INVESTING IN EARLY CHILDHOOD TO DELIVER ON OPPORTUNITY AND HEALTH MISSIONS

February 2025

Introduction

This submission covers investments necessary to deliver on the Government's Opportunity, focusing on interventions that best **support the achievement of the Prime Minister's early years (EY) milestone to increase the number of children reaching a good level of development at age 5 to 75% by 2028.** It also supports the aims of the Health Mission to increase healthy life expectancy and reduce health inequalities.

The rationale for focusing on early childhood is strong; as the period of life where intergenerational transfers of poor outcomes first occur and the foundations for future opportunities laid. The UN Committee on the Rights of the Child highlights that 'investment in early childhood development has a positive impact on children's ability to exercise their rights, breaks poverty cycles and brings high economic returns'. Investing in this time period, could be viewed as a form of social infrastructure, offering the most effective time for a government to intervene to help break entrenched patterns and thus improve education, health, wellbeing, and employment outcomes throughout childhood and into adulthood. **Reducing disparities and improving outcomes at this early age has the potential to pay dividends to the economy in the medium to long term.**

Evidence for investing in early childhood has long been known, but consistent policies and funding have not historically followed suit. Analysis by Pro Bono Economics reveals that spending on early intervention services (including Children's Centres and under 5 services) has fallen by 44% since 2010-2011 and now accounts for less than a fifth of total spending on children's services. **The Prime Minister's milestone could change this, should it spur investment in interventions that meaningfully address the root causes of disparities in early childhood development.** In doing so, such investment would also help the UK to meet its obligations under the UN Convention on the Rights of the Child (UNCRC).

This submission sets out a range of cross-departmental investments (DWP, DfE and DHSC) that combined, will support the achievement of the Prime Minister's EY milestone whilst working to achieve the Opportunity Mission's intention to break the link between background and achievement. It includes the following sections:

- **About the EY milestone:** key dimensions of the goal that need to be considered when targeting funding,
- **What matters for achieving good early childhood development:** an evidence-based theory of change for early childhood interventions,
- **Calls for investment:** recommended interventions for investment, with cost-benefit cases across 3 domains of support
    - Increasing family incomes
    - Early Childhood Education and Childcare
    - Health, wellbeing and support needs of parents, babies and young children

About the EY milestone

The goal is based on the Early Years Foundation Stage (EYFS) profile for children in England aged 4/5 years – captured at the end of the first academic year in which children turn 5. Often referred to as 'school readiness', **it is essential that it is not reduced to an academic assessment, rather recognised for being a picture of a child's interconnected brain and bodily development.**

The EYFS profile is based on children's skills and capacities as assessed against 17 goals, across seven areas of learning: communication and language; personal, social and emotional development; physical development; literacy; mathematics; understanding the world; and expressive arts and design. Thus, capturing a relatively holistic picture of a child's development, albeit with a bias towards those skills that most support a child's capacity to thrive at school. In order to reach a rating of 'good', children need to meet 'expected' levels of development across 12 areas of learning in the first 5 of these domains.

The assessment methodology does not offer a perfect way of assessing the national state of children's development. It is currently not moderated, and also does not capture information for all children in the UK. Firstly, because this is an England only measurement, and second because it only captures information for those children who attend school. However, **it is the most systematically collected information available as to children's early childhood development** at this age, with development checks at 2.5 years collected by health visitors not consistently collected or shared in a way that can be monitored nationally.

There are other indicators relevant to predicting health and education outcomes, which could be used to indicate likely progress towards improving early childhood development, including birth weight, infant feeding practices, vaccination rates as well as the 2.5 year development checks as referenced above. Where relevant, evidence is provided for interventions which are proven to have a positive impact on these indicators too.

The children who are and aren't meeting this goal

In 2022/2023, 67.7% of children in England were assessed as having a 'good' level of development, with **almost a third or approximately 200,000 children each year are not reaching this level aged 5**. Therefore to reach the 75% target (a 7.3% improvement on the latest figures), just under 45,000 more children need to be reaching a 'good' level by 2028. Whilst this figure has been critiqued for not being ambitious enough, **after more than a decade of disinvestment from early childhood services and in the face of rising child poverty, achieving this outcome will only be reached with significant additional investment being made.**

Within these figures there are significant variations as to who reaches this target. Age is key factor with children born in the winter term significantly more likely to be at a good level of development than their younger peers. Girls are also more likely than boys to reach the target across all ethnic groups. **Characteristics of inequality are also a strong predictor for reaching this goal. For instance, only 51.5% of children on free school meals reached a 'good' level of development, 16 points below the national average.** Areas with the highest concentrations of families living in deprivation saw scores on average 18.5% below areas with the lowest concentration of deprivation. Despite this, there are local authorities where income related gaps were reduced, for instance in Newham 66.8% of children on FSM were assessed as having a good level of development, 15 points above the national average for this group,

showing it is possible to disrupt this trend. Children with special educational needs (SEN) are the least likely group of children to reach a good level of development, with an average of 19.7% assessed as reaching that level. Whilst this figure disguises considerable complexity and variation in needs, the fact that in some local authorities over 30% are reaching a good level, whereas in others it is less than 10% suggests that inequalities in provision and support plays a role in outcomes.

