University of Essex

LITTLE STEPS EVALUATION

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June 2024

Acknowledgements

Researchers from the University of Essex School of Health and Social Care would like to offer our sincere gratitude to all who participated in this evaluation. We particularly acknowledge the parents and professionals from Little Steps for their insights, time and expertise, which have been instrumental in shaping the success of this program.

Funding

This study has been funded by a Better Start Southend/Early Years Alliance. Neither author declares competing interests.

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Executive Summary

Little Steps (LS) is a team jointly funded by A Better Start Southend (ABSS) in addition to the SCC Public Health Grant. It aims to support new parents under the age of 25 across the Southend, Leigh and Shoeburyness areas. LS offers tailored health visiting support to young parents who by virtue of age as experience are at greater risk of being negatively impacted, such as in navigated access to housing, statutory benefits, or peer support networks. This service developed alongside the later decommissioned FNP programme. While each service aimed to improve outcomes for young parents and their children, LS is unique in providing such a relationship-based tailored service across the Universal Healthy Child Programme community offer within the Children, Young People and Families Public Health Service.

This early evaluation aims to evaluate parent and child outcomes over the last two years of the service. A mixed-method approach was used to contextualise national, local and cohort data using team and parent feedback. This triangulation allows for insight into the extent to which LS is successful in its mission to support young parents and their children.

Evidence from the analysis confirms the following findings:

1. Little Steps has a high level of engagement.

2. Little Steps participants' children meet milestones comparable to wider peer group.

3. Little Steps enables peer network development.

The key finding from this evaluation is evidence to affirm that the LS programme has successfully contributed to enabling young parents and their children to meet milestones in comparison with their older peer parents (n=140). There is evidence to suggest that without LS, young parents would be less likely to engage with general health visitor services and thereby may be less likely to have supports in place to measure and enable their children to meet comparable peer developmental milestones.

In addition, the LS programme has developed a peer network of support. By working with families until their child is aged 5 both individually and collectively in the form of the Tuesday group, parents reported building new networks of support previously absent prior to giving birth. The absence of peer network was largely felt due to losing connection or commonality with their non-parent peers. While friendships were said to be maintained, the families themselves reported the bond fostered by sharing birth and parenting experiences have created a collective peer experience which they anticipate will continue beyond LS.

For sustainability, continuity, and improved effectiveness, LS should be fully integrated into the wider Health Visiting service while retaining its distinct approach,, consideration of a co-terminus designated workspace, adaptable groupwork space to account for age range, and a small accessible budget to support activity based learning.

Conclusively, the LS programme is contributing to the wellbeing of young parents and their children across the Southend, Leigh and Shoeburyness area. It contributes to the improvement of peer-led support, quality of life and safety of a marginalised community. Multi-disciplinary team working is improved. Professionals and families recommend its growth. We recommend the area be commended for their commitment to providing the best possible outcome for young parents and their children through the LS services continue to be supported to further develop.

Researchers

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Background

Teenage parenthood, defined as conception before the age of 20, remains a significant social issue in the UK, despite a declining trend in recent years. This literature review examines the outcomes for teenage parents and their children, exploring educational, economic, psychological, health, and social dimensions. The term teenage is used in this section only, replaced with young parent for the remainder of the evaluation. This reflects the literature inclusion criteria and is informed by focus group feedback regarding language preference.

Literature:

Historical and Demographic Context:

Historically, the UK has experienced relatively high rates of teenage pregnancies compared to other Western countries. Recent data from the Office for National Statistics (ONS) indicates a decline, yet the socioeconomic and regional disparities persist. Teenage pregnancies are more prevalent in economically disadvantaged areas, highlighting the need for targeted interventions (Office for National Statistics, 2023).

Outcomes for Teenage Parents

Educational Attainment: Teenage parents often struggle to complete their education. Studies such as Smith and Roberts (2011) reveal lower school completion rates and reduced chances of pursuing higher education. Barriers include childcare responsibilities, stigma, and a lack of supportive school policies.

Employment and Economic Status: Economic challenges are significant for teenage parents. The Social Exclusion Unit (1999) notes that teenage parents are more likely to depend on

welfare and have limited employment opportunities. This economic vulnerability often perpetuates a cycle of poverty.

Psychological and Social Outcomes: Teenage parents frequently face mental health issues. Boden et al. (2008) document increased rates of depression and anxiety among young mothers. Social stigma exacerbates these problems, impacting self-esteem and social interactions.

Outcomes for Children of Teenage Parents

Health and Development: Children born to teenage parents often encounter health and developmental challenges. Hoffman (2006) reports higher incidences of low birth weight and developmental delays. These early health issues can have long-term implications for physical and cognitive development.

Educational Outcomes: Educational performance of children born to teenage parents tends to be lower. Francesconi et al. (2011) find that these children often struggle academically, with lower school attainment and higher dropout rates. The lack of educational support at home and socioeconomic disadvantages contribute to these outcomes.

Social and Behavioural Outcomes: Behavioural problems are more common among children of teenage parents. Moffitt and the E-Risk Study Team (2002) highlight increased risks of behavioural issues and risk of exclusion. These children often face social skills challenges and peer relationship difficulties.

Interventions and Support Programmes

Various interventions aim to support teenage parents and their children. Government initiatives like the Family Nurse Partnership (FNP) and Sure Start provided critical support services. Evaluations indicate that these programs can improve health, educational, and social outcomes for both parents and children (Barnes et al., 2009). An evidence review by the Early Intervention Foundation (EIF) of FNP indicates sound evidence supporting its impact on children and parents' development (EIF, 2021). There are some parallels with FNP and LS. However, the effectiveness of FNP varies, and there is a need for more consistent and comprehensive support.

Discussion

The literature reveals several consistent themes. Teenage parenthood is closely linked to socioeconomic disadvantages, which impact educational and economic outcomes for both parents and children. Mental health issues are prevalent among teenage parents, and their children often face health and behavioural challenges. Effective interventions exist but require better implementation and accessibility.

Conclusion

This brief review underlines the multifaceted challenges faced by teenage parents and their children in the UK. Addressing these challenges requires a holistic approach, encompassing improved educational support, economic opportunities, and mental health services. Future research should focus on long-term outcomes and the effectiveness of interventions to inform policy and practice.

