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STUDY PROTOCOL

Protocol for the Start for Life National Evaluation: What works, for whom, under what circumstances?

[version 1; peer review: awaiting peer review]

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Abstract

Background

Launched in 2021, the joint Department of Health and Social Care and Department for Education Family Hubs and Start for Life (SfL) programme aims to improve support through pregnancy and early childhood. Funding is provided to 75 local authorities (LAs) with high levels of deprivation. As part of this, £170m DHSC funding was allocated for Start for Life services which focus on the 1,001 days between pregnancy and age 2. In January 2025, £57 million was announced for the continuation of Start for Life services in 2025/26. The programme seeks to improve key outcomes for parents and infants. This paper describes the national evaluation of the programme.

Methods

This study uses a mixed-method multilevel triangulation design to assess the impact and cost-benefit of SfL, and to determine which interventions are effective, for whom, and in what contexts. The evaluation consists of two main components: 1) a process and outcome evaluation: to assess changes at both service and individual levels. Qualitative data will be analysed thematically, while quantitative process data will be examined descriptively and triangulated with longitudinal qualitative data and broader process evaluation findings. System-level factors (e.g., workforce attitudes and practices) will be explored to determine their impact on parents and infants; 2) an impact and economic evaluation: this component will use the Synthetic Difference-in-Differences method to construct counterfactuals and evaluate whether the programme affected key parent’s and children’s outcomes, using both individual and LA-level data; it will also include a cost analysis, in which the study will monetise SfL benefits and compare them against the cost of the programme to assess whether it is more effective than usual care, with associated net cost savings.

Plain Language summary

In 2021, the Department for Health and Social Care and Department for Education launched the Family Hubs and Start for Life programme. This programme aims to improve support for families through pregnancy and early childhood. 75 local authorities (LAs) with high levels of deprivation received funding. £170m of this funding was allocated to help LAs develop Start for Life services, focussing on the 1,001 days between pregnancy and age 2. In January 2025, £57 million was announced to help these services continue in 2025/26. The programme aims to help improve key health and wellbeing outcomes for parents and infants. This research uses a range of methods to assess the impact of the Start for Life programme, compare the costs to benefits, and determine which interventions are effective and in what circumstances. There are two main strands to the evaluation: 1) assessing changes for parents, infants and staff at services and individual levels. This will be explored by using interviews and surveys; 2) an impact and economic evaluation. This strand will evaluate whether the programme affects key health and wellbeing outcomes for parents and infants. It will also include a cost-benefit analysis to see if the additional cost of the programme leads to an improvement in outcomes, compared to normal services.

Keywords

Start for Life (SfL), Family Hubs, Early childhood development, 1, 001 critical days, Parental mental health, Parent-infant relationships, Public health evaluation, Mixed-methods evaluation, Cost-benefit analysis, Health inequalities

This article is included in the Policy Research Programme gateway.

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Introduction

The 1,001 days between pregnancy and age 2 set the foundations for an individual's cognitive, emotional, and physical development, shaping long-term health, educational, and social outcomes[1]. This period represents an important window of opportunity to optimise outcomes for all children. However, negative early experiences, compounded by social inequalities, can lead to disparities in early development that persist and widen across later childhood, adolescence and into adulthood[2]. In response to this, in 2022 the government introduced the Family Hubs and Start for Life (SfL) programme, a c.£300 million package aimed at transforming support for families in 75 local authorities (LAs) in England with high levels of deprivation during this foundational period. The programme was extended over 25/26 with an investment of a further £126 million.

The Family Hubs and Start for Life programme, jointly led by the Department for Education (DfE) and the Department of Health and Social Care (DHSC), is central to delivering on the Government's ambition to raise the healthiest generation of children, supporting the commitment in the Plan for Change (December 2024) to strengthen and join up family support to improve support through pregnancy and early childhood. The programme seeks to integrate and enhance existing services through family hubs, ensuring parents and carers can access the support they need, when they need it. Its overarching goal is to improve health and education outcomes and reduce inequalities among babies, children, and families across England.