When determining what interventions to invest in to meet the milestone, **it is essential that action to reduce the disparity in outcomes at this age for different groups of children forms part of funding assessment criteria.** Under its UNCRC obligations, as set out by the UN Committee on the Rights of the Child, **Governments' are required to address inequalities among children by increasing or reprioritising budgets to help reduce those disparities.** Investments therefore need to be judged not only on whether they increase the number of children reaching the target, but on the basis of which children they are supporting, and whether they are working to reduce disparities or inadvertently widening outcome gaps that already exist. **To support in the achievement of this, UNICEF UK recommends that the spending review is subject to a Child Rights Impact Assessment (CRIA).**

What matters for achieving good early childhood development

The UNICEF and WHO Nurturing care framework sets out what children need to develop healthily. The framework reflects the fact that all aspects of a child's development beginning before birth are interconnected and that the health and wellbeing of parents and care-givers underpin its success. Therefore, **to be effective, early childhood development policies need to reflect the interconnected nature of brain and body develop**. This poses a challenge to traditionally siloed health, education and social security measures implemented along department lines, but responds well to the integrated intention of the Opportunity Mission.

Nurturing Care framework for good early childhood development

Good health	Refers to the physical and mental wellbeing of the child as well of the parent or caregiver, necessary to support their physical, cognitive and social and emotional development and protect them from ill-health
Adequate nutrition	Ensuring both the mother (particularly during pregnancy and whilst breastfeeding) as well as the child receives necessary nutrition to support healthy growth as well as supporting attachment and responsive care
Safety and Security	A safe and secure environment for the child and their families, free from physical dangers, including abuse and neglect, emotional stress as well as environmental risks
Opportunities for early learning	Opportunities for babies and young children to interact with people, places and objects in their environment. Reflecting that all interactions (positive, negative or absence of) contribute to brain development and lay foundation for later learning
Responsive caregiving	Ability of parent or caregiver to notice, understand and respond to their child's signals in a timely and suitable manner. Considered the foundational component as responsive caregivers can are better able to support the other four components

For each component of the framework there are risk factors, such as exposure to violence as well as protective practices, such as responsive feeding or responsive care practices which

effect outcomes. There is significant evidence as to the impact of toxic stress on a baby and young child's development. This means interventions aimed at improving early childhood development must consider two approaches: i) reducing risk factors and the underlying causes that increase the likelihood of toxic stress occurring and ii) increasing protective practices and access to support in the home and community.

Poverty is a commonly associated factor for a host of risks to early childhood development. **Babies and young children who grow up in poverty are more likely to have poorer health, education and economic outcomes throughout their lives.** The impact of poverty can result in lower birth weights, an increased likelihood of chronic diseases such as asthma, as well as tooth decay, malnutrition, obesity, and diabetes

Low-income families are less likely to have the resources to consistently provide protective factors that support development. Polling from UNICEF UK[iv] found how the experience of poverty and living on a low income is impacting parents and young children's lives. Parents reported cutting back on essential activities to support their child's learning and missing out on local support and services that can support their child's early development. For example, two-thirds of parents of 0-4 year olds (66%) have had their family lives negatively impacted by the rising cost-of-living (66%) and of these:

- More than 4 in 10 (43%) have cut down on activities their children go to (e.g. playgrounds and sports clubs);
- And 4 in 10 (39%) have reduced their spending on books, toys or crafting materials for their children.

When looking specifically at parents of 0-4s year olds from low-income households (£19,999 or lower per year):

- 1 in 4 (25%) cannot afford to take their child to baby groups and other activities to support their child's learning;
- And more than 1 in 3 (35%) cannot access services such as children's centres or family hubs in their local area.

Reducing the number of children born into and growing up in low-income families must therefore be considered a priority intervention by Government for improving early childhood development outcomes (see Call for Investment 1). Further, **interventions that provide support to families must be tailored to ensure they meet the needs of families on low incomes that have most to benefit from this support.**

Parents and caregivers, and their capacity to provide nurturing care to their children, are core to this framework and should be supported by the Government to do this. For parents and caregivers to be empowered to provide this care, not only do they need to have the money to cover the costs of essentials and provide a safe home, they also need to have access to essential health and education services for themselves and their children, as well as the personal knowledge, skills and capacity to meet their child(ren)'s needs.

Supporting **early childhood development therefore requires a holistic suite of interconnected interventions**. It is challenging to distinguish the efficacy of individual early childhood interventions, and potentially self-defeating where efforts to isolate effects of individual programmes overlook the cumulative effects of parents and children receiving multiple forms of support.

This submission therefore groups interventions into three broad groups, presenting existing evidence and the case for specific investments where available:

1. Increasing family incomes – social security approaches to reducing child poverty and improving early childhood outcomes
2. Improving access to formal learning opportunities through early childhood education and childcare (ECEC)
3. Meeting the health, wellbeing and support needs of parents, babies and young children including in their home environment

Following more than a decade of reduced investment in early childhood services and spending on benefits that support children there is not a cheap or quick fix to improve early childhood outcomes. The Calls for Investment set out below are therefore a starting point on which to build in future spending rounds.

