**Review of the Impact of Children’s Centres**

**(Findings from literature search)**

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# Background

The first 524 Sure Start local programmes were established between 1999 and 2003 and were aimed at families with children up to the age of four living in disadvantaged areas. The aim was to bring together early education, childcare, health services and family support to promote the physical, intellectual and social development of babies and children. They were geographically targeted to specific disadvantaged areas and all children living in the targeted area and their parents were eligible to receive services. Each programme chose its own mixture of services and delivery methods, based on an assessment of local needs and consultation with parents. They also aimed to reshape, enhance and add value to existing services and to increase co-ordination between services.

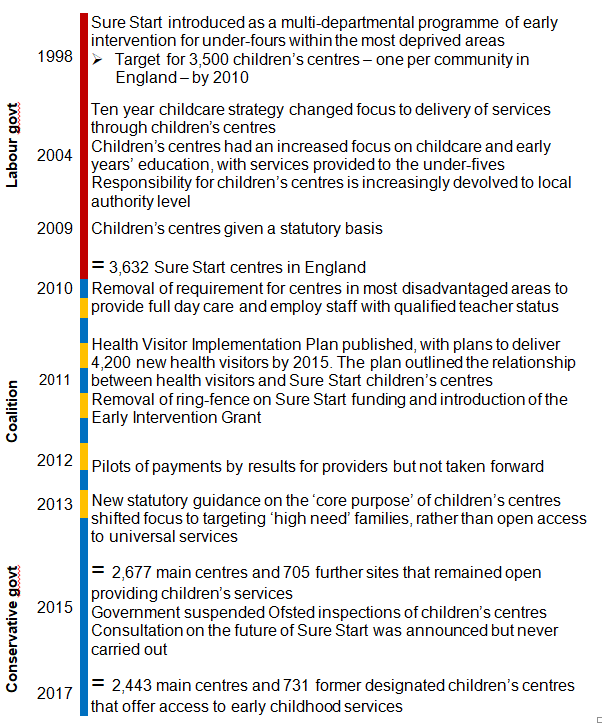
Since the removal of ring-fenced funding in 2011, local authorities have made widely different decisions about their children’s centres and services: some have closed most or all of their centres, while others have chosen not to officially close any. Instead, many local authorities have delivered cuts in other ways, such as curtailing opening hours, cutting back on services delivered through the centres or merging them.

Southend Unitary Authority is currently reviewing the children’s centre offer within its area. As part of this, A Better Start Southend commissioned the Health and Care Research Service at the University of Essex to undertake work to:

* Identify and review key research, reports and literature relating to children’s centre services or similar provisions in the UK.
* Identify up to six localities/local authority areas which have reviewed, reorganised or re-provided children’s centre services and undertake a desk review of impacts plus two or three telephone/virtual interviews with key individuals in these localities. Interviewees are likely to include commissioners/senior managers working with children’s centres in local authorities, CCGs and voluntary sector organisations.

A Better Start Southend is a national-lottery funded programme which responds to the link between economic deprivation and poor life chances. It provides free services to families with babies and very young children (age 0-4) in the six most economically deprived wards in Southend. The programme aims to improve children’s diet and nutrition, social and emotional development, and speech, language and communication, thus improving their longer-term life chances.

**Timeline for the development of Sure Start and Children’s Centres**



# Key Conclusions from Literature Review

**The evidence shows that:**

* Children’s centres have a positive impact on family, mother and child outcomes, including:
* Improved family functioning, parenting ability and home learning environment.
* Improved maternal mental health, confidence and skills as a parent.
* Improved early years’ development and pro-social behaviours of the child.
* Lower BMIs and better physical health for children at age 5, and an 18% lower probability of children being hospitalised by age 11.
* Higher than average reduction in child poverty in children’s centre ‘reach’ areas.
* Most of the value of the benefits comes from improved earnings/employment outcomes for the families using services. The economic benefits for children typically do not emerge for at least 15 years but include lower offending rates and higher educational attainment resulting in higher earnings as an adult.
* Parents value children’s centres, are very satisfied with them and find them helpful.
* Barriers to the use of children’s centres include: parents unaware of the service; parents prefer to use another children’s centre or service; they do not need to use the service; it is too far away/hard to get to.

**Proven effective practices are:**

* Good multi-agency working with well integrated and inter-disciplinary working.
* Provision of named programmes and sharing of good practice.
* High quality leadership, governance, team work and excellent staff.
* Focusing on the development of parenting skills.
* Removal of barriers to access/accessibility of services, including outreach.
* Good use of monitoring data and information, and the setting of targets.
* Engaging with and listening to the views of families.
* Good communication and interpersonal skills.

# Executive Summary

## 3.1 Evaluation of children’s centres in England

### 3.1.1 Financial value

* The average total weekly delivery cost was just under £10,000 per centre (at 2014 prices).
* Just under 60% of costs were attributable to the delivery of specific services while the remaining costs could be attributed to the general running of the centre. Staffing represented three quarters of costs while venue costs and other costs roughly accounted for equal shares of the remainder.
* Some children’s centre services provide positive value for money. Policies which have an impact on early child and family outcomes can potentially generate substantial monetary returns over and above the costs of delivering the services.
* Most of the value of the benefits is derived from improved later labour market outcomes for the children in the families using services. The majority of the benefits accrue to individuals through higher net earnings rather than to the Government.
* Parent support and specialist family/parent support services offer better value for money than the more child based services, but this is driven more by a lower cost per user than a higher benefit per user.

### 3.1.2 Impact on parents

**USING CHILDREN’S CENTRES HAS HAD A POSITIVE IMPACT ON PARENTS WHO ARE VERY SATISFIED WITH THEM, VALUING THE RELATIONSHIPS BUILT WITH STAFF AND OTHER PARENTS**

* Positive outcomes and benefits for parents were:
* Using children’s centres had a positive impact for most of the parents who use them, including on their confidence and skills as a parent.
* Families registered at centres experiencing ‘supported growth’ reported greater improvements in various measures of family functioning than those registered at ‘reducing’ centres (that were experiencing cuts).
* Children’s centres have a key role in providing mental health and employment support.
* There is a high level of satisfaction with children’s centres amongst parents. Parents find them helpful and they value the personal relationships built with staff and other parents, and the fact they can access different kinds of support in one place.
* Barriers to the use of children’s centres include: parents have not heard of the service; parents prefer to use another children’s centre or service; they do not need to use the service; it is too far away, hard to get

### 3.1.3 Impact on children

**CHILDREN’S CENTRE ‘REACH’ AREAS SHOWED GREATER THAN AVERAGE IMPROVEMENTS IN CHILD POVERTY AND SCHOOL READINESS**

* Child poverty levels in children’s centre ‘reach’ areas declined, and children’s centre areas showed a greater improvement than the corresponding local authorities and England as a whole. There is also a sense that reach areas were being ‘pulled up’ by improvements in the local district.
* The proportion of children achieving a ‘good’ level of development at the Early Years Foundation Stage showed a general improvement in the children’s centre ‘reach’ areas.
* Evidence from a small scale study showed improvement in parents’ capacity to support their child’s health and their ability to cope with difficulties. It also showed improvements in children’s ability to contribute to the learning environment and that the majority of the children in the sample were ‘better off’ in a range of developmental and behavioural ways.