By synthesizing the findings from various studies, this literature review highlights the critical need for targeted interventions and comprehensive support systems to improve the outcomes for teenage parents and their children in the UK.

Context:

From 2007, young parent services were provided by a Family Nurse Partnership (FNP) with A Better Start Southend (ABSS), a project spanning six wards across the city continuing from its inception in 2016.

The Little Steps (LS) Health Visiting Service, a part of Southend City Council's Children, Young People and Families, Public Health Service, was established in 2021 as part of test and learn model, to incorporate an enhanced model of delivery and a new role of a para- professional when working with young parents. FNP was only offering a small cohort of young parents a dedicated offer and inequalities were explored. The focus was offering all young parents at risk of inequalities to access an enhanced offer. FNP had also gone through several periods of staffing instability and business continuity models were being explored.

In late 2023, a board decision was taken to decommission FNP with a formal end date of 31st July 2024. Little Steps at this point would be the offer for young parents under the age of 21 in Southend.

While there is an evidenced need to support young parents, the impact of LS is yet unevidenced. The Healthy Child Programme (HCP) is an evidenced PH service, and this is delivered by Little Steps to parents under the age of 21 with an enhancement to the HCP offer of extra contact visits). Understanding the implications and effectiveness of the LS approach to the staff skills mix for delivery of support to young parents would help Southend City Council and ABSS partners to better understand the impact of the LS programme as the main service for supporting young parents across Southend.

The LS project's primary goal is to support teenage parents to improve outcomes for them and their children. As an enhanced health visiting offer Little Steps supports pregnant and postpartum parents to promote a supported transition into caring for their new baby until aged five. The development of the project was motivated by the decommissioning of FNP in the area calling for a new model of support for these young families' needs.

The LS enhanced and personalised offer operates in Southend, Leigh and Shoeburyness, offering personalised support to first time young parents who are at a higher risk of disadvantage due to parent age. Families are provided health visiting support both pre-natal and post-natal, with commencement of the intervention is pre-birth. LS support continues up to the child's five birthday, though anticipated that in the main contact will be in place until the child enters nursery aged three. Young parent is defined as first time parent under the age of 21.

LS activities are led by a dedicated team of three from the local council co-located in the wider health visiting team. The practitioners are responsible for tailoring health visiting provision to first time young parent needs, including parenting support and referral. Their role includes connecting young parents with other community-based services, specifically housing where the team reports the greatest demand for their support.

The content and duration of each intervention is tailored to the needs of individual families. However, the intervention is provided predominantly in family homes, entailing frequent contact and, where needed, support during meetings with other services, such a child protection conference. There is a weekly Tuesday parent support group where young parents are offered a drop in meetup with other young parents and their children. This support group is run in the centre of Southend, at SAVS. Consideration is being given to offering alternative provision to young parents in Shoeburyness with parent feedback being mixed as to whether the Southend group is sufficiently accessible or if a local group would be beneficial. The Tuesday group acts as a hub with regular attendance via public transport or walking.

Southend City Council, through A Better Start Southend (ABSS) commissioned the University of Essex to conduct a brief evaluation of Little Steps. The evaluation is in two parts, quantitative outcomes data and qualitative data encompassing team (n=3) and parent feedback (n=8). The evaluation adopts a mixed method approach to assess LS outcomes and gain insights into the LS approach and parental experience. This report presents a brief evaluation of LS with some attempt to triangulate findings though quantitative data comparison, both national outcomes and local FNP data.

Evaluation Methodology

The evaluation methodology was shaped by the stated aims of the LS services. Members of the evaluation liaised with report commissioning to design the research design to better understand LS aims in terms of user experience in the context of national and local data.

The evaluation used a mixed-methods, three-layered approach. This included quantitative data analysis, and contextualised qualitative narrative case studies to evidence social return on investment, specifically family maintenance.

We engaged the LS team to gain insights about the needs of the young parents they work with, as well as qualitative data about their experience working in the team.

Data Collection methods

- Quantitative: Administrative data analysis (collected via SystemOne)
- Qualitative: Parent Interviews/Focus Group & Focus Group with LS team.
- Analysis: of data and feedback provided about/by families linked to the list of intervention received by the families

This report seeks:

1. To identify the profile of those who have engaged with LS and to what extent do they and their children appear to have benefited from the service.
2. To identify the characteristics of Engagement with the Service.
3. To examine the outcomes of the service for young parents.
4. To explore the team's perception of the service they offer.
5. To investigate potential areas for development.

Some other questions that relate to the evaluation have been raised. It should be noted that this evaluation is limited to being brief in part due to this only being the second year of LS operation and the need for wider data to offer fuller comparison.

Table 1 provides an overview of evaluation activities, including data sources, collection methods, and procedures.

Table 1: Overview of Evaluation Activities

EVALUATION ACTIVITY	DETAILS	EVALUATION DATA SAMPLE SIZE
Analysis of administrative data	Data recorded by the LS workers for all clients accepted into the service since 2021.	140 mothers (and their children) who had participated in the Little Steps programme, who ranged from 17-24 years of age. *one younger than 17 was mentioned in qualitative data collection but advised had left the area.
	(i) Ages and Stages Questionnaire – 9 months, 24 months (Squires & Bricker, 2009)	140 children whose families were in receipt of the Little Steps service
Analysis of qualitative feedback dataset*	Review of focus group and interview feedback	2 Focus Groups (1 x 3 LS Team members, 1 x 8 Young Parents). 2 Young Parent interviews.
Triangulation of Findings	National data and FNP evaluation comparison.	

The measures listed in Table 1 were chosen to assess impact identified by the commissioning manager and the research team.

*The research methodology was flexible and reflective of young parent participant wishes. As such, following two interviews, it was agreed to move data collection method to focus group following the young parents stating they felt more comfortable discussing their experiences as a group.

Sample Selection and Participants:

All young parents and LS professionals were invited to participate in all relevant aspects of the evaluation. Invitation to participate was co-ordinated through the LS Team. Young parents were invited to participate in advance through advising of a researcher's attendance at the next Tuesday parent group then an on the day introduction including overview of the research including Participant Information Sheet and Consent Form. Ethical approval was provided by the University of Essex Ethics Board (ethics approval is ETH2223-2365).

Data Analysis

Quantitative data from administrative sources, and standard outcome measures were summarised using basic descriptive statistics in Excel. Pivot tables and filtering were used to compare data at a local and national level.

