



Identifying mechanisms for promoting Early Child Development (ECD) in Jersey

A report commissioned by the **UBS Optimus Foundation**

Report and recommendations.

Identifying mechanisms for promoting Early Child Development (ECD) in Jersey

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Executive Summary

Introduction

The UBS Optimus Foundation commissioned this report to examine opportunities for enhancing early child development (ECD) in Jersey both through raising the population average achievement and through reducing inequalities. In particular, this report aims to describe the 'landscape' of early childhood in Jersey; describe the services available to enhance ECD; identify gaps in these services and make recommendations for enhancing ECD. The material for this report was obtained through semi-structured interviews with a range of policymakers, managers, practitioners and service users together with perusal of relevant documents and site visits.

Services for preschool children: examples of good practice

There has been a strong policy commitment to improving preschool services in recent years: there is clear support for the 'First 1001 days' agenda focussing on pregnancy and early childhood, and the implementation of the first phase of Proposition 82 (the 'White Paper') has led to many of the excellent service developments.

We found many examples of excellent practice, for example:

Midwifery services Most General Practices now accommodate a community midwife in the practice and communication between GPs and midwives appear to be good.

Health visiting, provided by Family Nursing and Homecare; a charity largely funded by Jersey States has recently adopted a structured programme of intensive home visiting for 'vulnerable families' identified during pregnancy.

Childcare provided in nurseries or preschools in the regulated sector appears to be good, and there is an excellent awareness among staff of the importance of nurturing language development

Child and adolescent mental health services (CAMHS) and Social work services have both been under scrutiny as a result of recent case reviews, and several rapid improvement programmes are being implemented under strong new leadership.

Voluntary sector services are provided by many organisations: most notably Brighter Futures, Parenting Support Services, the Jersey Child Care Trust, and the NSPCC. These provide a mix of parenting classes and support, information and financial help with childcare. The services provided by these agencies at the Bridge Centre and elsewhere are very good and there appears to be good evidence of effective joint working

What are the gaps?

Several gaps in knowledge and services were found. There was a lack of data on preschool children, particularly those who move to the island after birth. This makes children vulnerable as they may not be known to services until they reach the age at which they are entitled to education services. Coverage of health visiting services is poor: children who move to the island may not be known to health visitors and uptake of child health developmental checks after six weeks is low. There is little communication between GPs and health visitors. There is insufficient support from CAMHS for community-based agencies and infant mental health and perinatal mental health services are limited.

Some families may be more at risk than others: children of working parents on relatively low incomes who work long hours may be particularly disadvantaged due to the limited time they can spend with parents, which may translate into attachment problems and speech delay. Some immigrant families may also be particularly disadvantaged, through parents working long hours and children being placed in unregulated childcare provision, some of which may be of a very poor standard. More generally, the scale and nature of unregulated childcare is not known and there is the potential that children receiving such care may receive low levels of adult engagement and stimulation.

Recommendations

1. Improve current service provision

Health visitor numbers should be increased and supported by adequate administrative arrangements. Every family with preschool children should know who their health visitor is and every child should have a developmental assessment at two years. Health visitors and nursery staff should have access to increased levels of consultation/supervision from experts in ECD and infant mental health.

2. Improve access to high quality services

The expansion of locally-accessible children's centres beyond the Bridge and Samarès would be desirable, either through the parish system or primary schools. Limited amounts of subsidised or free child care could bring in families who currently use unsatisfactory child care, potentially in the form of quality-assured provision such as that provided by Montessori centres.

3. Increase the quality of childcare and education services

High-quality publicly-accessible inspection of preschool establishments and schools should be introduced. Urgent consideration should be given to ways to improve the experience of children in informal or illegal childcare provision. Options might include an amnesty, with provision of training and formative inspections as well as financial incentives to those providers who declare themselves, and provision of limited amounts of free or subsidised child care in centres as described above.

4. A public health campaign on early literacy

There is an argument for the introduction of a national public health campaign supporting the value of reading to and having conversations with young children, possibly combined with carefully timed book giving.

5. Improve local ECD capacity through improving intelligence

The problems with data quality and communications between IT systems should be addressed as a matter of urgency. The use of a common identifier number in all public record systems would greatly improve the situation and make accurate data linkage possible. Coverage of the 2-year Ages and Stages assessment should be increased to as close to 100% as possible and aggregated data should be available to inform policy. There is a strong argument for a universal contact by health visitors with families of children at the age of one year. Data from the two year assessment and the school entry assessment should be used, in combination with data on service use, to assess whether provision is matched to need. It is important that all health professionals have access to a common child health record, possibly through the new EMISweb system. Communications between GPs and health visitors should be improved and formalised beyond the simple sharing of a clinical records. There is also a strong case for regular visits by health visitors to nurseries. It is important to understand better the needs of minority families living on the margins of Jersey society. We recommend that an investigation should be carried out into the needs of preschool children in the larger minority communities by native speaking researchers.

6. Evaluation

All new services implemented should be comprehensively evaluated using agreed outcome measures.

Conclusions

Although there are a number of barriers to Jersey becoming an exemplar for high-quality ECD practice, the island has many social and institutional strengths, many excellent services and many excellent practitioners and service managers. Services are however often fragmented and all the services are limited by the poor quality of data. We believe that there is potential for Jersey to become a pathfinder/demonstrator site for enhancing ECD at population level. Meeting the challenges in optimising ECD for all the children in Jersey will require some modest investments in a range of child and family services but equally importantly a strong commitment to measuring outcomes and establishing what works best in the Jersey context.