### 3.1.4 Effective practices

The key aspects for effective children’s centre provision include:

* Good multi-agency working with well integrated and inter-disciplinary working.
* High quality leadership, governance, team work and excellent staff.
* Sharing of good practice.
* Focusing on the development of parenting skills.
* Removal of barriers to access.
* Accessibility of services, either within a building or via outreach.
* Good use of monitoring data and information, and the setting of targets.
* Engaging with and listening to the views of families.
* Good communication and interpersonal skills.

## 3.2 Children’s centres in other countries

### 3.2.1 Australia

Children’s centres in South Australia were broadly modelled on the UK Sure Start programme. Centres are located in areas of community need and provide a ‘one-stop shop’ by bringing together a range of services for children aged 0-8 and their families. These services include early years’ education and childcare plus support for child development and families.

Although centres in South Australia have not reduced duplication of services in their area, they are reported to be helping to improve referral pathways in the broader community. Parents using children’s centres report high levels of wellbeing, social connectedness and positive parenting practices, although families who have additional support needs report less favourable outcomes.

Child and family centres in Tasmania are a place-based early years’ model that provide a single entry point to early years’ services for children and families living in amongst the most disadvantaged communities in Australia. The complementary, comprehensive and co-ordinated services are universal, with targeted and specialist services tailored to the specific needs of a community.

Tasmanian centres have overcome barriers to parental engagement in early years’ services in a number of ways. Centre users make more use of early years’ services than do non-users, and rate their experiences of these services more positively. Parents identify centres as informal, accessible, flexible, responsive, neutral, non-judgemental and supportive places where they feel valued, respected and safe. Parents said these qualities make the critical difference to their engagement and positive experiences of services and supports in centres, in contrast to some of their experiences in the past. Parents feel centres are welcoming places that are helping them to develop positive child, family, school and community connections. Parents report that involvement in training and learning opportunities through the centres has led to increased confidence, skills and knowledge; and education and employment opportunities.

What makes a user-friendly service?

* Geographical, physical and psychological accessibility.
* A ‘neutral’ doorway, meaning an entry which is non-stigmatising.
* Single-doorway services.
* A welcoming entry, including ease of access.
* The provision of information on services and resources.
* Cultural diversity in environmental design..
* Availability of outdoor space.
* Safety is an issue which provides a challenge
* Community and group work space.
* Co-location of interrelated services.

### 3.2.2 Canada

Toronto First Duty (TFD) is a model of service integration across early childhood programmes of child care, kindergarten and family support in school-based hubs, plus other services such as public health. It offers universally-accessible services that promote the healthy development of children aged 0-5, while at the same time facilitating parents’ work or study and offering support to their parenting roles.

Children have benefited socially and emotionally, and developed pre-academic skills. Higher levels of use of the programme increased children’s cognitive and language development. Parents whose children attended TFD programmes report being more involved in their children’s early learning and express high levels of satisfaction with TFD programmes. TFD has achieved the goal of equitable access for all families.

Staff have strong positive opinions of the professional benefits from integration. Factors facilitating higher levels of integration include:

* Strong leadership, with shared resolve and problem solving.
* Opportunities for staff time to meet.
* Common beliefs and an articulated site vision.
* Monitoring of integration and quality using measurement tools.
* Teamwork aimed at children’s development that also includes respect among blended professionals.
* Common professional development.
* Using the common curriculum principles provided.
* School space for co-location of care with kindergarten and other services.

### 3.2.3 Germany

Family centres bring together a range of health, education and creative services for families in the local community, plus space available for childminders. They are a universal service with an additional special focus on target groups such as immigrant or educationally deprived families. They collaborate with family education and advice services to make these services accessible to a larger number of families. Acting as a ‘hub’ of a network of family and child welfare services, family centres offer parents and their children advice, information and assistance in all stages of the early years. Many of these services are not offered by the staff of the centres themselves but by local partners or other professionals.

Family centres have succeeded in reaching families more easily in their neighbourhood. They are highly accepted and local youth offices consider them as an important element of their policy. The cooperation between family centres and counselling agencies is seen as a very positive element. However, resources have been shown to be a restraining factor and not every family centre is able to offer all the activities that are needed.

### 3.2.4 Netherlands

Parent and Child Centres are neighbourhood-based family health care service centres where doctors, nurses, midwives, maternity help professionals and educationists are integrated into multi-disciplinary teams. Although being part of the same multi-disciplinary team, midwives and maternity help professionals do not operate from the same building as the other core partners but from private, independent organisations often working from the client’s home. The centres’ aims are to improve parenting and identify social and health risks at an early stage.

The centres are easily accessible with continuity of care, better collaboration with easier contact and communication between professionals, especially for low-threshold cases. However, challenges include a lack of uniform multi-disciplinary protocols and work procedures, no standardised procedures to collect and store information, a delay in communication between hospital, midwives and centres and centres potentially being dominated by professionals rather than clients.

### 3.2.5 Northern Ireland

The Sure Start Programme in Northern Ireland was introduced originally as a health and social care programme, but the focus has now widened to include education outcomes. It is currently provided in the top 20% most deprived wards and focuses on improving the social, emotional and cognitive development of children or their literacy and numeracy skills. Each Sure Start project varies in its size and the services it offers, which are delivered by a variety of different staff, including health visitors, midwives, early years/family support workers and speech and language therapists. In addition a number of Sure Starts use volunteers to deliver activities such as providing crèche services. The services focus on a range of needs including childhood development, health and wellbeing plus parental support and support for specific vulnerable groups.

Partnership working is seen as strong, including health professional input in identifying families who may require additional support after a baby is born and referring them to services as soon as possible. Location and sharing premises also assists partnership working with voluntary and community sector organisations. The wide range of high quality programmes, information and support for parents contributes to improved emotional wellbeing for parents and improvements in the home learning environment. Pre-school settings have reported consistently on improvements in children’s settled behaviours, attention and listening skills. The highly effective practitioners, from varying professional disciplines, engage in continuous professional development and training which is cascaded to staff to enhance their delivery of programmes and services. There is effective inter-disciplinary team collaboration and sharing of information to identify and follow up on the needs of families and children at the earliest stage.

### 3.2.6 Norway

Family centres – known as family’s houses - are a complete range of services based in the same premises. They provide inter-disciplinary services for children, adolescents and their families in the municipalities. Both health and social services are located together. Universal services comprise an open kindergarten, support and counselling for parents including a parenting training programme and a drop-in language course for immigrants. More targeted interventions and services include healthcare services for children, pregnancy care, preventive child welfare services and pedagogical-psychological services.