The programme's objectives include to:

1. Improve immediate and long-term health, well-being and education outcomes by providing universal and targeted support to parents and carers

2. Contribute to a reduction in health and education inequalities for babies, children, and families across England through improving access to services for hard-to-reach groups and those in most need of additional support

3. Contribute to the evidence base for what works, for whom and in which contexts regarding the health, well-being and education outcomes for babies, children and families.

In England, there has been sustained cross-governmental focus on identifying early years services and policies that will level up the opportunities for children, regardless of their background[3]. These policies represent a response to the evidence that by age 5, some children are already so far behind in terms of development that they will be unlikely to close the gap.

The existing literature supports the use of a range of interventions during the 1,001 days[4], and many of these have been included in the Healthy Child Programme, which begins in pregnancy and is underpinned by a model of proportionate universalism[5]. However, evidence regarding the actual benefits of population and area-level models of provision such as SfL during the early years are limited in the UK to the Sure Start Initiative[6,7], and, more recently, A Better Start (process data only)[8], and to evaluations of single national programmes (e.g. FNP)[9].

The current proposal will address this evidence gap by evaluating the implementation, impact and cost-benefit of the Start for Life funding across England.

Methods and analysis

Patient and Public Involvement

Initial involvement included appointing a Peer Researcher as Co-Investigator, consulting with parent/carer champions at Anna Freud, and recruiting members to the Parent/Carer Advisory Group (PCAG). Early PCAG activities focused on identifying individual goals for involvement, refining sampling criteria, engaging community gatekeepers, and reviewing interview schedules with researchers. The peer researcher was involved in applying for funding, which included identifying the importance of setting research questions that focussed on examining the experiences of parents/carers and how these may change over time. The Peer Researcher co-facilitates PCAG involvement, with members contributing to the review of study materials, piloting interviews, refining data collection tools, supporting transcript analysis, and co-creating the parent/carer survey, which some members presented to the DHSC. Their input has been consistent throughout, particularly in shaping inclusive language and ensuring the study reflects diverse parenting experiences. Outcome measures (PHQ-9, GAD-7, MORS) were selected based on Start for Life routine measures, with the Peer Researcher and PCAG advising on their implementation to ensure sensitivity, accessibility, and inclusivity, while also addressing safeguarding considerations. Sampling criteria were developed collaboratively during the scoping phase to ensure inclusion of families representative of local populations and priority groups, with input from the Peer Researcher, PCAG, and parent/carer champions helping to identify underrepresented communities and refine recruitment strategies. PCAG members also supported outreach and contributed ideas for long-term engagement to ensure participants feel valued throughout the study. Finally, PCAG members are actively involved in shaping dissemination plans, advising on preferred formats, languages, and outreach methods, and will help raise awareness and share findings within local communities and parenting networks to ensure relevance and reach across diverse audiences.

Design

This study will employ a mixed-method multilevel triangulation design to assess the impact of SfL at individual, service and population levels. The aim of the evaluation is to determine which interventions and delivery elements have an impact, for whom, and in what contexts through the collection of process and impact data at the above levels. The quantitative and qualitative evidence generated will enable us to assess the factors that are associated with the optimisation of service provision and best outcomes for families, as well as the characteristics of less optimal service models. Specifically:

1. The system-level process evaluation will capture an overview of local SfL programmes, drawing on primary and secondary data from all 75 LAs to: a) understand key factors informing programme and service design and delivery, and b) inform the selection of a sub-set of LAs for 'deep dive' exploration.

2. The individual-level process evaluation will explore families' needs, expectations, access to, and experiences of services in the 1,001 days. This will be done through a longitudinal case series design[10].

3. The impact and economic evaluation will assess the benefits of SfL using both individual and LA-level data from a range of national data sources, and the Synthetic Difference-in-Differences method to construct counterfactuals.

We will combine primary and secondary data collection and analysis, drawing on theory-based and framework analyses to assess programme effectiveness and outcomes. Informed written consent will be obtained from all participants taking part in interviews.

The following sections have been organised according to the above levels of data collection.