Aims of this report.

- To describe the 'landscape' of early childhood in Jersey
- To describe the services available to enhance early child development
- To identify gaps in these services
- To make recommendations for enhancing early child development

Introduction

The UBS Optimus Foundation commissioned this report to examine opportunities for enhancing early child development (ECD) in Jersey both through raising the population average achievement and through reducing inequalities. The working definition of ECD here encompasses social, emotional and cognitive development in the preschool years, and it is assumed that sensitive, engaged and consistent parenting, the prevention of maltreatment, the maintenance of good health, high quality child care and early years education all play an essential role¹.

Methods

The material for this report was obtained through semi-structured interviews with a range of policymakers, managers, practitioners and service users together with perusal of relevant documents and site visits. Interviewees and sites are listed in Appendix A and interview topic guides are listed in Appendix B.

The case for investing in early child development

The economic and social benefits of high quality ECD interventions delivered efficiently are potentially dramatic, though obvious societal benefits can take some time to emerge. One well characterised example is the Family-Nurse Partnership programme offering support in personal development and in sensitive child rearing to disadvantaged mothers from mid-pregnancy until their child is aged two years. In a follow-up assessment when the children were 15 years old², compared with a control group, the rates of criminal activity, problem drug and alcohol use, high risk sexual behaviour, running away from home and smoking were halved. Similarly the HighScope Perry preschool education programme dramatically improved the life chances, employability, income and health behaviours of a similarly disadvantaged group after 37 years of follow up³. Studies such as these have led the Nobel-prize winning economist James Heckman to state that public expenditure on disadvantaged children in the preschool years gives the best possible return on public investment⁴. This high level of return on investment does not only apply to disadvantaged children, but in most countries more advantaged parents are able to 'invest' high levels of their time in their children. Our findings suggest that in Jersey many families who at first sight may appear to be reasonably well-off (for example those families with a combined income of up to £50,000 per annum) may struggle to provide good quality care and support for their children because of the high costs of child care and housing.

Preschool children in Jersey

Jersey has around 1,100 births per year, but since data are not held in any systematic way on children coming in to the island it difficult to give an accurate estimate of the total population of preschool children.

Jersey has a very high proportion of parents in full time work: over 80% of mothers of preschool children are employed. Around 1,000 preschool children live in families receiving income support. Levels of divorce and lone parenthood are reported to be higher than UK averages. There is a low rate of teenage pregnancy.

According to figures from the 2011 census, 50% of individuals living on Jersey are of Jersey origin. Another 33% are from England, Scotland, Wales or Ireland, and around 7% of the population is of

Portuguese (particularly Madeiran) origin. Other substantial minority groups include those from Eastern Europe, particularly from Poland which accounts for around 3% of the population. It is not clear how many families may be on the island without any formal legal status. Many Jersey-born individuals leave the island each year for educational or employment opportunities in the UK and many others return after lengthy periods away. It was striking that many of the service managers we interviewed had been in Jersey for less than two years.

By European standards, there are no exceptional challenges in terms of social deprivation, although many families face significant economic challenges relating to the high costs of housing, food and childcare. There appear to be specific challenges faced by many immigrant families, particularly among the substantial Portuguese minority, many of whom are in low paid work.

Services for preschool children

There has been a strong policy commitment to improving preschool services in recent years: the newly-elected government has expressed clear support for the 'First 1001 days' agenda focussing on pregnancy and early childhood, and the implementation of the first phase of Proposition 82 (the 'White Paper') has led to many of the excellent service developments described in the following section.

Midwifery services are generally provided in the Jersey Hospital and almost all births take place in the hospital maternity unit. Some general practitioners have recently been providing a comprehensive package of antenatal care, shared with community midwives, through a service level agreement with the Health and Social Services Department. Most general practices now accommodate a midwife in their surgery premises and the Bridge Centre (see below) has a community midwifery service hub. Relationships between GPs and midwives appear to be positive and there have been recent practitioner-led moves towards sharing clinical records. Most mothers who are eligible for subsidised health service support (those with a 'JY' social security number – see below) purchase a comprehensive package of GP/midwife shared care for £100, paid in instalments and mothers who are not able to pay appear generally to be supported in an informal way by GPs and midwives. Community midwives are all generic practitioners, although two have been seconded to work with the NSPCC Baby Steps programme. There is no midwife specialising in infant feeding support.

Parental leave has only recently been supported in principle by the States Assembly and the law is currently being drafted. The proposed law will mean that mothers will be entitled to 18 weeks unpaid leave, although some employers currently provide paid leave of up to six months. The general pattern at present among most working families appears to be of taking around four months, paid for from savings. We understand that breast feeding is initiated by most mothers, but continuation beyond six weeks is relatively uncommon, reportedly due to early return to work.