Location in the centre of the community is important for access and engagement by parents. Co-location with other services is seen as an advantage allowing more parents to access healthcare. Having free of charge services is seen as important, especially for families with low incomes. Centres provide an opportunity to meet other adults and receive social support in parenting and everyday life, as well as enabling children to develop new skills, meet other children and play. Parents value being able to drop by and the flexibility of services lead parents to make frequent use of the services. The centres have a positive impact on early intervention, including families in the early stages of a developing issue, acting as ‘door openers’ to other public services. Continuity of contact with the same professionals is important for all parents.

### 3.2.7 Sweden

Family centres are fully integrated with maternity healthcare, child health services, open pre-school and social care/preventative activities and operations. They provide a complete range of services which are fully co-located and which are administered jointly by local municipalities and healthcare in the area.

Open pre-schools at family centres can contribute to greater equity in health among different social groups and can be a powerful factor in public health care. They are a key meeting place for immigrant parents living in the suburbs. Parents visit the open pre-schools primarily for the sake of their children, but also in order to meet other people, exchange experiences and find help and support. Most staff report that the family centres have led to changes in how they work, which in turn increases the quality of interaction with the families. The professions involved in family centres belong to a common field of service and this facilitates collaboration within family centres and amongst staff. An agreed budget, guaranteeing staff from different authorities time to collaborate, benefits collaboration in the family centres.

Success factors for family centres were:

* Creating a framework for child centred social intercourse and a good atmosphere where parents support one another.
* Greeting visitors so that they are unafraid to cross the threshold.
* Furthering parent-child bonding.
* Supplying service and social counselling.
* Creating an opportunity for conversation and active listening to promote growth as a parent.

## 3.3 Evaluation of Sure Start local programmes

(NB: establishing the effectiveness of Sure Start centres is difficult as they were implemented in deliberately localised and different ways. This lack of consistency prevented an effective evaluation of Sure Start as a nationwide programme.)

### 3.3.1 Financial value

* On average, Sure Start local programmes cost around £1,300 per eligible child per year (at 2009-10 prices), varying from £450 to £2,500 per eligible child.
* The economic benefits for children typically do not emerge until at least 15 years after the intervention begins.
* By the time children reached five years old, Sure Start had delivered economic benefits of between £279 and £557 per eligible child, due to parents moving into paid work more quickly than parents in comparison areas. Several other outcomes have the potential to generate economic benefits in the future: lower offending rates for children; and higher educational attainment resulting in higher earnings as an adult.

### 3.3.2 Impact on parents and children

**AVAILABLE RESEARCH SUGGESTS THE SURE START PROGRAMME WAS HIGHLY VALUED BY PARENTS AND HAS HAD POSITIVE EFFECTS IN PROMOTING BETTER FAMILY, MOTHER AND CHILD OUTCOMES**

Positive effects resulted in better family, mother and child outcomes, including:

* Improved family functioning, parenting ability and home learning environment.
* Improved maternal mental health later on.
* Better pro-social behaviours of the child.
* Lower BMIs and better physical health for children at age 5.
* An 18% lower probability of children being hospitalised by age 11.
* Greater life satisfaction for parents.
* The negative effects were that mothers experienced more depressive symptoms and parents in Sure Start areas were less likely to attend school meetings.
* Since Sure Start targets the most vulnerable families, with a high level of needs, their outcomes are likely to reflect these high needs.

### 3.3.3 Effective practices

* The key influences that promote better child, mother and family outcomes are: offering named programmes; maintaining or increasing services; and multi-agency working.
* Outreach is effective in reaching out to and supporting families, including those who are hard to reach.

# Methodology

**4.1 Literature review**

The aim of the literature review was to identify published research and reports that evaluated effective working practices within children’s centres or the impact on/outcomes for families.

Searches for published research, evaluations and other reports were conducted between 22nd October 2020 and 15th November 2020 using the following search terms:

*“Children’s Centre\*”* OR *“Family Centre\*”* OR *“Sure Start”*

AND

*“Good practice”* OR *“Best practice”* OR *“What works”* OR *“Good Outcomes”* OR *“Working Practice”* OR *Impact*

Searches were limited to English language and by year of publication (2009 – 2020).

The databases searched for the keywords at abstract level included: Medline, PubMed, APA PsychINFO, APA PsychARTICLES, CINAHL and Web of Science. In addition, the key words were searched for in full using the Social Care Institute of Excellence (SCIE) online database, Google and Google Scholar.

A total of 32 England-based studies and reports were identified as being relevant to the review aims and are summarised within this report.

In addition, 15 studies and reports were identified for 7 other countries as being relevant to the review aims, so are therefore summarised in this report.

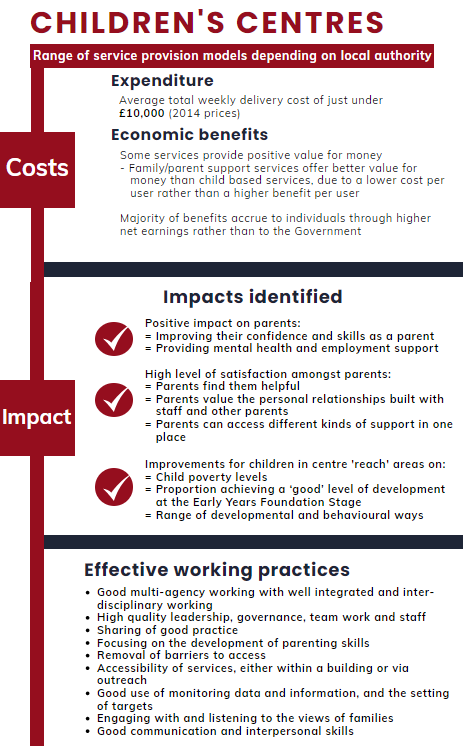
**4.2 Format of the report**

Findings about the Sure Start local programmes are included within the final section of this report since they relate to the original local programmes which are not standardised in their offer or policies. The findings relating to the more generic form of children’s centres in England, launched in 2002, are summarised in a separate section.

# Evidence on Children’s Centres in England

Following on from the Sure Start initiative of 1998, children’s centres were launched in

2002. This section looks at the evidence published since this point that relates to a more generic form of children’s centre offer than the Sure Start local programme offer.



## 5.1 Financial cost and value for money

There were 2 research studies identified looking at the financial costs and value for money of children’s centres.

### 5.1.1 Conclusions

The average total weekly delivery cost was just under £10,000 (at 2014 prices). Just under 60% of costs were to deliver specific services while the remaining costs could be attributed to the general running of the centre. Staffing represented three quarters of costs while venue costs and other costs roughly accounted for equal shares of the remainder. Across all services, the average cost per user hour was £30.

Key findings on value for money were that:

* Some services provide positive value for money.
* Policies which have an impact on early child and family outcomes can potentially generate substantial monetary returns over and above the costs of delivering the services.
* Most of the value of the benefits is derived from improved later labour market outcomes for the children in the families using services.
* The majority of the benefits accrue to individuals through higher net earnings rather than to the Government.
* Parent support and specialist family/parent support services offer better value for money than the more child based services, but this is driven more by a lower cost per user than a higher benefit per user.