Sample selection

1. Process and outcome evaluation

System-level process evaluation: sampling for the system-level process evaluation will be twofold and will include: i) primary and secondary data collection with all 75 funded LAs, including a cross-sectional survey of all SfL leads, a rolling programme of qualitative interviews with all SfL leads phased over years 1–3 of the evaluation, and descriptive analysis of MI data reported by LAs; ii) primary and secondary data collection in 10–12 deep dive case study LAs, sampled purposively with attention to maturity (a mix of Trailblazers and non-Trailblazers), LA characteristics, and meeting data requirements for a robust process evaluation. The phasing for the latter is as follows: 4 LAs – longitudinal (years 1, 2 and 3); 3–4 LAs – cross-sectional (year 2 only); 3–4 LAs – cross-sectional (year 3 only).

The sampling of professionals for qualitative research will be undertaken purposively to achieve a representative cross-section of strategic and operational-level SfL personnel drawn from the 10–12 LAs. We anticipate conducting qualitative interviews with 10–20 professionals per case study LA, supplemented with local workforce surveys, although this will be determined by the size and composition of SfL delivery in each site.

Individual-level process evaluation: this sample will be nested within the 'deep-dive' longitudinal case study LAs; a total of 60 families will be recruited in pregnancy from the 4 LAs and followed up longitudinally (n = 15 families per LA). Eligible families will be identified through local community groups and settings (such as children's centres, community-based antenatal services, and online fora). A combination of self-referrals and active targeted recruitment by the research team will be used to purposively sample participants as we aim to recruit families prior to and regardless of their knowledge of or access to any Start for Life offers. The unit of referral will be a "family", and this can include any composition of family unit, as long as there is at least one caregiver and one unborn child. The sampling criteria will be developed in the scoping phase with the PPI group and through stakeholder consultation to enable the sampling of families that are representative of the local population and priority groups that the Start for Life interventions aim to support (e.g., families from Black and minoritized ethnic groups and/or neurodivergent parents/carers). The criteria will be informed by the theory of change as well as local needs and priorities. Each year, an additional sample of 8–10 parents in different stages of the perinatal period will be recruited to participate in a single interview about service experience. They will be purposively sampled to capture additional cross-sectional data about parents' experiences of a broad range of infant feeding, parental mental health, and parent-infant relationship support services. For these interviews, we will purposively sample service users who may not be represented by the case study sample.

Outcome evaluation for individuals living in funded Sf Lareas: We will look at individual-level pre- to post-intervention scores and indices of reliable change across all SfL services where routine outcome measures of parental mental health and parent-infant relationships are collected and reported. We will also use a cross-sectional survey to collect self-reported outcomes and experiences from a sample of n=1200 parents living in SfL-funded LAs. The selection of sites will be based on triangulation of data from multiple sources, including financial reporting, maturity self-assessment ratings, and MI data.

2. Impact and economic evaluation

We will estimate the causal impact of the SfL on key outcome indicators from individual and LA-level data using the Synthetic Difference-in-Differences (SDID) method. Synthetic control methods in general rely on the existence of several untreated units, composing what is known as the 'donor pool'. The SDID assigns weights to untreated units such that the weighted average of their pre-treatment outcomes closely tracks the outcome trajectory of the treated units, while also weighting pre-treatment time periods[11]. LAs that did not receive SfL funding will be initially included in the donor pool. The cost analysis will build on the findings from the impact evaluation to compare SfL benefits with the costs of the programme.

Data collection and sources

A range of quantitative and qualitative data is being collected as follows:

1. Process and outcome evaluation

For the purpose of the service-level evaluation, we will collate summary-level Management Information (MI) data for all 75 programme LAs on a rolling basis. Data collection will also involve qualitative interviews with strategic-level personnel and focus groups with operational personnel engaged in SfL planning and delivery, which will focus on capturing their views about the programme, its implementation, and impact on families using semi-structured topics guides. Interviews with caregivers' will aim to capture their perceptions regarding their needs, expectations, access to and experiences of support in relation to breastfeeding, parental mental health and parent-infant relationships, and the overall SfL offer. Workforce surveys (i.e. short surveys exploring perceptions of programme coherence; effectiveness, knowledge and awareness of SfL offers and their implementation, self-reported practice outcomes and multi-disciplinary working); documentary analysis will involve extraction of key information from all tools and frameworks, workforce planning and training documents, and service-level data (e.g. Red Books).