Health visiting is entirely provided by Family Nursing and Homecare, which is a charity, in large part funded by the Jersey States. Midwives hand over the care of mothers and babies to health visitors on the 10th postnatal day. Women identified as vulnerable in pregnancy (as a result of mental health problems, learning difficulties, substance misuse or other social difficulties) have recently been notified to the health visiting team for consideration for recruitment to the Maternal Early Childhood Sustained Home Visiting service (MECSH). This high quality and relatively intensive service involves at least monthly visits from mid-pregnancy to the end of the child's second year. The programme is structured and is quality assured through supervision by a clinical psychologist or the team leader: four health visitor posts have been created specifically to support the introduction of MECSH across the full workforce. The MECSH programme is only available to mothers who have a level of competence in English.

There are 14.8 whole-time equivalent health visitors on Jersey (including the four new posts), so the average caseload of preschool children is at least 330 which is above the nationally recommended figure in the UK of 250. We heard a number of reports that many families do not know the name of their health visitor. The challenges faced by the health visiting service are thus substantial: although some families receive an excellent service through MECSH, these families have to have

their vulnerabilities identified antenatally. There is good evidence that only around half of all substantial problems likely to benefit from intensive health visiting input are identifiable at this early stage⁵⁻⁷. There may be some capacity for intensive health visiting input outside the MECOSH system but it is not clear that this is readily available. The commonly used system of weekly visits to children in the care system but looked after at home is much less common in Jersey than in the UK. Health visitors offer a 24-month developmental assessment but only around 60% of families take up this offer.

The lack of a system for statutory notification of immigrant children to the health visiting team means that many children may not come to the notice of a health visitor until they either attend the A&E department or their parents seek state-funded preschool education services. There appears therefore to be the possibility that a substantial number of children who could benefit from health visiting services do not do so, and the service may have limited capacity to meet this need.

Day nurseries, other forms of child care and preschool education are offered in many settings throughout Jersey. There are around 20 day nurseries, generally offering child care from children aged 0-5 years for up to 10 hours per day all year round. Eight pre-schools are available during term time only, generally 5-6 hours per day for children aged 2-5. Sixteen States pre-schools are based in primary school premises and are also open up to six hours per day during term time. Preschool nursery provision is supported by the States: children are entitled to 20 hours of term-time nursery provision from the September after their third birthday. Many parents choose to supplement this provision. There are around 75 registered family child carers (child-minders) providing care for up to six children and a further 50 accredited nannies, which are particularly of use to families with more than one child and unusual work patterns such as shift work.

The costs of child care are high. Full time care for children aged 0-3 years generally costs £5-8 per hour, or £855-£1368 per month whether provided in centres or by a registered family child carer. The cost of child care for families with two pre-school children is therefore commonly in the region of £2,000 per month. Costs for nannies are slightly lower, at around £10 per hour. Lone parents and parents with low income therefore struggle to afford centre-based child care and often seek less formal arrangements with care provided by family or friends. Some parents are entitled to claim Childcare Tax Breaks and the Childcare Component of Income Support. The JCCT provides some additional financial help with childcare to some families who could not otherwise afford it. This appears to be provided on the basis of health visitor referral. Some parents are forced to place their children in illegal child care settings with much lower costs (sometimes paying as little as £1 per hour, or payment made in kind). The scale of illegal child care is not known. Many other families come to informal arrangements with family members or friends, and we heard evidence that these arrangements are often unsatisfactory and sometimes border on illegality.

Although the information provided to parents by the Jersey Child Care Trust is useful, the system of annual registration of preschool care or education providers may benefit from review and there is no system of reporting to parents on these inspections, such as is provided by Ofsted in England or Education Scotland. Several interviewees commented that this situation is unsatisfactory both for parents and for the establishments. It is notable that Guernsey has recently engaged Education Scotland to report on its preschool provision.

Training for early years practitioners is provided largely at Highlands College, with some continuing professional development provided by the Jersey Childcare Trust. Around 850 people work in formally recognised child care work on Jersey. Most staff in early years child care or educational establishments have level 2 or level 3 diplomas in childcare education, and there is a less demanding 10-week 'taster course' for those considering careers in child care or education. Level 3 diplomas need to be held by a proportion of centre-based care staff for registration purposes. A degree-level course in childhood studies has been offered for the past seven years, and about 15 students join the course each year. The course contains a module on the development of social, emotional and language skills.

General practice on Jersey appears to be generally of a good standard although the system of annual appraisal and revalidation has only recently been introduced. Similarly, the system of

registration with a general practice is new and there appear to have been some problems in ensuring the accuracy of the registration system. General practice is funded privately although there is a co-payment system through which the government provides a fee of £21 per consultation. The general cost of a consultation to individuals is £41, although several practices have discounts for children. The level of accessibility for those families able to pay is excellent. Recently, three practices have been waiving the fee for attendances by children and this may trigger a similar approach from the other practices.

General practitioners have a service level agreement to provide immunisation services and the six-week developmental check. Immunisation uptake is excellent at around 96% for the infant programme. Immunisation coverage for the immigrant preschool population is not known but if parents are aware of the service they will attend a GP and the child will receive a social security ('JY') number. There is little evidence of any communication between GP and health visitors and we heard from several quarters (including from GPs themselves) that there is a need for improvements in awareness of GPs in issues related to ECD.

Accident and emergency medicine is free of charge to families. Unsurprisingly therefore the use of A&E services is extremely high: there were 17,000 attendances by children last year, more than one attendance per child. It is likely that attendance rates among preschool children will be relatively higher in parallel with patterns in UK general practice. Attendances are notified to GPs but we understand that these letters are commonly sent to the wrong GP, due to children having being registered at more than one practice.