Sources are:

| Robustness of studies ✰✰✰✰✰ |
| --- |
| *1) Evaluation of Children's Centres in England (ECCE) Strand 5: The value for money of children’s centre service (DfE Research Report DFE-RR561, 2016)* |
| *2) Evaluation of Children’s Centres in England (ECCE) Strand 1: First Survey of Children’s Centre Leaders in the Most Deprived Area (DfE Research Report DFE-RR230, 2012)* |

#### 5.1.2 Cost of children’s centres

The **local authority provided an average amount of close to £300,000 per centre** in 2010/11 and up to £3m for some children’s centres. Charging fees brought in an average revenue of close to £50,000 and partner agencies provided on average approximately £17,000. The largest area of expenditure was employment costs which accounted for three quarters of expenditure in 2010/11.

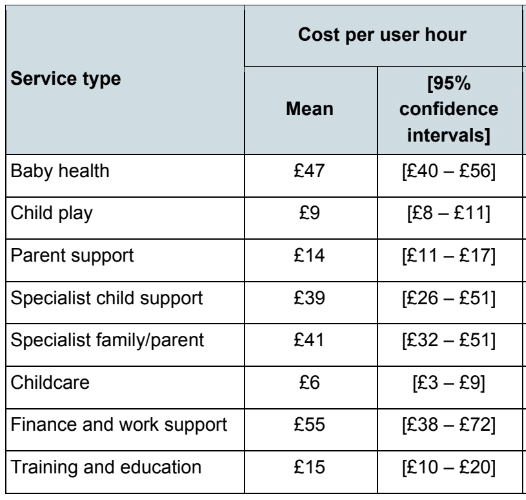
The average annual salary of staff was £15,001-£20,000 in 2011[[1]](#footnote-1). 3% of staff were paid over £40,000. Over half of all the staff delivering services were employed by the children’s centre (29% full-time and 25% part-time). Staff employed by other organisations comprised 28% and volunteers made up 18% of staff.

The **average total weekly delivery cost** was just under **£10,000** (at 2014 prices). This total cost included both the costs paid by the centres and costs implicitly paid by other government and private organisations or individuals through the provision of venue space and staffing without cost to the centre (including the value of volunteer time).

On average, **just under 60% of costs were to deliver specific services** in 2014 while the remaining costs could be attributed to the general running of the centre. **Staff costs formed the majority of costs (an average of three quarters)** while venue costs and other costs roughly accounted for equal shares of the remaining costs.

The average cost per user hour (at 2014 prices) for the main types of services offered by the centres is presented in the table below. Cost per user hour is the value of resources used to deliver one hour of a service to each child or family, including the use of resources specifically for the service and a share of the general running costs. Across all services, the **average cost per user hour was £30**. Services using more specialised staff and operated to a greater extent on a 1:1 basis tended to have a higher hourly cost while services offered using less skilled staff and with a tendency to be offered in groups had lower average costs.

**Hourly cost per user for different service types (2014 prices)**



#### 5.1.3 Value for money

Some important caveats about the value for money estimates should be noted:

* The value for money analysis is for hypothetical scenarios of possible impact sizes on child and family outcomes when a child is aged three. These scenarios are drawn from the observed associations between the use of services and improved outcomes.
* The findings are based on point estimates of mean values for all costs, benefits and other parameters without consideration of the sampling variation.
* Assessment of potential sources of the under-counting of the value of benefits suggests that the main omission is the value of any enhanced wellbeing associated with service usage, the value of which would accrue to individuals rather than the Government.
* There is a considerable degree of approximation in drawing on related but not necessarily completely appropriate evidence to derive the links between immediate outcomes and later lifetime outcomes.

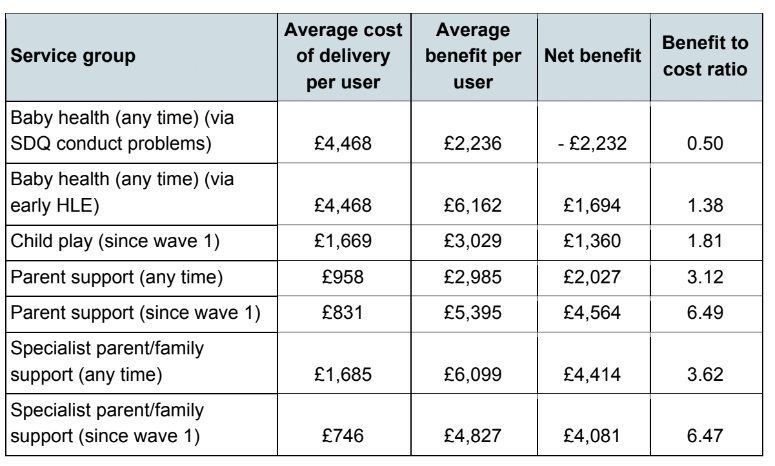
Given these caveats, the main contribution of this analysis is not to produce precise estimates on the value for money, but to identify some key findings about how children’s centres may offer a monetary return on their costs:

1. The study estimates that **some children’s centre services provide positive value for money** where the monetary valuation of improved outcomes exceeds the costs of delivery.
2. Policies which have impacts within reasonable bounds of magnitudes on early child and family outcomes can potentially generate substantial monetary returns over and above the costs of delivering the services.
3. **Most of the value of the benefits is derived from improved later labour market outcomes** for the children in the families using services. (Without the associated increase in earnings, the services would offer very little financial return.)
4. The **majority of the benefits accrue to individuals** through higher net earnings rather than to the Government.
5. **Parent support and specialist family/parent support services offer better value for money than the more child based services**. This is driven more by a lower cost per user than a higher benefit per user.
6. There is some weak evidence that impacts on the early home learning environment (HLE) at age three have a higher value of benefits than comparable impacts (driven by the same service) on child social development at age three.

The average cost of delivery for each service type was combined with the estimated value of the benefit of the service for each user to derive the measures of cost benefit summarised in the table below.

**Most services have a positive net benefit with the average benefit per user exceeding the cost.** Only when baby health services are assessed using only the SDQ conduct problems impact is there a negative net benefit. Interestingly, the parent services have a higher benefit to cost ratio than the more child based ones, with a ratio of over six for parent services used between the target child being aged one and three years. These highest returns are driven more by a lower cost per user than a higher benefit per user.