Qualitative data from the focus groups and interviews were analysed thematically.

The researchers met during the data analysis stage to confirm and enhance the validity of findings.

Limitations of the study

1. The provision of services similar to LS and its evaluation are often challenged by the need to establish trust and engage service users before inviting them into service evaluation. While valuing data collection methodology was tailored by the young parents, it would have been useful to have a longer or follow up focus group with young parents.

2. Absence of control group: This evaluation did not include a formal control condition. This poses challenges in identifying and attributing the precise impact of the LS intervention. Future evaluations could consider ways of comparing participants' outcomes with those of non-participants with a similar profile.

Findings

Quantitative component

Below, we describe the findings from the quantitative component of the evaluation. Specifically in this part, we were looking to address the following questions, in as much as is possible from the data held:

1. What (if any) evidence is there of positive impacts for young parents and their children arising from the Little Steps programme in Southend?
2. Are the positive developmental outputs (such as Ages and Stages) seen from FNP also seen from Little Steps?
3. What (if any) are the differences in support needed for the younger versus the older age groups?
4. What (if any) are the differences in support needed for other families in Southend who may be at risk of inequity?

Methods

A data request was made to Southend City Council to provide data from electronic patient record systems. This was for non-selected (i.e. all) patients receiving the Little Steps service, and included in the request was data on their:

- demographic details (parental age and ethnicity)
- housing status (sole or dual parent household 'household makeup), type of housing)
- socio-economic status (Mother's employment status, family employment status – where there were two parents, overall economic status)
- disability status
- contact with social services.
- recorded instances of domestic violence

Ages and Stages Questionnaire (ASQ) (Squires & Bricker, 2009) data from all children at 9 months and 24 months under the service was also retrieved. Furthermore, records on admittance to Accident and Emergency services was obtained.

One hundred and forty records on mothers who were beneficiaries of the Little Steps programme were provided by the Council. Upon receipt of the data, it was inspected for its adherence to quality and completion thresholds. For most variables, the data was 100% complete. The ASQ data, as a developmental assessment dependent on the child's age, varied in availability. For the ASQ 9-month data, 35 patient records lacked this information (25.0% missing) and for the 24-month data this increased to 131 (93.6% missing). Due to this, it was not possible to conduct any longitudinal analyses related to impact of the programme on the child's development, which is further compounded by the absence of control data (i.e. developmental data from children not under the Little Steps provision).

Throughout this report, we use the term beneficiaries to broadly describe the parents and children – the families- that received the Little Steps service. However, it should be noted that some demographic data presented pertains specifically to the mother as a beneficiary (this includes age and ethnicity).

Analysis

It is important to note that this quantitative evaluation remains entirely descriptive, due to the observational, cross-sectional nature of the dataset and the small sample size (n=140). The analyses described, and the corresponding findings henceforth, thereby should not be applied to any wider generalisations beyond the stated findings.

Demographic analysis

To characterise the sample, counts and proportions of the whole sample for the following variables were calculated: age, ethnicity, household makeup, type of housing, Mother's employment status, family employment status and overall economic status. Similarly, the extent of representation of learning disabilities was calculated, as was contact with social services and reasons for this, as well as incidences of domestic violence.

Age group analysis

Beneficiary data was grouped in two subgroups: the 'younger' and 'older' groups. The boundary denoting these will be determined by where the proportion of consecutive ages exceeds 50% (e.g., if beneficiaries who are 17, 18 and 19 comprise 51% of the dataset, their collective data would form the 'younger' group). Developmental outcomes including ASQ scores and other variables including the number of admissions to accident and emergency services will be compared between these two groups.

Intersectional analysis

Given the importance of intersectionality highlighted in much literature around health inequalities and public health policies, describing subgroups of the community who have intersecting identities where there may be multiple systems of oppression and disadvantage at play may be useful. This evaluation looked at subgroups who, based on other evidence on their intersecting identities may be considered more vulnerable beneficiaries. These subgroups are described. Due to the small sample size, comparative analyses was only conducted on any vulnerable groups representing a minimum of 10% (n=14) of the sample. The vulnerable groups explored in this analysis include:

- Those who are ethnically diverse AND younger OR in a single parent household OR live in temporary accommodation.
- Those who live in temporary accommodation AND are younger OR have not had contact with social services.
- Those whose family employment is status is unemployed and not studying AND are in a single parent household OR have a record of domestic abuse.

Comparative analysis of outcomes

Outcomes in the dataset including scores from the Ages and Stages Questionnaire (ASQ) (at 9 months (ASQ-9) and 24 months (ASQ-24)) and number of admissions to accident and emergency services will be compared across groups.

The ASQ is a common, validated and norm-referenced screening tool used to indicate developmental progress in infants and young children. It requires parents to report on their child's achievement of milestones. The ASQ at both time-points can be used in conjunction with an additional screen for social-emotional health (ASQ-SE). The main ASQ covers 5 domains, with 6 questions each. A maximum score of 10 is given for each question if the child has met the milestone, 5 if they perform the behaviour sometimes, and 0 if they are not yet doing it. Cut-off scores are provided for each domain, for each version of the ASQ to aid interpretation (Squires and Bricker, 2009; Batts-Hatfield, n.d.).
Average ASQ scores will be calculated for the overall sample, between the two age groups and between any sizeable vulnerable group identified. The number of children with scores below the cut-offs scores will be counted.
The total number of admissions to accident and emergency services will also be calculated and counted across suitable ranges.

Results

Demographic analysis

Mothers ranged in age between 17-24, with the largest proportion being aged 22 (representing 23.1%, n=31). According to data from the Office for Health Improvement and Disparities, the number of teenage mothers (aged 12-17) was just 0.6% in 2022-2023 (n=10) in the whole of Southend-on-Sea (which was like the year before), therefore it is possible that the Little Steps programme has captured the youngest parents. However, it is perhaps surprising that there are no mothers under the age of 17 recorded – in the qualitative field work it became apparent there were much younger mothers. It is possible that as minors, patient data for mothers aged 16 years or younger was not pulled from System1.