The A&E service has a liaison health visitor who peruses the list of attendances and identifies children where there may be cause for concern. Such children, and all children not otherwise known to the health service are referred to health visitors and other agencies as required.

Paediatric services are available on the island, and are free of charge to families. They are provided by three consultants and associated junior staff. One consultant has responsibility for community paediatric services and runs a child behaviour clinic. There was a view that, as with A&E, these services are regularly being inappropriately used, for financial reasons.

Specialist paediatric services are generally provided at the Overdale hospital and are free of charge. The most heavily used service is speech and language therapy, to which over 300 children were referred last year. A recent audit has revealed that 25% of all children on the island are referred to Speech and Language Therapy (SLT) which is a strikingly high proportion. It is likely that part of this phenomenon may be explained by the high level of awareness by early years staff in nurseries and preschool education establishments as a result of the Language for Life programme, but it is also possible that many Jersey children have developed in a language-impoverished environment. In addition, there is a potentially valid argument that assessment at age two is a little too early for health visitors to make an accurate decision on referral. The Bridge Centre (see below) offers input from one SLT. SLTs also visit some childcare centres on the island to offer in-house sessions with children. In addition, the first cohort of practitioners are midway through the 'Making it REAL' program, delivered by the National Children's Bureau, which focuses on practitioners working with parents to develop and increase language, communication and literacy skills and opportunities within the home environment.

Child and adolescent mental health services (CAMHS) are generally provided at the Overdale hospital and are free of charge. The CAMHS service has recently been under scrutiny as a result of a high number of teenage suicides. Several GPs complained that access to CAMHS is very poor, and the service is sometimes seen as inaccessible, particularly out of normal working hours. Nevertheless there are some examples of excellent practice, and there is some expertise in early childhood mental health. One psychologist provides consultancy in the form of case discussion groups for health visitors and this is to be commended.

Educational psychology services are provided by five government-employed educational psychologists. The focus of their work is on the child's environment and the systems providing educational support rather than on the specific abilities of the child. One educational psychologist has responsibility for preschool children and another has some expertise in working with the

families of young children. We heard reports that waiting times can be lengthy. One GP stated that he would appreciate better communication with the educational psychology service.

Social work services have been under scrutiny as a result of recent case reviews, and several rapid improvement programmes are being implemented. There appears to be an acceptance that standards of practice, particularly in residential children's homes, have been poor and much improvement is necessary. A number of strong senior management appointments have recently been made, and there is cause for optimism that services will improve. We heard that early intervention services for children with complex developmental needs have recently been substantially improved.

There are some particular challenges in relation to children who are looked after by the States. Around 100 Jersey children are currently in care, and some children with complex needs have had to be looked after off the island. The number of foster families is very limited and there has to date been no provision for professional foster care, so a high proportion of children, including young children, has been looked after in children's homes in contrast to usual practice in the UK. Some 'White Paper' funding has been allocated to the establishment of a professional foster care service.

Criminal justice services and the Police appear to be held in very high regard by other services, and it is clear that the police service has taken a very proactive role in preventive work alongside statutory and voluntary agencies and through the Building a Safer Society initiative. Although the police service has good representation of ethnic minorities among its staff, reaching out into the minority communities is reported to have proved difficult. There is no active policy of identifying illegal childcare provision but action is taken when problems become apparent.

Voluntary sector services are provided by many organisations, some of which receive States funding. Perhaps the most notable of these are Brighter Futures, Parenting Support Services and the Jersey Child Care Trust, all of which are based at the Bridge centre, and the NSPCC which is based in the new Gower Centre and the Pathways Family Centre. Brighter Futures offers a wide range of support services to families, including parenting programmes and the excellent Growing Together programme. It receives around 100 new referrals per year and about 150 families are in the active caseload at any one time. The Brighter Futures charity works closely with other agencies and there appears to be a fluid transfer of care between the targeted services provided by Brighter Futures and the universal services provided by Parenting Support Services.

The Jersey Child Care Trust also works creatively at the boundaries between services. JCCT provides supported places in child care services, an information service for parents seeking child care, an accreditation scheme for nannies and a special needs inclusion project. Most notably it provides good quality continuing professional development for staff working in the child care sector.

The NSPCC also runs a service in Jersey, aimed at the prevention of maltreatment through abuse or neglect. At a universal level, NSPCC has developed the "Coping with Crying" programme, and is planning distribution by volunteers of a DVD to all families as soon after the birth of a child as possible. In line with NSPCC services in the UK, the Jersey service offers the antenatal Baby Steps programme. This is a group-based programme for the most vulnerable families delivered by a midwife or health visitor along with a NSPCC social worker. NSPCC has made a number of new appointments and has aspirations to expand its services based on a public health approach, with its service developments accompanied by robust evaluations.

Children's centres. There are two children's centres on the island: the Bridge which was established in 2008 and the newly opened Samarès Pathway Family Centre.

The Bridge provides a very comprehensive set of services to families including those provided by the Jersey Child Care Trust, Parenting Support Services (providing universal support through the literacy-promoting JELLY clubs and other initiatives), Brighter Futures (providing more targeted services for families in need of additional support), health visitors, housing, a Learning Centre (supported by Highlands College), a speech and language therapist, midwives, and the Multi-Agency Safeguarding Hub. It also provides relaxation rooms used by staff and families. The overall impression of the Bridge is of a warm and welcoming environment, with a café designed to

increase informal contacts between parents. Nevertheless reducing potential stigma associated with use of the Bridge is seen as a challenge by some stakeholders. Confidence, which is linked to poor English language skills, is also perceived as a barrier in attending the Bridge for some immigrant families.