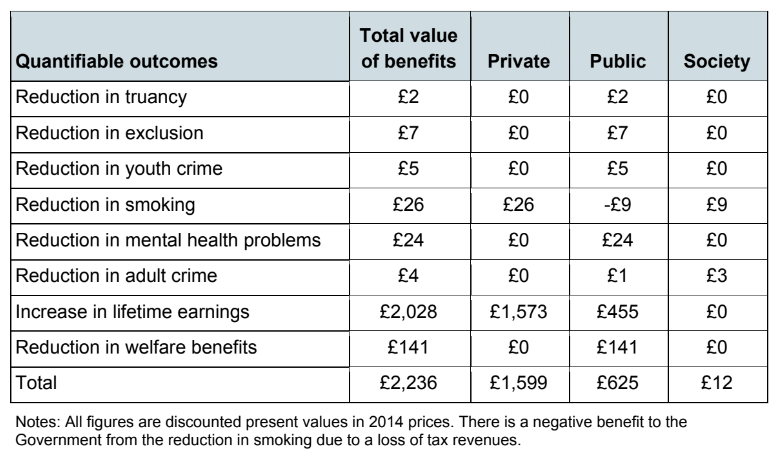
**Summary of value for money estimates (2014 prices)**



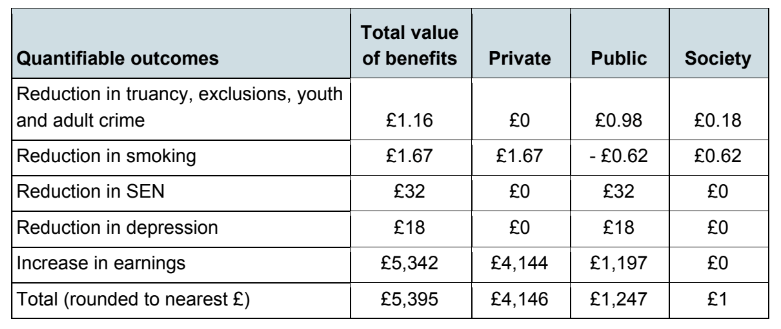
Monetary valuations of the potential benefits were estimated for the four types of services associated with improved outcomes. The two tables below present the evaluations for baby health services and parent support services. The latter is broadly representative of the findings for child play and specialist family/parent support services.

The tables highlight that most of the value of the benefits of the services is dependent upon the links to improved labour market outcomes - without the associated increase in earnings the services would offer very little financial return. The tables show that most of the benefit accrues to the individual rather than to the Government or society more broadly, mainly through increased revenues from Income Tax and National Insurance related to higher earnings rather than reductions in the cost of delivering other services.

**Value of benefits for baby health services (2014 prices)**



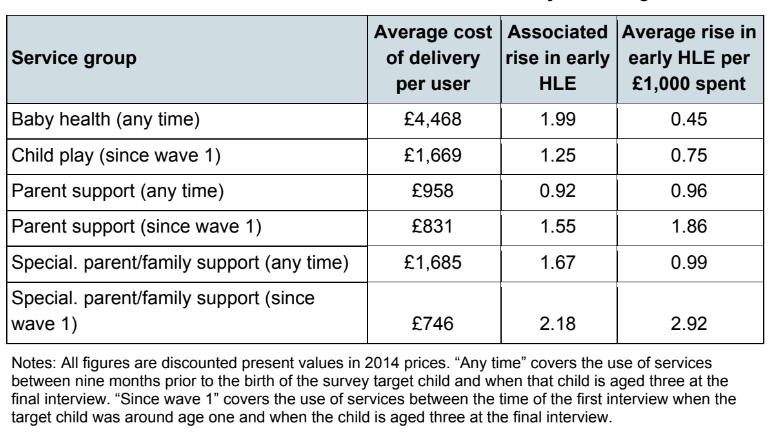
**Value of benefits for parent support services (since wave 1)**



Cost effectiveness compares the costs of achieving a change in a particular outcome through different interventions (in contrast to the comparison of financial returns to different interventions in cost benefit measures).

The table below presents the cost effectiveness of the different types of services in raising the early home learning environment (HLE) score: specialist family/parent support services and parent support services after the child is aged one offer the greatest potential increase for each pound spent, while baby health and child play services have far lower cost effectiveness. Given that the latter two services have other objectives, this finding may not be surprising.

**Cost effectiveness of services to increase early HLE at age three (2014 prices)**



## 5.2 Outcomes and benefits for parents

There were 11 research studies identified looking at the outcomes for and benefits to parents using children’s centres.

### 5.2.1 Conclusions

Using children’s centres had a positive impact for most of the parents who use them, including on their confidence and skills as a parent.

Families registered at centres experiencing ‘supported growth’ reported greater improvements in various measures of family functioning than those registered at ‘reducing’ centres (that were experiencing cuts). Children’s centres have a key role in providing mental health and employment support.

There is a high level of satisfaction with children’s centres amongst parents. Parents find them helpful and they value the personal relationships built with staff and other parents, and the fact they can access different kinds of support in one place.

Barriers to the use of children’s centres include: parents have not heard of the service; parents prefer to use another children’s centre or service; they do not need to use the service; it is too far away, hard to get to or parents have transport difficulties; and parents have no time or are too busy.

Source is:

| Robustness of study ✰✰✰✰✰ |
| --- |
| *1) Evaluation of Children's Centres in England (ECCE) Strand 4 Additional report: Changes in resourcing and characteristics of children’s centres. (DfE Research Report DFE-RR494, 2015)* |

Centres were classified, via cluster analysis, into four groups based on a range of information about the extent of reported budget cuts that affected staffing or services and the addition of any new services:

1. ‘Supported growth’ centres had reported little or no cuts that affected staffing or services and were adding new services;
2. ‘Positive stasis’ centres had reported little or no cuts that affected staffing or services but were not adding new services;
3. ‘Reducing’ centres had reported cuts that affected staffing or services and were not adding any new services;
4. ‘Restructuring’ centres had reported cuts that affected staffing or services but were also adding some new services.

**Families registered at centres experiencing ‘supported growth’ reported greater improvements in various measures of family functioning** across the national evaluation period than those registered at ‘reducing’ centres (that were experiencing cuts). These effects, though relatively small, were significant and positive. Such positive effects were also identified in further analyses focusing on families with higher levels of financial disadvantage. Centres experiencing ‘supported growth’ could be considered the most successful centres, growing in a time of national reductions and having a positive impact on families - especially the most disadvantaged.

The users of these ‘supported growth’ centres were more likely to live in highly disadvantaged neighbourhoods, to be financially disadvantaged, to have few qualifications and to show poorer mental health. Most were also classified as local high need centres so were also more likely to attract high need families from within their reach areas. What makes the ‘supported growth’ centres more successful is not known but what may play a part is their greater stability in organisation configuration (i.e. not restructuring) that is linked with increased resources. Many of these centres appeared to be more successful in attracting needy families from within their reach area, and this may have been facilitated by having a smaller geographical area to cover and by expanding rather than contracting staff and or services. They also tended to have higher numbers of staff than other centres, again likely to reflect more favourable budget position.