Fourteen ethnicities were identified in the beneficiary sample, though beneficiaries were predominantly White British (85.0%, n=119). The proportion of White beneficiaries appears higher than that recently reported in an evaluation of the Family Nurse Partnership (report in production) which reached a sample of whom 78.5% where White. This may require further exploration. Most data represented two parent households (74.3%, n=104) though living situation varied (with 44.3%, n=62, representing the largest group – as living with relatives, and 34.3%, n=48, in the private rental sector). Over 6.0% (n=9) lived in temporary accommodation including Mother and Baby units or homeless hostels. This compares with Office for Health Improvement and Disparities 2022-2023 data which indicates that in the whole of Southend, for every 1000 persons, there are 11.6 who are homeless with a dependent child. Given the target population size of ABSS, it is possible that there are some homeless families who have not been engaged with the Little Steps programme.

In terms of the mother's work status, many beneficiaries were unemployed (59.3%, n=83). However, when family employment status was examined (taking into account a second parent), a substantial proportion had at least one parent in employment or studying (62.9%, n=88), which included 35.0% with both parents in employment or studying (n=49). A further 35.0% (n=49) had both parents out of employment nor studying, and in a small proportion of cases this status was unclear in the data (2.1%, n=3). Overall, 59.4% (n=82) of the beneficiaries' economic status was being on benefits, with 34.1% (n=47) being employed. A

small proportion were identified as having no recourse to funds (1.4%, n=2) and others were classed as 'unemployed' (5.1%, n=7). Table 1 provides a summary of this descriptive data.

Table 1. Characteristics of the dataset including beneficiary age, ethnicity, housing, mother and family employment status.

Variable	Descriptor	n	%
Age	17	4	2.9%
	18	5	3.6%
	19	14	10.0%
	20	24	17.1%
	21	32	22.9%
	22	31	22.1%
	23	27	19.3%
	24	3	2.1%
Ethnicity	White British	119	85.0%
	Afghan	5	3.6%
	Albanian	3	2.1%
	Mixed	2	1.4%
	Romanian	2	1.4%
	Polish	2	1.4%
	Bangladesh	1	0.7%
	Mixed British	1	0.7%
	Bengali	1	0.7%
	African	1	0.7%
	South African	1	0.7%
	Hasidic Jewish	1	0.7%
	Mauritian	1	0.7%
Family composition	Two-parent household	104	74.3%
	Single parent household	36	25.7%
Housing	Lives with relatives	62	44.3%
	Private rent	48	34.3%
	Housing association/council rent	20	14.3%
	Hostel/temporary accommodation	5	3.6%
	Mother and Baby Unit	4	2.9%
	Home owner/ Mortgage	1	0.7%
Employment status of Mother	Unemployed	83	59.3%
	Employed or studying	57	40.7%
Employment status of Family	Both parents employed or studying	49	35.0%
	Neither parent employed or studying	49	35.0%
	One parent employed or studying	39	27.9%
	Unclear	3	2.1%

Social services and needs

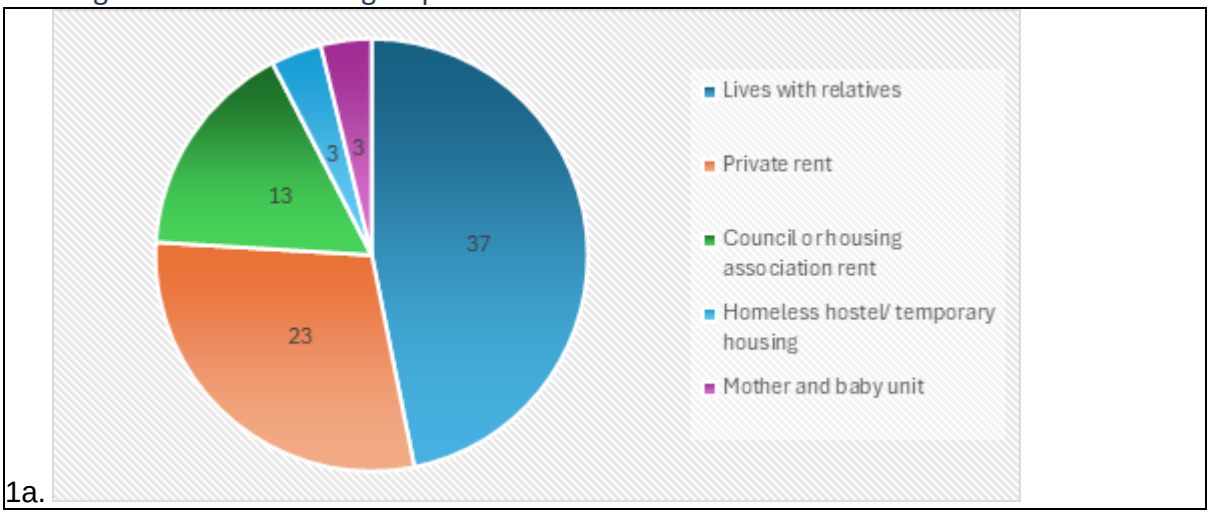
Very few beneficiaries in the dataset indicated a learning difficulty (2.9%, n=4). Three of the four were either Autistic or were suspected Autistic. Over a quarter of beneficiaries had one instance of social services involvement (25.7%, n=36) and a small proportion had multiple instances (1.4%, n=2). The reason for social services contact was not consistently reported, however seven datasets (5.0%) had social services incidences related to drug/substance abuse by a parent (notably, this was linked to cannabis). A small but substantial proportion (10.0%, n=14) of the beneficiaries had a recorded incident of domestic abuse.

Age group analysis

Beneficiaries aged 17, 18, 19, 20 and 21 comprise 56.4% of the dataset, therefore the 'younger' age group was defined as those aged between 17-21 (n=79). The 'older' age group comprises datasets of those aged 22, 23 and 24 (n=61, 43.6%).

The younger group were slightly more ethnically diverse than the older group, though were still predominantly White British (representing 82.3%, n=64 in the younger group, and 88.5%, n=54 of the older group). A slightly larger proportion of the younger group (77.2%, n=61) represented dual-parent households compared with the older group (70.5%, n=43). The younger group were slightly more likely to live with relatives (46.8%, n=27) compared with the older group (41.0%, n=25). The latter group correspondingly had higher rates of private renting (41.0%, n=25) which was less common in the younger group (29.1%, n=23). The older group included fewer beneficiaries living in temporary accommodation or Mother and baby units compared with the younger group (4.9%, n=3 and 7.6%, n=6 respectively).