The Samarès Pathway Family Centre is very recently opened, and is based in a former caretaker's house adjacent to a primary school. The centre provides a range of formal and informal services for families with young children. It is too early to be clear about the extent to which the centre will provide accessible and effective support to families.

Structured parenting programmes are largely provided by Brighter Futures. The programmes offered include Circle of Security (Brighter Futures), Mellow Parenting (CAMHS in conjunction with Brighter Futures) and Incredible Years (being introduced by Brighter Futures in 2015). Overall in 2014, 138 families with children aged under 5 were referred to Brighter Futures. The various parenting groups for under 5's run by the centre saw 313 families undertaking programmes in 2014 (some families undertook more than one programme).

Problems with data

One of the most serious problems we identified relates to the lack of coherent data on preschool children, and this deficiency was pointed out to us by almost all our respondents. Children born in Jersey are "visible" because they have used antenatal services and their births will have been registered. A 'JY number' is issued at the time of birth registration. Children's health care will have been transferred by midwifery services to a health visitor on the tenth postnatal day and these children will also be registered with a general practitioner. Jersey-born children thus are likely to be immunised, to have a developmental assessment at six weeks and to be known to a health visitor. In contrast, children who come to the island commonly remain unknown to services until they are eligible for their free preschool term-time nursery provision. The JY number issued by the Social Security agency to adults seeking work in Jersey is only issued to the immigrant adult and not to any dependent adults or children. The children of families moving to Jersey may thus be particularly vulnerable since they will not be known to services until the child's family actively seeks health care or education services. This vulnerability is compounded by the fact that the social and family networks of their families may be very limited.

There are some data systems in place which could potentially be used to identify children in a comprehensive way, but they do not communicate with each other:

- The general practice records system (EMISweb) which migrated to a hosted system in September 2014. There have been some problems with duplicate records and the system is not yet fully functional. Some midwives have started to use the system in preference to the hospital-based TRAC system.
- The A&E system captures data on those children who attend, and is useful in identifying some children at developmental risk, but the episodic nature of A&E care makes integration of the data into a meaningful whole difficult. A&E letters are commonly directed to the wrong general practice.
- The public health computing system which includes data on immunisations, the six-week check and A&E attendance. Data on immunisations, the six-week and two-year check are returned on paper forms for input, but the data are not available online to professionals. The health visiting records system is largely paper-based. A limited amount of data is transferred onto the child health database held by the Health Department
- The social work system is currently being redesigned
- The education services system is potentially useful for children over three years of age
- Further data systems related to employment and car ownership are currently being explored with regards to identifying individual level information on the population, including the 'Tell us Once' data sharing initiative and the Populus system.

The main impact of this fragmented system is that it is virtually impossible to know whether the services which are provided, many of them excellent, are in any way matched to need.

Summary: what are the major gaps in services?

Gaps in data and knowledge

We came to a strong conclusion that the major barriers to optimising ECD on the island are much more to do with inadequate data, patchy inter-agency communication and uncertain whole population coverage than with problems with individual services. A fundamental problem is that there no way of ascertaining whether need is in any way matched to provision of services and there are certainly very many families who live 'under the radar' and who do not benefit from any of the services on offer. It is therefore likely that the best 'return on investment' would come from initiatives to gather data, coordinate services and to ensure good access and minimum standards of care.

Communication between A&E and general practice IT systems is poor. Communication between general practitioners and health visitors is rudimentary at best. This lack of communication makes it difficult for any of the health agencies to have a comprehensive record of child health needs.

Gaps in service provision

The population coverage of health visiting services, although excellent for those families receiving more intensive input, is poor, particularly at the later preschool stages. It is likely that many children moving to Jersey will not be known to health visitors and the rate of coverage of child health surveillance assessments after six weeks is poor.

There is insufficient support from CAMHS for community-based agencies. Infant mental health services (eg for parent-infant psychotherapy and assessment of attachment) are limited although Brighter Futures provides some high quality programmes. There is no inpatient provision on the island for new mothers with serious mental illness, and no specialist perinatal mental health support.

The safeguarding system is fragmented although the establishment of the multi-agency safeguarding hub is likely to improve this situation.

Systemic gaps in support for ECD

We received some evidence that, as a result of economic necessity, children of working parents in Jersey may be disadvantaged in terms of good quality time spent with their parents. This may translate into an increased risk of problems in attachment and in language delay.

We were made aware that some immigrant families may be particularly disadvantaged. Some such families appear to be, in the words of several of our respondents "flying below the radar." Their children may have limited contact with parents who are working long hours, possibly illegally and may be placed in substandard child care provision.