SfL teams will be responsible for gathering consent for contact by the evaluation team to administer the quantitative and qualitative data collection – either on a rolling basis, or via a single consent-gathering exercise prior to the first data collection point. We will also seek consent for data linkage. Following consent to contact, SfL teams will supply sample lists and URLs to the evaluation team. Surveys will be administered by sending an online survey link to all consenting parents and carers, with URLs. It will be enabled for self-completion in 7 languages. Response tracking and two rounds of reminders with a telephone booster will be used if necessary. Telephone surveys will be deployed for non-responders to maximise the overall response rate and minimise sample bias.

For the 4 longitudinal case study LAs, we will liaise with SfL leads to plan and coordinate primary data collection, and surveys will be web-based and administered with a diverse workforce sample for case study LAs, with sample-building and cascading coordinated via SfL and Family Hubs teams.

For the purpose of the individual-level process data, caregivers in each case study family will be invited to take part in a yearly in-depth in-person interview and telephone interviews every 3 months. Caregivers will also complete the same standardized questionnaires that will be used for the individual-level impact evaluation to enable data triangulation. To maximise the retention rates and ensure high quality interviews, the same researchers will follow up the same families over time, thus building up a rapport and engaging the families in meaningful interviews over the study period. Support will be available to ensure accessibility (including interpreters, mobile devices and data for online meetings, or travel expenses for face-to-face meetings). Generous participant payments will be made for every part of the research in which a family participates, in the form of shopping vouchers to compensate for their time. The PPI group will advise on engagement and retention in the study on an ongoing basis.

For the purpose of the individual-level data from families living in funded SfL areas, we will assess parental depression (PHQ-9[12]), anxiety (GAD-7[13]), and parent-infant bonding (MORS[14]) pre- and post-intervention for a limited number of interventions using locally-collected data, where available. The cross-sectional survey of parents and carers will capture their need for support with infant feeding, parental mental health and parent-infant relationships, the extent to which they feel that these needs have been met by local services, and, where they have accessed such services, their experiences of these. The survey will also include the PHQ-9, GAD-7, and MORS.

2. Impact and economic evaluation

We will use national microdata at the individual and LA-level. The main source of data will be the Fingertips Child and Maternal Health Data, available from the Office for Health Improvement and Disparities public website, which includes key measures such as vaccination coverage, health visiting metrics, breastfeeding rates at 6–8 weeks and ASQ-3 scores. Individual-level data from the Education & Child Health Insights from Linked Data (ECHILD) database will also be used[15]. The ECHILD contains linked administrative data from NHS hospitals, as well as education and social care services, covering all children in England. It includes data from: Community Services Data Set (CSDS), which records information such as mandated health visits and referrals to community health services; Maternity Services Data Set (MSDS), which includes variables such as APGAR score, birth weight, and first feed status; Mental Health Services Data Set (MHSDS), which includes information on secondary care for parents and children, for mental health and learning disabilities (such as referral, reason, and treatment); Hospital Episode Statistics (HES), which includes information on admitted patient care, critical care, accidents and emergencies, outpatient care and mortality records; Children In Need (CIN)/Children Looked After (CLA), with records of all children referred to children's social care services, including those looked after by a Local Authority. Cost data will be drawn from SfL administrative records and the best available sources (e.g. the NHS National Cost Collection for the costs of NHS services, or previous studies).

Data analysis

1. Process and outcome evaluation

Qualitative and quantitative data from both service and individual-level process data collection: the qualitative data will be analysed thematically, and the quantitative data will be examined descriptively, including patterns of change over time in parental mental health. This will be triangulated with the longitudinal qualitative data and the wider process evaluation data to explore the impact of system-level factors (e.g., changes in workforce attitudes and practices) on parents.

Individual-level data from families living in funded SfL areas: this data will be analysed using a range of descriptive and inferential statistics to assess reliable change over time (i.e. pre to post) for each of the three main outcomes being measured, and, for the survey responses, to assess differences across groups.