Figure 1. Pie charts of the representational split of housing status across the younger and older cohorts, with *n* indicated. (a) Top. Housing status of the younger group. 1 (b) Bottom. Housing status of the older group.



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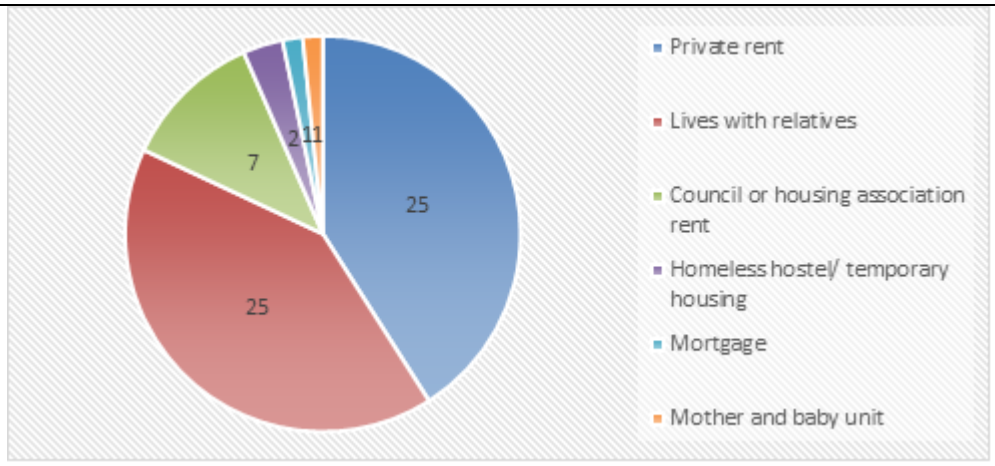

1b.

With regards to employment status of Mother, many more were in employment or studying in the older group compared with the younger group (49.2%, n=30 and 34.2%, n=27, respectively). This was reflected in the employment status of the household, where, in the older group, fewer households were totally unemployed (29.5%, n=18) compared with the younger group (where total household unemployment comprised 39.2%, n=31).
Overall, in this sample, the younger group were more likely to be ethnically diverse, be in a dual-parent household, but be living with family. The younger group were also most likely to be out of employment than the older group.

Intersectional analysis

The vulnerable groups identified largely corresponded to a very small numbers of beneficiaries. However, some groups were more sizeable. For example, 18.6% (n=26) of the sample had a family status of unemployed and not studying, as well as being in a single parent household. Younger and ethnically diverse mothers represented 10.0% (n=14). These two groups, as the only groups represented by 10% or more in the dataset, are the only ones selected for comparative analysis of outcomes (see the next section). The full breakdown of intersectional identities in the sample is outlined in Table 2.

Table 2. Representation of intersectional identities in the sample, indicated by count (n) and proportion (%).

Intersectional identity	**n**	**% of total sample**
Ethnically diverse	***21***	***15.0%***
+ Younger	14	10.0%
+ Single parent household	1	0.7%
+ Live in temporary accommodation	1	0.7%
Live in temporary accommodation	***9***	***6.4%***
+ Younger	6	4.3%
+ No contact with social services	5	3.6%
Family status unemployed or not studying	***49***	***35.0%***
+ Single parent household	26	18.6%
+ Record of domestic abuse	7	5.0%

Comparative analysis of outcomes

Ages and Stages Questionnaire

Only 105 of the 140 datasets contained ASQ-9 data, with only 36 including ASQ- SE data at 9 months. At 24 months, only 9 ASQ-24 datasets were recorded, with 8 of these containing ASQ-SE data. The absence of ASQ data, especially ASQ-24, in general is due to the recency of the Little Steps programme and the fact that many of the children in receipt of services are not old enough for these assessments. Given the significantly small proportion of ASQ-24 data and ASQ-SE data, only ASQ-9 data has been used for analysis.

On average, children in receipt of the Little Steps service are developing in line with expected milestones. Analyses examining cutoff scores indicated that very few children did not reach this measure, with just 2 children falling below the cut off in gross motor, fine motor and problem-solving domains and 1 in the personal-social domain. All children scored beyond the cut-off for the communication domain indicating good level of communication development.

Inspection of the sub-group analyses reveal that on average the groups are performing similarly across domains. The ethnically diverse and younger groups do have slightly lower averages in gross motor, fine motor, problem solving and personal-social domains, however, this is also the group with fewest datasets (n=8) therefore this should be interpreted with caution.

Gross motor also appears to be the domain where having multiple intersecting identities may be most negatively impacted. In this domain, the overall average was 47.3, largely echoed by the average for the younger group (48.0) and older group (46.7), but a slightly lower scores are observed in the ethnically diverse and younger group (41.3) and unemployed and single-parent household group (42.1). However, again it must be emphasised that all scores fall above the cut-off therefore this does not indicate any issues.

Table 3. ASQ-9 average scores across groups, with Cutoff scores noted for reference.

Sample	Average score per ASQ-9 domain				
	Communication Cut off: 13.97	**Gross motor** Cut off: 17.82	**Fine motor** Cut off: 31.32	**Problem solving** Cut off: 28.72	**Personal social** Cut off: 18.91
Overall	54.6 (n=105)	47.3 (n=105)	54.5 (n=105)	51.5 (n=105)	49.9 (n=105)
Younger group	53.8 (n=49)	48.0 (n=49)	53.2 (n=49)	50.9 (n=49)	49.7 (n=49)
Older group	55.4 (n=56)	46.7 (n=56)	55.7 (n=56)	52.1 (n=56)	50.1 (n=56)
Ethnically diverse and younger	55.0 (n=8)	41.3 (n=8)	53.1 (n=8)	49.4 (n=8)	47.5 (n=8)
Unemployed and single parent	53.4 (n=19)	42.1 (n=19)	56.8 (n=19)	51.1 (n=19)	49.7 (n=19)

Admissions to Accident and Emergency (A&E)

Almost one third of the sample had never attended A&E (31.4%, n=44), with 22.1% (n=31) having only attended once. There were a considerable proportion of families who had taken

their child to A&E on multiple occasions (46.4%, n=64), including over 5% having attended six or more times (5.7%, n=8). It is important to note that baby's age has not been accounted for in this analysis, which would have a significant impact on likelihood of admissions (i.e.. the older the child, the more possibilities/likelihood to have an experience requiring admission to A&E). Figure 2 indicates the number of admissions made by respective proportions of the sample.