Calls for Investment across DWP, DfE and DHSC

1. Increasing Family Incomes – financial mechanisms to reduce child poverty and improve early childhood outcomes *(primary department of interest, DWP)*

Recent trends in child poverty show that the UK saw the biggest increase in child poverty levels of OECD and EU countries between 2012/14 and 2019/21, a 20% increase. Households with young children are at an increased risk of experiencing poverty and of the 4.3 million children living in poverty in 2022/23, 50% of those were in a household with the youngest child under 5.

Investing in social security that increases family incomes and providing financial support at the most vulnerable times of a child's development, **is the most direct mechanism the Government has to reduce child poverty** and is proven to be effective at improving child outcomes. A review of 34 studies investigating the impact of money on children's outcomes found that an increase in income of around £860 in 2017 prices was associated with improvements in children's cognitive outcomes by between 5-27% of a standard deviation.

The below Calls for Investment are first steps that the UK Government could take to begin tackling child poverty in a way that supports early childhood development, but would not be enough to end child poverty. UNICEF UK is currently working on additional analysis of policies that could eradicate child poverty including analysis of changes to Child Benefit, parental leave entitlements and a further expansion of ECEC. Once ready, this analysis will be shared with relevant Government teams.

1.1 Call for Investment: Fund the removal of the Two-Child Limit and the Benefit Cap for all families in receipt of Universal Credit

There are currently 1.6 million children affected by the two-child limit. Due to the way in which the policy was designed, it immediately impacts babies in households affected by the limit as soon as they are born and all children currently affected are age seven and under. A quarter (25%) of all households affected by the limit are one parent households with a child under 3 years old. 87% of households affected by the Benefit Cap include children and 57,000 families with a child under age 5 are impacted by the Benefit Cap.

Although separate policies, the two-child limit and Benefit Cap must be abolished together so that families with children currently affected by the Benefit Cap are eligible for any changes in

benefit entitlements as a result of the two-child limit being abolished. CPAG estimates that there are around 150,000 children impacted by both the two-child limit and the benefit cap. For these families, only removing the two-child limit would not make a difference to their household income, as their benefit entitlements would still be limited by the Benefit Cap.

How removing the two-child limit would support early childhood development

Research by Nesta on how the two-child limit impacts child development demonstrated how this policy is resulting in negative consequences for both parents and young children. The research found that parents experienced diminished opportunities for children's learning and early education for their children. It also highlighted that severe and increasing financial hardship resulted in lowered mental health for both parents and children and decreased parenting capabilities. As highlighted above parents play a significant role in supporting their child's early development. Poor parental mental health is a key risk factor for children's development as it can affect the quality of the parent-child relationship.

Cost-benefit case for removing the two-child limit and benefit cap

NEF analysis suggests that by ending both of these policies the Government will immediately lift 280,000 children out of poverty and reduce the depth of poverty for an additional 980,000.

The same analysis also estimates benefits to the wider economy, suggesting that GDP would increase by up to £1.5bn in the first year if both policies were abolished. Further benefits to the wider economy include implications due to the reduction in child poverty levels by the end of the current parliament, including:

- Lower demand for public services by £1.7bn a year in the medium term
- Result in higher annual net earnings by £1bn over the longer term, with an additional £540m returned to the government through taxation and lower spending on social security.

Estimated Cost: New Economics Foundation (NEF) analysis estimates the cost to be **£2.5bn a year**, rising to **£3.5bn by 2029/30.** The analysis estimates that the two-child limit accounts for most of these costs at £1.9bn a year from April 2025 and £2.6bn a year by 2029/20.

1.2 Call for Investment: Fund the expansion of eligibility of the Sure Start Maternity Grant beyond the first child and increase its value in line with the Scotland Pregnancy and Baby Payment

The Sure Start Maternity Grant provides a one-off cash payment to help with the costs of a newborn. The grant is currently available for parents in receipt of Universal Credit for the first child only. The value of the grant is £500, and this value has not increased since 2002. The costs associated with having a new baby have increased during this time, meaning that the value of the grant has diminished significantly in real terms since it was first introduced.

The Scotland Pregnancy and Baby Payment is worth £754.65 for the first child and £377.35 for subsequent children. The value of this more generous grant more closely reflects real terms value of an increased Sure Start Maternity Grant. It also recognises that further grants are required to help families respond to costs associated with subsequent children, whilst reflecting the fact costs may be lower due to reuse of items purchased for the first child.

What happens during pregnancy can impact children's early development and may also have impacts on later health and wellbeing outcomes. Supporting parents throughout pregnancy can help to lay the foundations for children's healthy development. Increased income during this time enables expectant parents to purchase the resources required for a healthy pregnancy, including healthy foods, attending classes and also purchasing necessary items for the arrival of their baby. An increase in income during this period can also reduce stressors during pregnancy, which is essential for a healthy pregnancy.

