mothers and people expecting multiple births. Midwives have reported that between 8 and 10% of their working time is spent on parent education.

Case Studies

Leksand Model
A new organisational model for parent support was developed in Leksand and this has been repeated in other areas of Sweden. It has also been used in Finland, Russia and Denmark (Wave Trust, 2012). In the Leksand model, parenting groups are established in pregnancy but the same groups of parents continue to meet after the baby has been born and continue to meet as the children get older and the families have subsequent children. The advantage of this approach relates to the strengthened relationships between the parents, higher levels of participation by fathers, and the ease at which the group can choose to continue to meet as the children grow older. The groups are led by one of the parents, midwives and nurses participate but do not lead the groups. It has been reported that this enables parents from different social classes to feel relaxed in the groups (Swedish National Institute of Public Health, 2006).

Right from the Start
This is an 8 week video and manual based parenting programme for parents of small children. It is based on attachment theory and is also being used in Canada. This aims to enhance parent-child interaction and facilitate secure attachment.

International Child Development Programme
This is a group programme for parents with small children and also exists for parents with preschool and school-aged children. The programme aims to develop positive interaction between adults and children and is built around eight interactive themes (Swedish National Institute of Public Health, 2006).

Child Health Centres
In Sweden, Child Health Centres are financed by local taxes. The majority are nurse run and GPs or paediatricians work 3 or 4 hours a week at the centres as part of their consulting services. The centres also include psychologists, orthoptists25, audiology assistants and dentists. Children and parents attend child health centres between 14 and 20 times in the child’s first year and then annually until the child starts school. Parents are offered a chance to participate in nurse-led parent groups during their first year on topics such as children’s need for love, contact and bonding, normal development, safety, parenthood, relationships, smoking and alcohol. Checklists on safety in homes and cars are also distributed and discussed at certain ages (WHO, 2013).

25 Orthoptists investigate, diagnose and treat defects of binocular vision and abnormalities of eye movement (NHS Careers Online).
PORTUGAL

The Association Aprender em Parceria (A PAR) programme
The A PAR programme was established to reduce social, educational and health problems. This is an early childhood intervention that aims to support and help the parents of young children living in disadvantaged areas. It is similar to the PEEP programme that operates in the UK. The A PAR programme aims to promote positive bonding between parents and children, self-esteem, positive attitudes towards learning, achievements in numeracy and literacy and improve the social support between families and within communities (WHO, 2013b).


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