Figure 2. Admissions of infant made to accident and emergency services, indicated across ranges and represented as a % of the total sample.

In the sub-group analyses, there were some small differences the number of admissions to A&E across groups those these were small. There was greatest representation in the 0-1 incidences by the younger (and younger and ethnically diverse) groups. The highest representation in the 6 or more group was the unemployed and single parent group (making up 5 of the 8 cases).

Table 4. Proportion (and n) of datasets reporting categorical number of admissions to accident and emergency services across the sample and sub-groups.

	Number of admissions to accident and emergency services			
Sample	**0-1**	**2-3**	**4-5**	**6 or more**
Overall	53.6% (n=75)	32.9% (n= 46)	7.9% (n= 11)	5.7% (n= 8)
Younger group	63.3% (n= 50)	25.3% (n= 20)	6.3% (n= 5)	5.0% (n= 4)
Older group	41.0% (n= 25)	42.3% (n= 26)	9.8% (n= 6)	6.6% (n= 4)
Young and ethnically diverse	64.3% (n= 9)	14.3% (n= 2)	7.1% (n= 1)	14.3% (n= 2)
Unemployed and single parent	50.0% (n= 13)	23.1% (n= 6)	7.7% (n= 2)	19.2% (n= 5)

Figure 3. Admissions to accident and emergency services across groups, as per categorical ranges, represented as % of the total sample.

Regional data for Southend-on-Sea from The Office for Health Improvement and Disparities indicates that for every 1000 persons aged between 0-4 years, there were 64.4 admissions to Accident and Emergency services between 2022-2023. This suggests that the rates reported by Little Steps beneficiaries are potentially heightened in comparison to the average, given that 22.1% of our sample had been admitted at least once.

Conclusion

Though a small dataset, it can be used to provide context to the beneficiaries of Little Steps and some indication of the impact. Specifically, in response to the research questions:

> 5. **What (if any) evidence is there of positive impacts for young parents and their children arising from the Little Steps programme in Southend? And, 6) Are the positive developmental outputs (such as Ages and Stages) seen from FNP also seen from Little Steps?**

The data analysis here indicates that the families who participate in Little Steps have children developing largely in line with national expectations in the early infant stages, though they may have slightly higher rates of admissions to A&E. Based on the data from this evaluation, It is not possible to tell whether the rate of developmental progress would have been made without Little Steps. There is some evidence to support that FNP, upon which LS is based, causally implicates a positive relationship between these, as indicated by controlled trials (EIA, 2021).

There were some indications of a possible upward trend in the ethnic diversity of mothers, in that the younger mothers in the service were more ethnically diverse overall. This could be the result of the Little Steps programme successfully engaging more diverse families over time or may be the result of a local population increase in ethnically diverse families.

6. **What (if any) are the differences in support needed for the younger versus the older age groups?**

There are some differences in the younger and older groups of mothers who engaged in Little Steps though the small volume of data makes it difficult to ascertain whether there are actual differences in support needs. This is compounded by the uncertainty around the data capturing younger mothers. Temporary housing was also slightly more common in the younger group, therefore even greater consideration around the context in which families are living may be especially pertinent for younger parents who do not live with relatives or have stable housing.

7. **What (if any) are the differences in support needed for other families in Southend who may be at risk of inequity?**

Many families in the sample face challenges which may impact on their ability to access and benefit from programmes such as Little Steps. For example, in this sample, there was a considerable proportion of single-parent households where the parent was out of work and not studying (although it should be noted that many of these would be likely to still have infants under a year). It may be that these families require additional consideration in future programmes, particularly in relation to financial implications of accessing services (e.g. transport costs) as well as in areas where familial/partner support may be considered particularly valuable such as if a child is not developing typically. There was some relationship between single parents and rates of A&E admission – this could reflect the challenges of single-parenting in relation to the requirements of attending to a child, or also in decision-making and reassurance around a child's health status – both of which may benefit from two perspectives. Whilst there was no disadvantage in developmental progress, gross motor skills may be one domain where more work could be targeted in the Little Steps interventions and especially those that have multiple intersecting identities.

Qualitative Component

The qualitative component of the evaluation aimed to contextualise the Quantative data findings through discussing the experience of working in the LS team and being a beneficiary

of the service. This component included feedback from three staff members and eight young parents. Due to the nature of data collection method, participating young parent demographic data was not collected. The small sample size, on the day time constraints and move to focus group data collection method limited the ability to draw more substantial conclusions. For example, several young parents were noticed sitting separately from the main group of young parents. When asking the team, it was noted the timing would not be beneficial to the young person, such as for example, one young parent was preparing for her child to be adopted. It is important to note, therefore, that any inferences made would benefit from further evaluation to include all young parent feedback.

Below, we describe the findings from the qualitative component of the evaluation. Specifically in this part, we were looking to address the following questions, in as much as is possible in the time allowed:

1. What (if any) evidence is there of positive impacts for young parents and their children arising from the Little Steps programme in Southend?
2. How (if needed) might young parents wish for the LS to change?
3. What (if any) evidence is there of an approach to LS by its Team members?
4. How (if needed) might the team wish to develop the LS programme?

Methods

Qualitative data was collected over one two-hour period attending a pre-Tuesday young parent playgroup team meeting using a semi-structured focus group method. The playgroup was then observed offering young parents the opportunity to be interviewed one-to-one with two parents taking up this offer. One of those parents suggested the original offer of a focus group alternative might sit better with the group. It was agreed they would ask the group with the consensus being the group would prefer to meet as a focus group. Eight parents attended the focus group which was conducted on the playroom floor with their children playing. Due to the ad hoc nature of the focus group, it was not possible to independently canvas all parent preferences and as such it was noted some parents continued to sit separately. Follow-up discussion with the LS team members highlighted those parents who did not participate were aware of the option and had not expressed reasons for not participating. It was suggested some parents may not have been best placed to participate due to personal circumstances on the day. It therefore should be noted that a limitation of the qualitative findings is that it could be argued a full impression was not possible to be achieved. It would be important for further evaluation to consider additional qualitative methods such as the option of a follow-up telephone interview. Initial quantitative data findings were discussed in brief ahead of the focus group with a reflective discussion conducted after qualitative data collection to allow for contextualisation through triangulation.