Cost-benefit case for expanding the Sure Start Maternity Grant in line with value of the Scottish Pregnancy and Baby Payment

Whilst evaluations of the impact of the Sure Start Maternity Grant are not available, previous analysis of the Health in Pregnancy Grant (a universal grant) that was in place between 2009 and 2011 found that **the provision of such benefits in pregnancy improves infant health, including increases in birth weight and reduced prematurity by 9-11%.** Low birthweight is associated with a range of poorer health and development outcomes including reduced growth, cognitive development and neurodevelopmental conditions.

This analysis found that the benefits of the Health in Pregnancy Grant were **most significant for babies born to younger mothers, particularly those on low incomes and suggests that the effects could be in part due to a reduction in stress during pregnancy because of the grant.**

Estimated Cost: £65 million. This represents an increase of **£39 million** to the current estimated cost of the one-off £500 payment being made to the first child only.

Costing calculations: 605,479 births in 2022 of which 43.4% were first born children. 20% children live in households receiving UC. Assuming birth rate is same for UC households as rest of population then c120,000 births per year will be in households receiving UC and therefore potentially eligible for the Sure Start Maternity Grant.

- *£39.3m for the first child (120,000*0.434*£754.65)*
- *£25.6m for subsequent children (120.000*0.566*£377.35)*

*Total cost **£64.9m. Including existing estimated cost of £26m** (calculated at 120,000*0.434*£500)*

We do not have data on current take-up of the SSMG, but take up rates are rarely 100%. For example, take up of the Healthy Start scheme is around 65%. It's likely that costs might be lower based on actual take up. Families receiving Universal Credit will likely fluctuate, affecting eligibility numbers.

2. Improving access to formal learning opportunities through early childhood education and childcare (ECEC) *(primary department of interest, DfE)*

The Government has already made significant commitments to expanding ECEC entitlements and have made it clear that they see access to ECEC as essential for the achievement of the EY milestone. Access to high quality learning through early childhood education and childcare is a well acknowledged route to supporting children's development. This is particularly true for children from disadvantaged backgrounds when quality of provision is high and is accessed at a young age and for a sustained period. The SEED Study found that for the 40% most

disadvantaged children, using a minimum of ten hours per week of formal early education and childcare no later than age two, combined with a mean use over twenty hours per week between age two and the start of school, increases the chances of achieving expected EYFSP levels in school reception year and improves children's verbal ability in school year one. Universalising access to ECEC provision would support all children in meeting the good level of development but particularly those children currently locked out of funded provision.

Multiple longitudinal studies including the Effective Pre-school, Primary and Secondary Education Project (EPPSE) and the Study of Early Education and Development (SEED) show evidence that children who attended quality pre-school provision had better learning outcomes in the short and long-term. These benefits were compounded for those children from low-income backgrounds. Children who attend high-quality ECEC are more likely to succeed in school, graduate and secure good jobs. They are less likely to engage in criminal activities or rely on social welfare. OECD analysis estimates the return on investment to be substantial.

However, there is a strong risk that the investment currently being planned, will not sufficiently shift the dial on early childhood development outcomes unless it is expanded to reach those children who stand the most to gain from it and is of sufficient quality. The interventions highlighted below are therefore focused on closing gaps in access and improving quality of provision particularly for children from low-income families.

2.1 Call for Investment: equalise access to government-funded hours for all children from two years old irrespective of their location, parents' employment, or immigration status

Access to ECEC is currently limited for some children with their eligibility to funded hours determined by family income/working status. Most of the country's poorest families are excluded from the government's flagship entitlement of 30 hours of funded early education and care (Sutton Trust 2021). This further entrenches disadvantage because families who are struggling most are locked out of accessing one of the best routes out of poverty for their children: high-quality early years education (IPPR 2024) Additionally, current policy restricts access by refuges and asylum-seeking children because it is based on parents' ability to work (UNICEF 2023). Gaps in participation in ECEC can be addressed by equalising access to government funded hours.

Cost-benefit case for equalising access to 30 hours of funded early education

High public and private rates of return on quality ECEC are well evidenced, particularly for the most disadvantaged (UNICEF 2019). Future fiscal benefits for children from low-income households are estimated to be more than 2:1 (New Economics Foundation 2023). An ECEC system that is focused on giving every child the best start in life and reducing inequalities is therefore an indispensable component of a wider approach to early learning that can be transformational for children, their families, society and the economy.

Estimated costs: Sutton Trust (2024) estimates that expanding the 30 hour offer to all 2,3&4 year olds **would cost an additional 600m-1.3bn to the currently planned scheme expansion**

- Universalising 30 hour offer for all 3 & 4 year olds **additional £270m - £510m**
- Universalising 30 hour offer for all 2 year olds. Estimated cost: **additional £330m - £810m**

This figure would need to be adjusted to account for children who are currently not eligible and fall between the two existing offer categories of disadvantaged children and working parents.

These are based on assumptions of extending the 30 hour entitlement, 38 weeks per year, to families on low incomes and keeping the £100,000 salary cap. Additionally, in 2025/26, when 'working families' of two year olds become entitled to 30 hours per week, extend this also to low income families.