Recommendations

An optimal environment for preschool children involves attention to several key aspects of wellbeing:

- Safety
- Health
- Support in learning and development of skills
- Nurturance
- Physical activity
- Being respected
- Being allowed to develop responsibility appropriate for the child's age
- Being included in the society in which they live

Attention to all these domains is the hallmark of the societies which lead the UNICEF 'League Table' of child wellbeing. In general, Jersey probably scores reasonably well in most of these domains compared to much of the developed world, but it lags far behind countries such as Norway, Sweden and Finland which have exceptionally high standards of child welfare. Factors such as paid parental leave, the quality of child care services, the privileging of early childhood problems in terms of service access and cultural issues such as the value placed on family mealtimes all contribute to child wellbeing at a societal level. The following recommendations represent practical steps that could be taken towards improving the quality of children's lives in Jersey, improving access to services and reducing inequalities in life opportunities.

1. Improve current service provision

- a) Efforts should be made to ensure that health visitor numbers are increased, that the existing workforce is supported by adequate administrative arrangements. Every family with preschool children should know who their health visitor is.
- b) Health visitors and nursery staff should have access to increased levels of consultation/supervision from experts in ECD. There is a good case for appointment of one or two community-based infant mental health specialists who could work alongside the existing CAMHS team but have an explicitly outward-facing and preventive role.
- c) Specialist expertise in infant mental health could also be used to good effect to support the management of serious perinatal mental illness and it is possible that the development of this capacity might allow some mothers and babies to be kept on Jersey rather than being transferred to England to a specialist mother and baby psychiatric unit.

2. Improve access to high quality services

- a) The expansion of locally-accessible children's centres beyond the Bridge and Samarès would be desirable. Families dependent on public transport find travel to these centres difficult with preschool children. There may be the potential for the Parish system to be of great value in this regard. Although historically Parishes had an important role in family welfare provision, this has now become a centralised function. At present, most Parish social provision is directed towards the older population and we think that it could be possible for two or three Parish-hall based children's centres to be established, perhaps in les Quennevais/St Brelade and Maufant/St Saviour initially. If it proved difficult to engage Parishes in this initiative, primary schools might provide an alternative accommodation solution. The uptake of services in the new primary school-based Samarès centre should be evaluated to guide further developments. Limited amounts of subsidised or free child care could bring families who currently use illegal or unsatisfactory child care 'into the fold' and give them access to many of the high quality services that are available. This could potentially take the form of quality-assured provision such as that provided by Montessori centres but uptake and retention would need to be carefully monitored.

3. Increasing the quality of childcare and education services

- a) A system of high-quality publicly-accessible inspection of preschool establishments and schools should be introduced, bringing Jersey into alignment with recent developments in Guernsey.
- b) Urgent consideration should be given to ways to improve the experience of children in informal or illegal childcare provision. It is clear that many working families cannot afford regulated child care, and that vigorous attempts to prohibit unofficial childcare could prove disastrous. Nevertheless the current situation is highly unsatisfactory and some children are undoubtedly receiving a very poor service. Provision of unofficial childcare may prove to be a 'wicked' problem but options to tackle it creatively should be sought. Options might include an amnesty, with provision of training and formative inspections as well as financial incentives to those providers who declare themselves, and provision of limited amounts of free or subsidised child care in centres as described above.

4. A public health campaign on early literacy

To support the implementation of the 'Making it REAL' program, there is a strong argument for the introduction of a national public health campaign supporting the value of reading to and having conversations with young children, possibly combined with carefully timed book giving along the lines of the Bookbug approach (www.scottishbooktrust.com/bookbug). The Language for Life has had a very positive impact on children in Jersey, and the programme should be sustained in the long term.

5. Improve local ECD capacity through improving intelligence

a) The problems with data quality and communications between IT systems should be addressed as a matter of urgency. The use of a common identifier number (such as used in the Scandinavian countries) in all public record systems would greatly improve the situation and make accurate data linkage possible. The "JY number" is the obvious candidate for this purpose and it should ideally be issued to children moving to Jersey at the same time as it is issued to their working parents.

b) Coverage of the 2-year Ages and Stages assessment should be increased from the current level of 60% to as close to 100% as possible. Addition of the Strengths and Difficulties Questionnaire and possibly the Sure Start Language Measure⁶ would allow quantitative assessment of the levels of attainment in the whole population. School entry assessments should also include a standardised measure of social and emotional functioning such as the Strengths and Difficulties Questionnaire. There is a strong argument for a universal contact by health visitors with families of children at the age of one year.

c) Data from the two year assessment and the school entry assessment should be used, in combination with data on service use, to assess whether provision is matched to need on a population level.

d) It is important that health professionals (particularly GPs, midwives, health visitors and A&E doctors) have access to a common child health record. The recent introduction of EMISweb offers an excellent opportunity for this to become a reality. The introduction of tablet-style computers for all health visitors would enable direct data-input onto this system. Training for all sectors will be required on coding to ensure that data are recorded consistently. Once a comprehensive dataset of children living on the island is available, health visitors should have knowledge of a clearly defined caseload and population coverage could be improved.

e) Communications between GPs and health visitors should be improved and formalised beyond the simple sharing of a clinical record. One useful mechanism could be the hosting of 'vulnerable children's' meetings in general practice, where all children at developmental risk that are registered with the practice could be discussed on a regular basis with a health visitor. There is also a strong case for regular visits by health visitors to nurseries.

f) It is important to understand better the needs of families living on the margins of Jersey society, particularly some families in the Portuguese/Madeira community. We recommend that an investigation should be carried out into the needs of preschool children in this community by a Portuguese-speaking researcher.