### 5.2.2 Other studies

| *1) Evaluation of Children’s Centres in England (ECCE) Strand 2: Baseline Survey of Families Using Children’s Centres in the Most Disadvantaged Areas (DfE Research Report DFE- RR260, 2013)* |
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| Robustness of study ✰✰✰✰✰ |
| 5,717 families from 128 of the centres interviewed for Strand 1 were interviewed for the first time when their child was 9-18 months old. |
| 15% of families said that they had not used any activities or services at the named children’s centre recently. This was usually due to:   * Preference: they preferred to use another children’s centre * Distance: it was too far away or hard to get to * Time constraints: they had no time or were too busy * Awareness: they had not been aware that the children’s centre existed * Lack of need: they did not need to use any family services or activities   Exploratory analysis identified two broad groups based on the types of services parents were using and how much they were using them:   * ‘Limited’ users of family services (19%) – these families tended to only use health related services. * ‘Heavy’ users (38%) – these families used lots of the centre’s services and activities, especially activities for parents and toddlers. * The remaining 43% of respondents showed no clear pattern in how they used the centres.   Generally satisfaction with the services and activities from the named children’s centre was very high. Just under half of parents (49%) said that they were ‘very satisfied’ and a further 29% said that they were ‘fairly satisfied’.  Families who used activities or services at the named children's centre typically found them very helpful. For each of the 22 service categories the majority of users considered them to be ‘very helpful’ and the proportion of users who rated them as ‘very’ or ‘fairly helpful’ ranged from 88% to 100%. |
| *2) Breaking barriers: How to help children’s centres reach disadvantaged families. Dr Sam Royston and Laura Rodrigues for The Children’s Society (2013)* |
| Robustness of study ✰✰✰✰✰ |
| A face to face survey in the South West of England with 170 families living in areas with some level of deprivation, who do not currently use children’s centre services.  Interviews with parents on the Isle of Wight and in the North East of England who use children’s centres. |
| The key findings from the survey of parents in disadvantaged areas were:   * 42% of parents had never used a children’s centre because they had not heard of the service. * 73% of parents were not aware of what services were provided by their local children’s centre. However, 87% of those who did not speak English as a first language were not aware of the services offered in their local children’s centre, compared to 70% of respondents who were native English speakers. * 49% said that the reason they were not going to children’s centres was because they were using alternative early years’ services, such as local playgroups and nurseries.   Key findings from parents using children’s centres were that:   * A quarter of respondents said they found it difficult to use their local children’s centre, with transport being one of the most common reasons given. * Although 59% preferred children’s centre services to be delivered from one central location than a range of different locations, a significant proportion (41%) wanted services to be provided in different locations. * Those using children’s centres highlighted the importance of staff creating warm and welcoming environments for parents. |
| *3) ‘These places are like a godsend’: a qualitative analysis of parents’ experiences of health visiting outside the home and of children’s centres services. Sara Donetto and Jill Maben (2014)* |
| Robustness of study ✰✰✰✰✰ |
| This study draws upon data from semi-structured interviews with  44 parents across two ‘Early Implementer Sites’ of the ‘new health visiting service vision’ in England |
| Mothers stressed how useful they found being able to access children’s centres and activities to connect with other parents (mainly mothers). Benefits included:   * Socialisation and feeling less isolated * Being able to share experiences of parenting, ask questions of professionals and access tips and suggestions from other mothers.   Participants saw children’s centres as a friendly and welcoming environment. Activities within the centres made it possible for parents to identify the health visiting team worker with whom they trusted, or felt most comfortable. |
| *4) Children’s Centre Census by 4Children (2015)* |
| Robustness of study ✰✰✰✰✰ |
| The 4Children annual Children’s Centre Census in 2015 received  Responses from nearly 400 centre managers, who were collectively responsible for approximately 1,000 sites nationwide. This included a survey of 600 parents across the country who use children’s centres. |
| Key findings from children’s centre managers were that:   * Parents particularly valued the personal relationships they built with staff and other parents through using children’s centres, and the fact they could access different kinds of support in one place, which are not easily replicated by other services. * Centres now had a key role in providing mental health and employment support, and many were also involved in delivering the Troubled Families programme * A quarter of centre managers said that, in the last year, at least 50% of the parents they had provided employment support to had moved “significantly closer to employment” – similar numbers said that at least 25% of those they worked with successfully moved into work.   Key findings from parents were that:   * Children’s centres are a regular feature in the lives of many of those who use them (55% said they used their local centre at least once a week). * Attending had a positive impact on the vast majority of children (90.5% of parents said that attending a centre has had a positive impact on their child). * Using centres had a positive impact for most of the parents who use them (83% of parents said that attending a centre had a positive impact on their confidence and skills as a parent). * 79% of parents said that if they were unable to use their local children’s centre this would make life harder for them and their family. 34% said it would make a “big difference” and that life would become “a lot more difficult”. * When asked about the one thing that their Children’s Centre offers that they don’t get elsewhere, the top three areas parents highlighted were: * The chance for them and their children to meet new people. * Staff who are friendly and welcoming. * Being able to get different kinds of support in one place.   This picture shows quotes from parents when talking about their children's centres |
| *5) Children's Centres as spaces of interethnic encounter in North East England. Judith Parks (2015). Social & Cultural Geography, 16:8, 888-908.* |
| Robustness of study ✰✰✰✰✰ |
| The study is based on interviews with 50 parents/carers who were using children’s centre and affiliated services within two areas of North East England. There was a mix of parents who had lived in the local area all their life and parents who were first generation immigrants. |
| This research found that children’s centres came to represent the host community for many new migrants who used the services. Children’s centres can provide new migrant parents/carers with opportunities to experience a particular version of the local community which facilitates encounters that are less ‘stressful and uncertain’ than encounters in the wider host community.  Interethnic encounter in children’s centres was often seen by new migrant parents/ carers primarily as an opportunity to improve English language skills. It was thus an integral part of processes of migration for BME service users, meeting a different need to that of local ‘indigenous’ parents/carers. This was reflected in the fact that the majority of BME service users in the two selected children’s centres were first-generation migrants, possibly suggesting less need or motivation to use children’s centres among second-generation migrants. |
| *6) All Party Parliamentary Group on Children’s Centres Family Hubs: The Future of Children’s Centres - Strengthening family relationships to improve Life Chances for everyone (2016)* |
| Robustness of study ✰✰✰✰✰ |
| Evidence from various sources including one witness from a local authority, who had extensive experience as a front-line employment adviser working through children’s centres. |
| A great deal of the evidence provided to the APPG emphasises that building a parent’s confidence is a key part of providing employment support through children’s centres, and that for many of those who access these kinds of services simply reaching the point where they can contemplate attending an interview represents a major achievement.  The evidence highlighted some key lessons that can be learned from the experience of delivering employment support through children’s centres. This included the importance of developing strong relationships with local employers so that centres are aware of vacancies and also skills gaps in local job markets. Links with Jobcentre Plus are viewed as crucial, but witnesses indicated that a strong mandate for joint working is needed in order for such relationships to be effective and endure over time. |
| *7) City of London Review of Children’s Centre Services Summary Report (2016)* |
| Robustness of study  ✰✰✰✰✰ |
| Interviews with 107 mothers, fathers, other carers/family members, childminders and nannies attending children’s centres in the city of London. |
| Parents interviewed consistently commented positively about their satisfaction with the services and the way in which they have improved outcomes for their children. |
| *8) Fathers' Involvement in Sure Start: What Do Fathers and Mothers Perceive as the Benefits? Carol Potter & John Carpenter (2010) Practice: Social Work in Action, 22:1, 3-15* |
| Robustness of study ✰✰✰✰✰ |
| This is based on a case study of a Sure Start programme in the North East of England which was effective in engaging fathers, including the views of 17 fathers and 8 mothers on the benefits of father involvement. |
| Perceived benefits for fathers included:   * Increased engagement with their young children and concern for their psychosocial development. * Improved relationships with children. * Increased social interaction with other fathers and consequently access to greater peer support. * Learning from the experiences of other fathers. * Increased knowledge and skills through education. * Changing understanding of the fathering role * Access to a better quality of life for the whole family. |
| *9) Scrutiny Inquiry Report Children’s Centres. Leeds Council Scrutiny Board (Children and Families) (2017)* |
| Robustness of study ✰✰✰✰✰ |
| Based on interviews with parents in four children’s centres visited as part of the Scrutiny Enquiry. |
| The enquiry found that parents valued their centres highly. They provided some very positive feedback, particularly about the influence centres have had in improving the confidence of their children, mixing with their peers and most importantly being happy. Parents felt that their children’s centre was like an ‘extended family’ where they are able to network with one another and create friendship and support groups; therefore reducing isolation and its consequent impact. Parents told the enquiry that they felt less isolated and more confident so they could build relationships and prepare for employment. |
| *10) Consultation about proposals to consolidate Brent children’s centres and redevelop remaining centres as Family Hubs. Brent Council and Barnado’s (2019)* |
| Robustness of study ✰✰✰✰✰ |
| The findings are from a mixed method approach to the council’s consultation, including 29 informal interviews with parents/carers conducted by children’s centre staff and an online survey of 544 parents/carers/childminders. |
| Brent Children’s Centres were strongly valued by most parents/carers.  For more than half of parents/carers, children’s centres services considered most helpful/helpful were:   * Health visiting services (67%). * Let’s Talk sessions which give families access to early years speech and language information, advice and assistance (58%). * Stay, play and learn sessions including those that are for children cared for by childminders (54%). * Childcare information and advice (54%).   For more than half of parents/carers with children aged 0-4, the most important features about how services are offered were that they:   * Have information, advice and services available in one place, which rises to more than two thirds of all young parents and parents from mixed ethnicity backgrounds. * Are free, with 25% of parents/carers reporting that low cost services are key. * Are within a 20 minute walking distance from their homes, which was even more important for more than 60% of disabled parents/carers.   For 37% of parents/carers, the importance of having access to confidential advice from trusted professionals was key. However, half of families with children with SEND and lone parents rated access to confidential advice from trusted professionals as key. |