2.2 Call for Investment: increase the rate of Early Years Pupil Premium (EYPP) to match that of children in primary schools

In April 2015 DfE introduced the Early Years Pupil Premium (EYPP) to provide additional funding for young children from disadvantaged backgrounds. The main purpose of this funding is to help prepare young children for schooling. Currently the EYPP is paid at half the rate of Primary Pupil Premium (it only applies to part-time entitlement hours) resulting in an inequity of funds between children in nursery and those in primary school.

To provide vital targeted supported for disadvantaged children, the Early Years Pupil Premium should be increased to a per hour rate equivalent to the primary school Pupil Premium. Increasing the rate would better meet the additional needs of this group, allowing settings in the most disadvantaged areas to, for example, invest in staff professional development, and recruit a better qualified workforce. This targeted intervention for disadvantaged children would support them to achieve the 'good level of development'.

Cost-benefit case for increasing EYPP

In England's education system, pupil premium is one of the most important tools available for addressing the link between family income and education outcomes (Education Endowment Foundation 2023)

Whilst there have been no formal evaluations of cost effectiveness of EYPP, this targeted intervention, we point to the Evaluation of Early Years Pupil Premium which found its use resulted in:

1. an increased focus by frontline staff to consider ways to better support and provide for eligible children, including those with additional needs;
2. an improved awareness and understanding of children's family backgrounds and ways to provide wrap-around support;
3. Two-thirds (65%) of group-based and 73% of school-based providers said EYPP helped them to increase the services they provide to disadvantaged children. (Department for Education 2017)

Estimated cost: £203m / year. This represents an **increase of £135 million** to planned expenditure

Costing calculations: Based on Primary Pupil Premium of £1480 per child. Recent EYPP uplift from £388 per year to £570 (46.9%+) per year totalling £25m. To uplift to Primary level of £1480 per year, assuming £25m/46.9% = £533k per 1% increase, £1480PP/£388. EYPP = 381% increase x £533k = £203m).

*Current 2024/5 budget £68 million meaning policy requires an **additional £135 million***

2.3 Call for Investment: fund a national workforce strategy for early years settings covering recruitment; retention; pre-service and in-service training; and career pathways

Research highlights a strong relationship between the level of staff qualifications and the quality of early childhood education and care (Manning 2019, Nuffield 2021). NESTA (2023) analysis suggests that local authorities with a higher proportion of early years settings staffed by graduates also tend to achieve better outcomes for children.

In the OECD area (2025), the most prevalent qualification required for teachers is a bachelor's degree or equivalent. But in England, despite recent reforms, qualification levels vary across the sector and currently only 11% of group based employees are graduates (DfE 2024).

Internationally, ECEC systems including Estonia, New Zealand and Ireland are advancing workforce plans for the development of graduate leadership.

2.3.1 Graduate Leadership Fund

A Graduate Leadership Fund should be introduced to help ECEC settings to attract graduate qualified staff with enhanced pay and status, with the long-term aspiration of having a qualified teacher in every setting. The fund (as per the previous Graduate Leader Fund) would include both Recruitment Incentives to incentivise providers to employ a graduate and a Quality Premium to reward settings where staff achieve graduate Early Years Teacher status to support salary enhancement. Against a backdrop of high workforce turnover, such a policy intervention is also likely to support workforce retention and thereby reduced cost for ECEC providers.

Cost-benefit case for Graduate Leadership Fund

There is a small but positive association between the presence of a degree-qualified early years worker and children's learning outcomes, as measured at age five by the Early Years Foundation Stage Profile (EYFSP) – the statutory assessment used to determine young children's attainment (Bonetti and Blanden 2020)

An evaluation of a Graduate Leader programme (2008-11) provided positive evidence that the use of specialised early years graduate training pathways can lead to improvements in quality within the PVI sector. The impact assessment findings show that EYPs were effective in leading change for preschool children (30 months to 5 years); settings which gained an EYP made significant improvements in quality over those that did not.

Estimated cost: £605m (201.m/year) for full roll out or £288m (96m/year) for 20% most disadvantaged areas

Costing calculations: We estimate that full roll out of a Graduate Leadership Fund could cost £201.5 million per year, or £605 million over three years, to deliver nationwide. This is based on inflationary increases from the 2008-11 programme which to support all full day care PVI sector providers in employing a graduate or Early Years Professional (EYP) (currently 21,200 group-based providers in the private and voluntary sector).

However, targeting areas of deprivation where higher qualifications would lead to the most benefit, and where providers are already suffering most financially, would lower costs. Sutton Trust estimate cost of initiating graduate leadership in 20% most disadvantaged areas to be £96m per year or £288m over three years.

2.3.2 Continue provision of Stronger Practice Hubs

Continuous professional development (CPD) is another fundamental pillar for supporting the ECEC workforce and achieving higher and more consistent levels of quality within ECEC

systems, and thereby children's outcomes (OECD 2025). Early Years Stronger Practice Hubs provide advice, share good practice and offer evidence-based professional development for early years practitioners. The Early Years Stronger Practice Hubs programme launched in November 2022 and is supported by the Education Endowment Foundation (EEF) and the National Children's Bureau (NCB) and is funded until March 2025. (NCB) and is funded until March 2025.