6. Evaluation

a) All new services implemented should be comprehensively evaluated using agreed outcome measures. The recent national policy adopted by NSPCC in this respect is commendable, and that organisation could play a useful role in helping to establish effective evaluation methods.

Can Jersey be made the world's best place to grow up?

Although there are a number of barriers to Jersey becoming an exemplar for high-quality ECD practice, the island has many social and institutional strengths, many excellent services and many excellent practitioners and service managers. Services are however often fragmented and all the services are limited by the poor quality of data.

If Jersey is to transform itself into a world leading centre for ECD, and there is little doubt that this could be achieved, there would need to be strong institutional leadership and advocacy. The States now have a firm commitment to the 'First 1001 Days' agenda and the impending establishment of an Early Years Taskforce is an important development. A Jersey centre for ECD with strong links to the existing services based in the Bridge and elsewhere, strong support from government agencies and strong community links could potentially offer a way forward. This centre could offer national intelligence on ECD (using anonymised and linked data on child development), a research function (for example in understanding the needs of marginalised families), an evaluation function, consultancy services to health visitors, other early years practitioners and GPs, and an educational function for professionals and families. Most importantly, a newly established ECD centre would need to have due regard for the many excellent services and resources that are already present⁸.

In the rational development of any interventions to improve wellbeing, evaluation should play a key role both in defining the goals of the intervention and in terms of ensuring a sound process for optimisation^{8,9}. The evaluation of any introduced ECD programme should be focussed on key outcomes, and the whole-population assessment of social, emotional, cognitive and language development at various ages, as well as rates of child maltreatment, should be assessed. Such whole population measures, linked to data on uptake of interventions, will allow an assessment of which interventions work best in the Jersey context, both to reduce ECD inequality and to improve overall ECD status. Process evaluation is also an important component of the implementation of any complex intervention:¹⁰ it is needed to explain which components or contextual factors have contributed to the effectiveness of interventions, if they are effective, and to learn how to improve them if they are not effective. Quantitative and qualitative methods will be needed to examine how well the interventions are implemented, the mechanisms by which they achieve impact, for which members of the target group they work best, and how the social and institutional context influence their delivery. This approach should ultimately allow successful interventions in Jersey to produce benefit elsewhere.

In summary, we believe that there is potential for Jersey to become a pathfinder/demonstrator site for enhancing ECD at population level in the developed world, and there are already many excellent services and an excellent policy environment. Meeting the challenges in optimising ECD for all the children in Jersey will require some modest investments in a range of child and family services but equally importantly a strong commitment to measuring outcomes and establishing what works best in the Jersey context.

Appendix A: interviews conducted and sites visited.

- *Government:* Senator Ian Gorst (Chief Minister), Deputy Roderick Bryans (Minister for Education, Sport and Culture), Deputy Anne Pryke (Minister for Housing), Senator Andrew Green MBE (Minister for Health and Social Services), Deputy Kristina Moore (Home Affairs Minister), Ruth Johnson (Assistant Director, Social Policy), Dr Zoe Cameron (Senator), Andrew Heaven (Deputy Director of Commissioning)
- *Jersey Childcare Trust:* Fiona Vacher (Chief Executive)
- *Family Nursing & Home Care:* Julie Gafoor (CEO), Michelle Cummings, (Head of health visiting team), a health visitor and a Looked After Children's nurse
- *Safeguarding team:* Liz Plastow (Designated Nurse)
- *Child and Adolescent Mental Health Service Team:* Dr Cheryl Power (Consultant Clinical Psychologist & psychology service lead)
- *Staff training:* Emma Ogilvie (Director, Resilience Skills Training)
- *Education Department:* Justin Donovan (Director of Education), Seán O'Regan (Head of School Development and Evaluation), Nicola Mulliner (Head of Early Years), Debbie Key (Policy & Performance Officer for the Safeguarding Partnership)
- *Joint Safeguarding Partnership Board:* Glenys Johnson OBE (Independent Chair)
- *Educational Psychology:* Julian Radcliffe (Principal Educational Psychologist) and Cliff Chipperfield (Head of Inclusion)
- *Speech & Language Therapy Services:* Lisa Perkins (Head of SLT Service & children's specialist support services)
- *Building a Safer Society:* Gill Hutchison (CEO)
- *Centre Point Trust:* Eleanor Hart (Nursery manager) and nursery team leaders
- *Paediatrics:* Dr Mark Jones, Community Paediatrician
- *Midwifery:* Elaine Torrance, Deputy Director of Operations, Divisional Lead for Women's & Children's Services, Head of Midwifery, Jersey General Hospital
The Bridge Centre: Tricia Tumelty (Director)
- *Brighter Futures:* Wendy Hurford MBE (President), Dr Kevin Kelly (CEO), staff and families at the Bridge Centre
- *Parenting Support Services:* Christine West (senior facilitator)
- *Community and Social Services:* Jo Olsson (Interim director of social work), Damian Allen, interim Managing Director, James Clarke (Head of Residential and Support Services) and three social workers
- *General Practice:* Dr Gordon Callander, Cleveland Practice
- *Health and Social Services Department:* Dr Nick Lyon (medical director, primary care), Dr Susan Turnbull (Medical officer for health), Dr Linda Diggie (Head of Healthcare services)
- *National Literacy Trust:* Dr Cathy Hamer (foundation years advisor)
- *Catholic Church:* Monsignor Nicholas France (Dean and Parish Priest)
- *Police and Criminal Justice Services:* Dr Helen Miles (Director of Criminal Justice, Criminal Justice Department)
- *Further/Higher Education:* Lynn Blakemore (Programme Manager for FdA and BA(Hons) Childhood Studies), and Catherine Farnon, (Lecturer in Childhood Studies) Highlands College
- *NSPCC:* Sharon Copsey (Head of Service, South West)

Sites visited: The Bridge Centre, Centre Point Trust Nursery, Leeward Nursery, Samarès Pathway Family Centre, William Knott Centre at Overdale Hospital.