Staff Focus Group

The focus group offered insight into how LS developed prior to the decommissioning of FNP in the area. The team shared their collective experience including from the earlier iteration

under Sure Start. One participant was relatively new to the team though not to the area of practice. The focus group was recorded with the transcript analysed thematically.

Analysis

Tailored provision

The team felt there was a benefit in having a tailored, dedicated programme for young first-time parents and their children. This was born out of the team's collected practice experience. One team member spoke of LS as:

> "good, old fashioned health visiting".

This was accepted by the other team members and understood as something they would like for all parents, but with workload pressures there was concern that the young parents they worked with would be less able to engage with a generic health visiting service which allowed less opportunity for staff consistency and flexibility. The team agreed that they too have felt the benefit in working with a dedicated cohort however have needed to be active to maintain connections with their wider health visiting colleagues. This has included benefiting from being co-located in the wider health visiting team, albeit hot desking, though it was felt the LS Team would benefit from having a dedicated shared space in parallel. This was evident for example in continued confidence in the referral processes through maintaining checks at different stages of pregnancy to ensure all eligible for the LS programme were referred. Overall, it was reflected that the LS Team afforded positive opportunities for young parents by having a dedicated team who remained connected to wider services. Moving forward, it was agreed some work needed to be undertaken as to framing how endings with the service will be supported. Note was made of the expectation that face-to-face health visiting meetings would cease once the child entered nursery or aged 3 whichever later. It was however acknowledged that the first two years of the project had considered beginnings when the next step would be to consider transitions out of LS. For future evaluation, it would be useful to consider engagement over the five-year programme with outcomes. It would be useful to put in place milestone markers to capture longitudinal impact data for study, such as following a parent and child recipient of LS services to secondary school.

Enhanced health visiting role

The team recognised they had an inclusive relationship-centring, strengths-based approach to health visiting work with young first-time parents. It was acknowledged that this was perhaps considered innate rather than a practice approach decision meriting capturing in guidance for future new staff or iterations of the LS approach elsewhere. The team were well connected across local service provision and recognised housing as a significant challenge for young parents. It was felt accessing benefit entitlement was a met need with note made of young parents being proactive. The relationship-based approach was noted by all young parents as critical to their engagement with the service.

Differing demand

It is not possible from this evaluation to consider the extent to which housing concerns were shared across health visiting or particular to LS programme beneficiaries. When asked if

there were other common themes concerning young parents, note was made of cannabis use being of significant concern across the cohort. This was not evident from the quantitative data or mentioned by the young parents. Given time constraints during conducting the focus group, it was not possible to explore this point further such as recording and response. Future evaluation would benefit from closer exploration.

Young parent interviews (N=2)

Two parents self-selected to meet separately from the group for semi-structured interview. It should be noted that they are partners and while interviewed separately their experiences may not be reflective of the group. For example, the father participant was the only man to attend that session which he confirmed during the interview was uncommon but comparatively a small number.

Fathers

It was noted that fathers are welcome to attend the group, those who do only do so with the mother and child. While both interviewees noted paternity leave meant some fathers may attend without their partner, both considered it unlikely. The male participant was asked if he felt his needs as a young father were met by the LS programme. While it should be noted that it is not possible to extrapolate from one participant's view, the view that the LS programme was supportive and inclusive of fathers is relevant. This was for example noted in acknowledging the different experience of motherhood while acknowledging similar experiences of disconnection from social networks and pressures. When asked if a father specific event would be beneficial, the participant took some time to respond before offering that they could see a benefit in being able to share experiences but did not believe fathers would wish to connect in the same way the young mothers had. Future evaluation would benefit from exploring the extent to which young fathers were engaged in the process and consider comparative outcomes with young mother beneficiaries.

Stigma and societal expectations

Both interview participants shared their perspectives on navigating societal expectations and personal choices, particularly considering their decision to have a baby at a younger age. The participants spoke about the emotional toll of parenthood, including the impact on relationships, specifically friendships, and feelings of loneliness during this period. For example, both noted experiencing changes in established friendship groups such as peers moving onto university places. While both said they did not consider this a loss of friendships, they each reflected that becoming a parent was something they could not actively discuss due to not having the shared experience. This was particularly evident in changed social networks when socialising differently meant the regularity of contact with friendship groups diminished. Both parents reported they had experienced stigma as a result of being young parents though the father participant offered this was mainly directed at mothers. The female participant spoke openly about her experience of post-partum depression and the impact of stigma. She offered that from the point of sharing her pregnancy news, she found few acknowledged her experiencing her becoming pregnant as a

rationale, active decision to being a younger mother. The participant said she often experienced intrusive questions which she described as “rude”, including asking whether her pregnancy was planned or as to her accommodation status. She felt her partner was less likely to meet such criticism, sharing an example of walking in the town with a pram and finding people less likely to accommodate the space she needed on the pavement. The participant offered she would likely feel more able to address “discrimination” with her second child but that she has not felt as able to at this stage.

Both participants offered that it was through the LS programme that they gained confidence in being parents. Both were keen to stress their family and friendship networks but that there was something distinctly “about us” that allowed the LS team to offer tailored support where both participants felt less able to approach their established network. It was evident from their discussions that there was a want for independence such as seeking teething advice first from the LS team then peer beneficiaries of the LS programme. While they offered that they had access to other sources of advice, growing independent parenting skills through interdependence with LS programme staff and beneficiaries was considered invaluable.

Young Parent Focus Group (N=8)

The focus group was requested by the young parents. From observation, there has been some anxiety about meeting someone new individually while there was also a reflection that much of their experiences were shared. Participants, in sharing consent, noted their children’s voices would be included in the recording but not the analysis. The focus group was conducted on the floor of the playroom in a circle with the recording device placed central. The focus group was conducted as a semi-structured with no attempt made to avoid cross conversations to avoid interjecting. Beyond the initial question about their experience of LS so far, the direction of the focus group was determined by the group.

Analysis

The focus group comprised of seven mothers and one father. It was noted that throughout motherhood, support systems are crucial for navigating the challenges of childbirth and early parenthood. Participants shared their experiences of seeking and finding solace in support groups, emphasising the importance of empathy and understanding from health visitors. They highlighted the value of having a supportive network during difficult moments, such as feeling judged or isolated as a young mom. Overall, the conversation underlined the significance of building a strong support system to help mothers navigate the ups and downs of motherhood.