The 18 Hubs (two in each of the government office regions in England) provide advice, share good practice and offer evidence-based professional development for early years practitioners.

Cost-benefit case for continuing development of Stronger Practice Hubs

Whilst Stronger Practice Hubs have not been formally evaluated, they have become established as a regional infrastructure for the delivery of evidence informed professional development. As Sutton Trust 2020 note: 'The costs of establishing and sustaining a highly qualified early years workforce are significant, but should be seen as an investment in human capital for future generations.'

These proposed interventions are actions which reflect the Government Opportunity Mission's next steps for meeting the milestone, which included a commitment 'to work in partnership with the sector, reforming training and support for the workforce to drive up standards'.

UNICEF UK would welcome the opportunity for further dialogue on a wider ECEC workforce strategy.

Estimated Cost: £10.8m / year

Costing calculations: We estimate Stronger Practice Hub programme £24.3m Stronger Practice Hub (based on indicative initial costs) £450k per Hub x 18 hubs x 3 years = £10.8m

3. Meeting the health, wellbeing and support needs of parents, babies and young children *(primary departments of interest, DHSC and DfE)*

Improving children's health and wellbeing is a prerequisite for achieving the Opportunity mission, the EY milestone as well as the Health Mission's goal to reduce health inequalities and increase life expectancy. We know that children who are unwell, experience developmental delays or do not access the right nutrition, physical activity or stimulation are not only at greater risk of health problems throughout their lifecourse but are less able to engage with education and, later, employment. When we look at the bare facts of children's health in the UK – with higher rates of infant mortality, obesity and mental ill-health than many comparable nations, and worsening child health outcomes in recent years – there is clear cause for concern.

Addressing ill-health in childhood is also critical lever in tackling the compounding effects of child poverty. Children in poverty are more likely to experience infectious diseases and chronic conditions like asthma or diabetes. By the time they start school, children from the most deprived areas are twice as likely to be obese. Developmental delays, disabilities and mental ill-health are also more common among economically disadvantaged children, with children with SEN twice as likely to be on FSM. The Millennium Cohort Study also found children from the lowest income quintile were 4.5 times more likely to develop a severe mental ill-health issue.

There is direct read-across between improving babies and young children's health and meeting the early years milestone. Taking some of the seven areas of learning from the EYFS Profile: nutritional deficiencies and lack of physical activity threaten children's motor skills (Physical Development); poor emotional wellbeing impinges on children's ability to self-regulate and build positive relationships with others (Personal, Social and Emotional). Disabled children and children with special educational needs such as hearing impairment and neurodevelopmental conditions experience much poorer educational outcomes than their peers. When these children and their families are not able to access timely support, the impact on their language development (communication and language) and other learning domains can be significant.

Health and wellbeing in early childhood relies most fundamentally on parents' and caregivers' ability to provide nurturing care. This is in part a question of ensuring families have the financial resources, employment and childcare conditions needed to meet their children's basic needs (as outlined above). But it is also about families being able to access the services and support to give the care most conducive to their child's development.

3.1 Call for investment: ensure every child can access the benefits of a Family Hub by expanding programme to the remaining 77 Local Authorities.

As the Nurturing Care Framework sets out, the needs of babies and young children are multi-faceted and interrelated. Physical, social-emotional or cognitive outcomes are not so separable under the age of five, and the family circumstances that influence them are similarly complex. **Integrated services in a Family Hub (or Sure Start / Children's Centre) model are therefore the right way to provide holistic support in an accessible, community setting.** In the National Evaluation of Sure Start (NESS), more integrated services were shown to be particularly effective in reaching families who might not otherwise engage with health or parenting services and having positive impacts on the family environment. Early evaluations of Family Hubs also point to the potential for significant cost savings – nearly £30 million over 7 years in Essex - through reduced duplication, streamlined commissioning and co-location.

There are, however, two major pitfalls in the current Family Hub programme, requiring investment at the upcoming Spending Review. The first is that – unlike Sure Start before it – it is currently limited to 75 local authorities. While these choices were rightly informed by levels of deprivation – and therefore likely need – these aggregate numbers can mask smaller concentrations of need in more affluent areas. Furthermore, in not scaling services to all areas, the UK is failing to uphold its obligations under the UNCRC to promote every child's right to the best possible conditions for their development.

Family Hubs – embedded within local communities and accompanied by wider outreach efforts (see below) – are often the 'front door' to that support, so **it is only right that Family Hubs be made available to every family.**

Cost-benefit case for expanding Family Hubs to remaining 77 LAs

Evaluations of the economic case for Family Hubs are in their early stages and limited by the lack of consistent, comparable data. However, early signs are positive and there are signs of **significant, cashable savings through co-location of services (reducing estates budgets) and streamlined commissioning and management systems (reducing workforce spend).**

Essex expects to save £29 million over 7 years (an annual saving that is significantly more than the expected annual spend per LA). HM Treasury could stipulate the learning be drawn from these cost saving measures as a condition of funding to new Family Hubs.