Appendix B: topic guides.

Policymakers/stakeholders

Briefly introduce the study and describe the aims. Highlight the key ethical issues (confidentiality, anonymity, and consent) and ask for permission to record the interview.

1. The respondent's work in the field of ECD
 - Can you tell me what your role is and what your work encompasses?
 - Can you tell me a little about your work in relation to social, emotional and cognitive development of children in Jersey
2. The respondent's experience of services in Jersey
 - Can you tell me what services you have for enhancing early child development in Jersey?
 - How successful or unsuccessful have these services been (please give specific examples)?
3. Specific difficulties encountered
 - Have there been any particular difficulties in implementing services around social, emotional and behavioural development in Jersey?
 - Are there any specific difficulties around social, emotional and behavioural difficulties in the population of preschool children in Jersey that we should be aware of?
4. What do you think are the gaps in services promoting early child development in Jersey
5. What are seen as the main obstacles to optimising early childhood development (ECD) in Jersey?
 - PROMPT: demographic, multi-agency working, support for interventions, administrative barriers, financial barriers
6. Perceptions of possible ways to overcome these obstacles
7. Are there any groups of Jersey's children that could gain particular benefit from interventions such as home visiting programmes or high quality preschool education?
8. Are there particular issues in providing support to immigrant families without residence rights?
9. [IF RELEVANT] Are you aware of any data that are collected around child development?
 - How are these data collected (PROMPT: who completes, what systems, identifiers, data linkage?)
 - What is the quality of these data like?
 - Are there any (other) areas of child development or outcomes that you would like to see monitored?
 - Do you foresee any problems to collecting data around child development in Jersey?
10. How easy would it be to measure the impact of interventions? For example would there be support for the systematic assessment of language attainment and social and emotional functioning across the whole population?
11. Ideas for improving ECD in Jersey
12. Ideas for reducing inequalities in ECD in Jersey
13. To what extent would the Government give support to the idea that Jersey might become a pathfinder/demonstrator for the international community in relation to high quality ECD provision?
14. Anything else that you would like to tell us about early child development or child services in Jersey?

Practitioners

Briefly introduce the study and describe the aims. Highlight the key ethical issues (confidentiality, anonymity, and consent) and ask for permission to record the interview.

1. The respondent's work in the field of ECD
 - Can you tell me what your job is and what your work encompasses?
 - Can you tell me a little about your work in relation to social, emotional and cognitive development of children in Jersey
 - What sort of training, if any, have you had about social, emotional and cognitive development of children?
2. The respondent's experience of services in Jersey
 - Can you tell me what services you have for enhancing early child development in Jersey?
 - How successful or unsuccessful have these services been (please give specific examples)?
3. Specific difficulties encountered
 - Have there been any particular difficulties in implementing services around social, emotional and behavioural development in Jersey?
 - Are there any specific difficulties around social, emotional and behavioural difficulties in the population of preschool children in Jersey that we should be aware of?
4. Barriers to effective working
 - What are the barriers to working with children and their families in Jersey?
 - PROMPT: demographic, multi-agency working, administrative barriers, financial barriers
5. Perceptions of possible ways to overcome these barriers
6. What do you think are the gaps in services promoting early child development in Jersey?
7. Are you aware of any data that are collected around child development, either by yourself or other agencies?
 - How are these data collected (PROMPT: who completes, what systems, identifiers, data linkage?)
 - What is the quality of these data like?
 - Are there any (other) areas of child development or outcomes that you would like to see monitored?
 - Do you foresee any problems to collecting data around child development in Jersey?
8. Ideas for improving ECD in Jersey
9. Ideas for reducing inequalities in ECD in Jersey
10. Anything else that you would like to tell us about early child development or child services in Jersey?

Parents

Briefly introduce the study and describe the aims. Highlight the key ethical issues (confidentiality, anonymity, and consent) and ask for permission to record the interview. If group setting remind participants of confidentiality within group and rules of group.

1. The respondent's experience of services in Jersey
 - Can you tell me what services you have used for help or advice in relation to your child(ren)?
 - How helpful or unhelpful have these services been (please give specific examples)?
2. Were you aware of any other services which you could have used if you were concerned about your child?
3. Specific difficulties encountered
 - Have there been any particular difficulties in accessing services for your child in Jersey?
4. Barriers to effective working
 - What are the barriers to parents using services in Jersey?
 - PROMPT: demographic, financial barriers, attitudes towards help-seeking
5. Perceptions of possible ways to overcome these barriers
6. What do you think are the gaps in services promoting early child development in Jersey are?
7. How do you feel about asking for help and support from professionals with parenting?
8. If you could have a new service for preschool children in Jersey, what would it be?
9. Anything else that you would like to tell us about early child development or child services in Jersey?

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