Action items identified by participants as adding value to the LS programme:

1) Improve the space to better accommodate children of different ages.
2) Ensure new mothers feel welcomed and included when joining the group. (Note: from observation, this was in reference to the group welcoming new parents as

comments were consistent about how welcoming the LS team had been including for example, calling ahead to encourage attendance then meeting at the door to welcome them in).

3) Consider ways to address the inconsistent experiences still seen with midwives to better support young mothers. (Note: this was a common experience expressed by the group to varying degrees. For example, one participant spoke of a midwife speaking over her head and only to her own mother rather than directly to her. When asked, the participant share that this experience had impacted her experience of becoming a new parent significantly).

Outline

Childbirth experiences and feelings of judgement among new mothers. The group shared that meeting other people and making friendships during pregnancy was positive. This had allowed them to forming peer friendships which all participants felt had helped then to prepare and to become a mum. This was particularly relevant to reducing feelings of being judged.

The participants shared experiences with childbirth and breastfeeding noting the experience as largely difficult. Negative birthing experiences were foregrounded in the focus group which with more time might be better explored. The negative experiences related to both giving birth and ward experience.

Participants spoke to Little Steps as a welcoming space they had not experienced elsewhere. Two commented on attending another mother and toddler group and while they did not find the other parents unwelcoming, they felt more settled attending the Little Steps dedicated space. All participants spoke of experiencing challenges in connecting with other mothers and feeling supported in their role, with some sharing personal experiences of disappointment and others offering encouragement.

Discussion and Recommendations

The Little Steps programme aims to enable young parents, and their children meet outcomes comparable with their peers. It fills a key gap in service provision where general health visiting teams are less able to provide bespoke provision. The service builds on evidence from previous interventions (such as FNP) and uses a combination of relationship-based support, education and practical support. The service provides a whole-family support to young first time parents through to five years post-birth. This resonates with the wide-ranging impacts of FNP documented elsewhere (EIF, 2021).

This section presents a summary of the LS service evaluation We consider the programme's approach, linking with other services, and reported impact by young parent service users.

We provide recommendations for the continuity and expansion of the service. Due to the short evaluation period, it is not possible fully assess the programme's effectiveness.

Feasibility and Acceptability

Findings from all components of this evaluation found that the LS programme is highly engaging to young first-time parents, the intended users. Findings highlight that referral processes are robust and suited to the intended target population. Take up for the programme is strong, demonstrated by young parent engagement across the programme offer.

Characteristics of Engagement

The characteristics of service users highlight vulnerability and the need for tailored support.

The evaluation shows a high level of engagement with young first-time parents. Evidence highlights that engagement levels good with health visiting services, including engagement with the in-person parent drop in playgroup provision. Engagement levels were so far sustained across the intervention period, albeit the service is two-years in. Findings affirm a high level of engagement with the support programme among young parents who attend with their child. Evidence from this evaluation shows that the pregnancy period motivates engagement with the LS programme.

Implementation Characteristics

The service was highly appreciated by the young families, with families highlighting the importance of the supportive relationship they had with the LS Team. There is strong evidence that the high level of engagement experienced by the service was facilitated by the relationship-based, therapeutic approach employed by the LS practitioners. The success of interventions has been argued to depend on establishing strong therapeutic relationships (Paley & Lawton, 2001).

The LS staff have good working relationships with professionals and work in partnership with young parents to access provision including housing. The Programme’s approach to recruiting practitioners with an established range of related experiences and professional backgrounds facilitated a smooth transition from the FNP to LS programme. The referral identification process, the tailored, holistic service, and a good collaborative working relationship between LS Team members and their wider council counterparts contributed to a flexible, responsive approach to targeted support to young first time parents. The team member's knowledge-based insights, reflexive collaboration and joint-working practices fostered the programme's success.

Considering most of the young parents reported having experienced a reduction in social networks since pregnancy, the Tuesday club provision provided a space for added value whereby young parents shared experiences and built an alternative peer support network, both in terms of mutual advice but also social support. For example, the young parents spoke of negative birthing experiences and occasions whether they felt stigmatised for

being young parents. It was evident that the group afford mutual peer support to discuss these experiences as well as offering connection out of hours, such as when seeking teething advice from each other or meeting to socialise. There is evidence of longevity to these relationships included parents speaking of when their children would start school together in some four years' time.

Recommendations for the Service

Findings from the evaluation highlights some key strengths and areas for development within the programme as outlined below:

1. **Contingency Budget:** A readily accessible small contingency budget would be beneficial. It would allow the LS Team to develop a structured creative programme, such as the Valentine's Day arts and crafts and the Health and Safety sessions highlighted by the young parent respondents. Some consideration should be given to adapting the current Tuesday playroom provision to consider a broader age range of young children accessing the service. For example, at present while the age-group is predominantly under 2s, there will come a time when older children and babies will need to use the space differently.

2. **Whole Journey Mapping**: Mapping relating to the whole five year journey would allow the team to consider the next three years of the programme. This would encompass the transition once their children enter nursery and again when starting school. While the intention is to stop face to face contact once children are in nursery, some consideration may be given to how parents might be supported beyond that point, for example, where a birthday card system might offer encouragement and support.

3. **Practice documentation:** Documentations relating to the underlying principles, ethics, and practice would be beneficial for further programme development. This would provide guidance for incoming team members providing new staff's consistency in quality and allow for replication.

Recommendation for future evaluation

Due to the sample size and time limitations, it is difficult to assess the full impact of the LS programme quantitatively. Further evaluation is needed to establish the full extent and causal relationship to positive changes identified. This should include seeking regular young parent feedback. It was beyond the scope of this evaluation to undertake a full comparison of Little Steps with neighbouring programmes such as FNP and alternative provisions, but it may be useful for a future evaluation to consider these as part of a wider network that the LS Team contributes to.

CONCLUSION

This report presents the results of a brief evaluation of the LS programme. Data was collected from multiple sources to evaluate programme impact.

Results indicate that referrals systems have been appropriate, there has been a high level of young parent engagement with positive outcomes for families. Findings indicate potential support mechanisms, including the team's tailored, relationship-based approach, the collaborating partnership between team member practitioners, and the unique mix of responsive therapeutic, educational and practical support. Further evidence from larger sample sizes is needed to provide comparative outcomes.

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