As for the monetised benefits of Family Hubs – in terms of improved child and family outcomes – the early evidence is necessarily uncertain. Recent evaluations of Sure Start, however, point to the need for patience and political bravery when investing in the early years. While impacts were mixed in the short-term, there were clear improvements in GCSE results, criminal behaviour and hospitalisations in Sure Start areas after a decade or more. Children's life chances should not be subjected to the cynical expectations of savings being realised within the current Parliament but take a long-term view.

Estimated costs: Our initial estimates put **expanding the Family Hubs programme to the remaining 77 upper-tier LAs in the region of £212m over three years (2026/7 - 2028/9).**

Costing calculations: Costs are based on an average of £920,000 per LA from the £69 million annual top-up funding for 2025/6.This would be additional to the investment needed to continue the Family Hubs programme in the existing 75 LAs.

3.2 Call for investment: restore the health visiting workforce by recruiting an additional 1000 health visitors a year over the course of the spending period to unlock the benefits of all early childhood investment

The second pitfall of previous investment in Family Hubs is that it is undermined by gaps in the underlying services. The premise of the Start for Life and Family Hubs programmes is that it is most effective – not to mention cost-efficient – to detect and intervene in issues early. But early intervention relies on midwives, health visitors and other primary care professionals detecting health issues as soon as they become apparent and being able to refer on to specialist support. Neither of these conditions is currently in place while there are significant workforce shortages in health visiting and maternity – as well as across primary care – and while the access and quality of specialist services varies so much by where in the UK you live.

Relevant departments will be aware of the current acute challenges facing health visiting: the decline in health visitor numbers, the unsustainable increase in caseloads and the rise in case complexity and demand (in large part due to rates of child poverty). In the 2023 Institute for Health Visiting survey, 79% felt their service lacked the capacity to offer a package of support to all children with identified needs. This is to say nothing of the risk that needs are not being identified in the first place, when as many as 1 in 5 children are not receiving their mandated health reviews. These reviews are the key stepping stones on the path to achieving a good level of development at age 5. All of this shows how integral investment in the health visiting workforce will be for both meeting the early years milestone and unlocking the benefits of spend on early childhood elsewhere.

The cost-benefit case for rebuilding the health visiting workforce

It is necessarily difficult to capture the full cost-effectiveness of an early intervention and prevention service like health visiting. Its benefits – like Sure Start – take many years to fully materialise and are broadly spread across a range of measures (from education and employment to antisocial behaviour and criminality) that make it difficult to attribute causality. Nonetheless, numerous high-quality studies have shown that health visiting – delivered in the

home and by suitably qualified professionals – improves critical variables for childhood development, including breastfeeding rates, detection and management of postnatal depression, parenting skills, home environment, and child sleep, cognitive development and reduction in injuries (see also here).

For the reasons above, what cost-effectiveness studies have been undertaken on health visiting are likely to understate its full effects but indicate a good value service even at very high intensities (£3246 per woman above 'standard' NHS service). Cuts to health visiting since 2015 also provide their own insights into the impact of the service, with a concomitant increase in the number of 0-4 year olds admitted to A&E. Unlike other age groups, **a majority of infant A&E attendances are non-urgent and therefore potentially avoidable with the right community-based support for parents**. For example, a review in North West London found that 59% of babies who were brought to A&E did not require any treatment or further investigation and were sent home after parental reassurance, at a cost of £1.8million per year, per area. This is one of a number of signs – from declining vaccination rates to increasing children's social care referrals – that **saving on health visiting represented a false economy.**

We support the Institute for Health Visiting (IHV's) call for the Government to recruit an additional 1000 health visitors each year over the spending period. This is premised on building towards an eventual target of 5000 additional health visitor, capacity that would be consistent with a caseload of 250 families per health visitor. Crucially, this would enable **continuity of carer.** Evidence from maternity shows that continuity of care is critical in unlocking not only better outcomes – for example, fewer infant and maternal deaths - but improved value for money. Our research last year showed the particular importance of continuity of carer for families in poverty, whose children are more at risk of missing their developmental milestones (including achieving a good level of development in Reception).

Estimated costs: By the IHV's estimation, this would cost in the region of **£52.9m in 2026/7, £105.8m in 2027/8, and £158.7m in 2028/9 - or a total of £317.4m across the three years.**

3.3 Call for investment: continue and expand the Start for Life programme to all remaining local authorities

One of health visiting's most valuable roles is in providing universal triage of families' needs, ensuring that parents and caregivers who need support can be referred to specialist services. The Start for Life programme has boosted investment in critical such services like infant feeding, perinatal mental health, parenting support, and home learning all of which support core elements of the Nurturing Care Framework. As with Family Hubs, there is both a rights-based and moral argument for extending the Start for Life Programme to the remaining 77 upper-tier local authorities. But there is also a strong cost-effectiveness argument, given the value for money and savings presented by the constituent services.

Supporting mothers to breastfeed for as long as they would like to and giving parents the knowledge and skills to provide the right nutrition for their children are foundational to longer-term health and development. **Alongside improvements to children's immune systems and a reduction dangerous infections, breastfeeding has been consistently associated with better cognitive development at age 5 – worth as many at 5 IQ points – suggesting a direct and immediate link to achieving the early years milestone.** The UK's relatively low (but rising) breastfeeding rates – with 53% of infants breastfed at 6-8 weeks compared to 92% in Norway in 2023/4 - mean there is room for improvement and impact.