## 5.3 Outcomes for children

There were 3 research studies identified looking at the outcomes for children.

### 5.3.1 Conclusions

Child poverty levels in children’s centre ‘reach’ areas declined, and children’s centre areas showed a greater improvement than the corresponding local authorities and England as a whole. There is also a sense that reach areas were being ‘pulled up’ by improvements in the local district.

The proportion of children achieving a ‘good’ level of development at the Early Years Foundation Stage showed a general improvement in the children’s centre ‘reach’ areas.

Evidence from a small scale study showed improvement in parents’ capacity to support their child’s health and their ability to cope with difficulties. It also showed improvements in children’s ability to contribute to the learning environment and that the majority of the children in the sample were ‘better off’ in a range of developmental and behavioural ways.

Source is:

| Robustness of study ✰✰✰✰✰ |
| --- |
| *1) Evaluation of Children’s Centres in England (ECCE) The extent to which centres ‘reach’ eligible families, their neighbourhood characteristics and levels of use. (DfE Research Report DFE-RR35, 2014)* |

There are caveats about the nature of the data analysed in this report due to different programmes and procedures that local authorities use to collect and analyse data from children’s centres. However, a consistent picture emerges from the analysis of this data.

Almost all local authorities had a defined ‘reach area’ for each of their centres mainly using LLSOA (local areas with populations around 1,500) or electoral ward boundaries. A sample of user postcodes demonstrated that the large majority of registered users at each centre came from its reach area (average 82%).

Analysis of socio-economic indicators of poverty and low income, unemployment, education, health, housing, crime and transport showed that the children’s centre reach areas were on average more deprived than both the national average and the local authorities in which they are located. However, there was significant variation across the reach areas.

**Child poverty levels in the reach areas declined**, with the proportion of children in poverty falling from 30.6% in 2006 to 27.3% in 2011. This improvement was also seen nationally, but children’s centre areas on average showed a larger improvement than the corresponding local authorities and England as a whole over the same period (a 3.3% percentage points fall, compared with a 1.1% percentage point fall across England).

Those areas starting off with the highest levels of child poverty were also those areas that showed the biggest reductions in child poverty levels. There is also a sense that reach areas were being ‘pulled up’ by improvements in the local district - reach areas with large reductions in child poverty are located in local authorities which also saw large reductions in child poverty. Reach neighbourhoods also showed changes in overall deprivation levels (based on IDACI 2004 and 2010), with 56% of all LLSOAs in the reach areas moving to a different deprivation ‘decile’ - of these, 15% of all areas moved by more than one decile.

Data on **children achieving a ‘good’ level of development at the Early Years Foundation Stage showed a general improvement in the reach areas**, with a steady year on year increase between 2008/09 and 2011/12. There was wide variation within the individual reach areas, with the greatest improvement seen in the areas with the worst starting position. The most improved reach area saw a 29% increase in the proportion of children achieving a good level of development at Early Years Foundation Stage, and indeed the majority of reach areas saw improvements. At the other end of the scale, seven reach areas saw a fall in the level of children reaching the target EYFS, with one reach area seeing a 14% fall.

### 5.3.2 Other studies

| *1) Children’s Centres in 2011: Improving outcomes for the children who use Action for Children Children’s Centres. James Blewett, Jane Tunstill, Shereen Hussein, Jill Manthorpe and Sarah Cowley (2011)* |
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| Robustness of study ✰✰✰✰✰ |
| In July-September 2010, Action for Children recorded self-reported outcomes of all closed cases among 6 selected children’s centres operated by them (202 cases in total). |
| Children (where appropriate) and their carers were asked about 43 identified areas at the time of closing the case, relating broadly to being healthy, staying safe, enjoying and achieving, making positive contributions and achieving economic well-being. The 202 children/young people and their carers identified 156 areas of improvement, 85 areas where they felt that they maintained their initial level and only 5 areas where they felt that their position had deteriorated:   * Areas of greatest improvement related to parent/carers’ capacity to support their child’s health, and their ability to cope with difficulties. * Other major improvements related to a child’s ability to contribute to the learning environment. * In the very small number of cases where users felt that they experienced deterioration, there were problems related to substance misuse and safety within the family.   The analysis of the 53 cases generated an overall picture of ‘children doing after contact with the centre staff and the services on offer. Researchers were cautiously confident in concluding that the majority of the children in the sample surveyed were ‘better off’ in a range of developmental and behavioural ways, almost all of which involve “health issues”. These included:   * Developmental progress as recorded by health visitors as age appropriate. * Babies being breast fed. * Nutritional choices/behaviour – parents adopting different dietary habits, and reporting fewer eating difficulties with their children. * Take-up of immunisation options. * Engagement (where necessary) with mental health professionals. * Reduction in parents using A&E departments for child health problems. |

| *2) Scrutiny Inquiry Report Children’s Centres. Leeds Council Scrutiny Board (Children and Families) (2017)* |
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| Robustness of study ✰✰✰✰✰ |
| Based on interviews with parents in four children’s centres visited as part of the Scrutiny Enquiry. |
| A number of parents advised the enquiry that their children’s communication skills had improved considerably since attending the centre, through the support provided and through forming friendships with their peers. |

## 5.4 Good practice

There were 7 research studies identified looking at working practices within children’s centres.