2. Impact and economic evaluation

Impact evaluation: to estimate the causal impact of SfL on parents' and children's outcomes, we will use the Synthetic Difference-in-Differences (SDID) method[16]. The SDID combines features of traditional synthetic control and difference-in-differences approaches by considering both time and unit weights in the estimation of treatment effects. Specifically, the method assigns weights to untreated units and pre-treatment time periods such that the weighted average of the untreated pre-treatment outcomes closely tracks the trajectory of the treated units, and the weighted average of pre-treatment periods closely resembles post-treatment outcomes for untreated units. Treatment effects are then estimated via a doubly-weighted two-way fixed effects regression, where both unit and time weights are applied. We will also examine whether effects differ by relevant groups (e.g. socioeconomic status, ethnicity), and include sibling fixed effects in the analysis of individual-level data. Following best practice, we will perform extensive robustness tests, and also assess the sensitivity of the results to the use of alternative methods.

Cost analysis: drawing on findings from the process and impact evaluations, we will monetize short-term benefits of SfL by combining the estimates obtained from the best available sources (e.g. the NHS National Cost Collection for the costs of NHS services, or previous studies) and compare these against the cost of the programme, to assess whether SfL is more effective than usual care, with associated net cost savings. We will follow NICE guidelines (including recommended discount rate and performing extensive sensitivity analysis) and carry out a Cost-Benefit Analysis to compute the Return on Investment (RoI) from the perspective of those providing and using the services. For the CBA, we will supplement the short-term outcomes from the impact evaluation with medium-term health and developmental outcomes (from the National Pupil Database and the National Child Measurement Programme), using surrogate-index methods to account for not-yet-realised returns[17]. Upon consultation with DHSC, we will also provide an assessment of the trajectories of the returns, including the likely break-even point[18].

3. A synthesis of the data across the workstreams will enable us to address the overarching questions described above and will be undertaken in conjunction with our PPI co-applicants. Specifically:

a. System-level process data will be combined with impact data to assess the factors that are associated with optimal services and the best outcomes for families, and to elicit best practices that can be applied across the 75 funded areas and beyond.

b. System and service-level data will be used to identify the factors that drive and shape service delivery, and the individual/family process-level data will be used to identify the acceptability of services to families, and stakeholder views regarding factors that affect uptake and impact.

c. We will test the overall Theory of Change for the SfL programme, drawing on all data sources to explain the observed impacts at programme and strand levels, and synergies between SfL and Family Hubs.

Ethics and Dissemination

The main ethical considerations will be concerned with a) participant burdens and/or risks b) the physical and psychological safety of the study researchers; and c) consent, data protection/confidentiality. We will ensure that all researchers abide by the recognised GDPR, GCP, and Safeguarding procedures, and that they have been appropriately trained and certified.

The final outputs, engagement and dissemination plans will be co-produced with families, and will aim to identify key audiences and channels, and leverage maximum research impact through a range of methods including policy workshops, practice guidelines and parent-friendly information. We will also connect with networks established via the national centre for family hubs and AFC's Early Years in Mind network.

Participants and the wider population will be kept informed about the progress of the study and findings throughout the duration of the study using a range of accessible methods (i.e. newsletters, leaflets, website, blog and social media) and where relevant different languages and formats. We will support our PPI group to perform a role as Learning Champions, raising awareness of the evaluation within the SfL LAs, and disseminating more widely via parenting networks as multipliers. Through this approach we will aim to boost awareness and reach with culturally and linguistically diverse communities and with families who may not be accessing SfL services.

The findings of the research will be disseminated to relevant audiences using conference presentations, and publications in academic, policy and methods journals. We will also hold at least one roundtable session, bringing together civil servants, professional associations, third sector partners, and parent and carer representatives to consider the implications for policy and practice.

Ethics and consent

Ethics committee approval has been secured from the University of Oxford and IDREC. The study also has ethical approval from the Hampstead Research Ethics Committee (24/LO/0371).

Informed written consent will be obtained from all participants.

Dissemination

The findings of the research will be disseminated to relevant audiences using conference presentations, and publications in academic, policy and methods journals. We will also hold at least one roundtable session, bringing together civil servants, professional associations, third sector partners, and parent and carer representatives to consider the implications for policy and practice.

Disclaimer

This study/project is funded by the NIHR. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Data availability

This is a study protocol and no data are associated with this article.

Data sharing

There will be no data sharing because: a) the interview and survey data cannot be sufficiently pseudonymised to be made publicly available, and explicit consent for data to be shared in this way was not collected. The remaining data is already publicly available.

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