Parents' mental wellbeing and capacity to give sensitive and responsive care is critical for their children's developing brains and bodies. Parental mental ill-health, on the other hand, has direct deleterious effects on infants' cognitive, emotional and physical development - again, with clear read-across to development scores in Reception. Without early and decisive intervention, these issues have a cascading effect, with children of mentally unwell parents much more likely to suffer from a mental health condition themselves and achieve less well at school and beyond. For this reason, the results of our most recent parents' survey are concerning, with 63% reporting struggles with their mental health and of those, only 29% said they had received timely support. This shows the distance yet to travel until perinatal mental health services have the resources and recognition that they warrant.

The cost-benefit case for expanding the Start for Life programme to remaining 77 upper-tier LAs

Infant feeding support. UNICEF's own analysis shows that - even for a narrow range of just 5 illnesses - **moderate increases in breastfeeding could save the NHS £40 million a year** and reduce pressure through decreased GP consultations and hospital admissions.

This annual saving is greater than the combined yearly cost of expanding the Start for Life infant feeding support across the country (£18.7m (77 additional LAs) + £18.5m (original 75 LAs)). The true favourability of the cost-benefit ratio is likely to be much higher.

Perinatal mental health and parent-infant relationships. Parental mental ill-health is estimated to present social costs worth £8.1bn for each one-year cohort of births – with £1.8bn of direct costs to the public sector (health and social care (71%), education (16%) and criminal justice) (13%)). These costs are generated using only the three most common perinatal mental health conditions (anxiety, depression and psychosis) and exclusively maternal mental health (rather than that of other caregivers).

By contrast, the interventions proposed as part of an expanded Start for Life programme – including parent-infant psychotherapy, peer support or psychological therapies for parents – have been found to be highly cost-effective. **In this context, the additional expenditure on - and expansion of – the Start for Life programme is both rational and urgent.**

Estimated costs: **£175 million over three years (2026/7 - 2028/9).**

Costing calculations: Costs are based on an average of £760,000 per LA, assuming similar projected costs to the £57 million annual top-up funding for 2025/6. Assuming that the distribution between services would remain the same as for 2025/6, this would represent:

- *£112 million for perinatal health and parent-infant relationships support*
- *£56 million for infant feeding support*
- *£7 million for publishing Start for Life Offers and setting up Parent-Carer Panels*

This would be additional to the investment needed to continue the Start for Life programme in the existing 75 LAs.

3.4. Introduce a Children's Health Investment Standard

The Darzi Independent Investigation of the NHS highlighted the inequity of health spending for babies, children and young people. Children are high users of health services, and this is particularly true for babies and infants who, for example, rely more on universal health services like health visiting but are also the age group most likely to attend emergency settings. However, while children frequently use health services and make up 24% of the population, they account for just 11% of NHS expenditure. The gap between service demand and service funding is even wider for mental health services, with only 8% of all mental health spending going to babies, children and young people's mental health support, a figure which includes funding for mental health support teams in school as well as CAMHS.

In order to protect children's rights and deliver on the government's intention to create the healthiest generation of children ever, there must be a rebalancing of some health resources towards childhood. UNICEF UK therefore **recommend that a Children's Health Investment Standard is introduced,** as a key mechanism to move towards fairer funding for children's health.

A Children's Health Investment Standard would function in a similar way to the existing Mental Health Investment Standard (MHIS) by requiring ICSs to proportionately increase their spending on children's health services at a faster rate than the increase of their overall health spending. The mechanisms and accountability frameworks are already in place for the MHIS, and provide a structure that could be extended to children as an underserved group.

Introducing an Investment Standard for child health does not necessarily require an overall increase in funding for Integrated Care Systems, but ensures they gradually move towards more *equitable* health service funding and restore their services for children. Without this standard in place, and given the increase in autonomy for ICSs, most systems will continue to prioritise acute and adult-focused services, while children's health services fall further behind. Investing in children's health offers a significant return as it can prevent ill health later in life and introducing this Investment Standard would therefore also support the government's ambition to 'left shift' some resources away from acute provision and towards prevention. Announcing the introduction of this standard at the time of the spending review would demonstrate strong commitment to more equitable health spending as per the intention of the forthcoming 10-year health plan.

About the UK Committee for UNICEF (UNICEF UK)

The UK Committee for UNICEF (UNICEF UK) is a UK registered charity that raises funds for UNICEF's emergency and development work around the world and advocates for lasting change for children in the UK and worldwide. We have also been delivering programmes in the UK for more than 25 years, in line with our universal mandate to be there for every child.

We work in all four nations of the UK reaching around 2.5 million children each year through our Baby Friendly Initiative, Rights Respecting Schools and Child Friendly Cities programmes. We put our years of experience working for children around the world into practice in the places that reach UK children day in, day out. We're working with the hospitals where they are born, the schools where they learn and grow, and the services that shape their lives.

To follow up or discuss any aspect of this submission please contact Claire O'Meara, Head of UK Policy comeara@unicef.org.uk