### 5.4.1 Conclusions

The key aspects for effective children’s centre provision include:

* Good multi-agency and multi-disciplinary working.
* High quality leadership, governance, team work and excellent staff.
* Sharing of good practice.
* Focusing on the development of parenting skills.
* Removal of barriers to access.
* Accessibility of services, either within a building or via outreach.
* Good use of monitoring data and information, and the setting of targets.
* Listening to the views of families.

The most popular method for raising awareness was word of mouth, plus events and through referrals or signposting from professionals, partner agencies or local community groups and networks.

Sources are:

| Robustness of studies ✰✰✰✰✰ |
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| *1) Best Practice for a Sure Start: The Way Forward for Children’s Centres. Report from the All Party Parliamentary Sure Start Group (2013)* |
| *2) Evaluation of Children’s Centres in England (ECCE) Strand 1: First Survey of Children’s Centre Leaders in the Most Deprived Area (DfE Research Report DFE-RR230, 2012)* |
| *3) Evaluation of Children’s Centres in England (ECCE) Strand 3: Delivery of Family Services by Children’s Centres. (DfE Research Report DFE-RR29, 2013)* |

The Director of Early Childhood at Ofsted set out the common factors which underpin the best children’s centre provision. The best centres ensure:

* The effective **removal of barriers to access**.
* That they **identify the most vulnerable** target families and their needs.
* They focus on development of **parenting skills**.
* They work in **partnership with other agencies**.
* They are characterised by **high quality leadership, governance, team work and excellent staff**.
* They set themselves **challenging targets** with clear benchmarks.
* That **local authorities actively contribute** to improvement and development.
* They successfully draw on the **views of children and families**.
* They make **good use of data**, and don’t rely on anecdotal evidence.
* They **know how much progress** children are making and can show families where parents are better able to engage in parenting as a result of their intervention.
* They have a **good understanding of local childcare provision**.
* They **continue to track children and family outcomes** when they leave – e.g. when children start school.

Centre managers placed particular importance on four aspects of service delivery and ethos:

* Being able to **talk informally to staff** like health visitors, midwives, or social workers.
* Having workers willing to **ring up other professionals or services** if parents need information or a referral to another service.
* Workers **visiting families at home**.
* The **physical accessibility of the centre**, for example to wheelchair users.

In respect of having a shared vision and partnership, centres differentiated between partners who worked with a universal approach (schools, JobCentre Plus, health) and those with a more targeted focus (social care). Health was seen as especially close in terms of shared vision. However, tensions were common due to differences in professional backgrounds and cultures, line managements and funding, targets, and eligibility levels for services. It was widely recognised that multi-agency collaboration required the building of trust, which took time.

In terms of multi-agency working:

* A moderate to high level of **shared vision with partners** was identified, particularly when providing services to a centre’s target groups.
* The most common multi-agency working practice at management level concerned referral procedures (e.g. the Common Assessment Framework) and informal ways of keeping in touch (e.g. ‘brown bag’ lunches).
* Most managers reported that they encouraged their staff to **share best practice and work together across services and boundaries**, and they facilitated staff to work collaboratively.
* **Bringing staff together from different agencies and different professions was often raised as challenging**.
* **Different professional cultures created tensions** especially about the balance between open access and targeted services, and between adult-focused support and child development activities.

### 5.4.2 Promoting children’s centres

Children’s centre leaders felt that word of mouth was the most popular method for raising awareness – it was considered effective by 99% of leaders. Other forms of raising awareness which were found effective by over 90% of the leaders were through the health visitor (95%), fun fairs or events (94%), referrals or signposting from partner agencies (94%), the children’s centres outreach practitioner (92%) and local community groups and networks (91%).

### 5.4.3 Other sources

| 1. *Improving Children's Services Networks: Lessons from Family Centres. Tunstill, Jane; Aldgate, Jane and Hughes, Marilyn (2007)* |
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| Robustness of study ✰✰✰✰✰ |
| This book detailed and evaluated expert research into the developing role of family centres (leading to the creation of children’s centres) based on research carried out for the government, including in-depth data from 415 centres. |
| The authors identify a number of lessons regarding service delivery to families:   * The commitment and consistency with which family centres engaged with families is of critical importance. The starting point of this relationship was a fundamental respect for families, which they modelled in their policies as well as in their day-to-day interactions with parents. * Services should be planned in partnership with parents, who if given the opportunity can be highly perceptive about their own needs. However, not all parents will be equally confident about making explicit their preferences or needs. Strategies to overcome inhibiting factors include a range of aggressive outreach strategies, including the offer of translating and interpreting services, transport when necessary, and efforts to build the confidence of parents and model the respect in which they are held. * Families need a broad range of interventions which include both practical services and more complex work, such as enhancing parenting skills. Centres also need to offer parents the opportunity to develop their own personal and occupational skills, in addition to their skills as parents. * Providing information needs to be a central feature in the work of centres. At the same time, strategies need to be in place to ensure the continuity of knowledge if personnel leave so that specialist knowledge and information are not lost. * Centre-based services have the potential to enable families to help each other, as well as accessing services. However, while creating links between families can be very positive, care needs to be taken in relation to any issues that might put children at risk of harm (e.g. by encouraging links between the tiny minority of families whose children are at serious risk of a range of abuses). * Many families do not have access to support for parenting within their own extended families or their communities. They value being offered the opportunity to draw on support from non-stigmatising services within their local communities. * The way in which such support is offered needs to recognise that parents are experts on their own strengths and needs. They themselves, if empowered to do so, can take an active and illuminating role in the assessment of their own circumstances. * Parents appreciate a range of services which provide support both to them and their children. It is a mistake to underestimate the extent to which the majority of parents aspire to be good parents and want what is best for their children. Parents who use family centres often want to use services in a way that will optimise the chances of their children having wider opportunities than they have enjoyed themselves. * What parents like about family centres is that the services are provided in the context of a warm and welcoming atmosphere. Characteristics parents associated with a positive atmosphere were both a lack of stigma and an explicit acknowledgement of their strengths by staff. |
| * There are considerable advantages to both staff and families if diversity of gender, race and ethnicity are represented on the staff group. Families can then have a choice over which staff members they relate to. Giving families choice is an important part of changing the culture of centre-based services to one which emphasises the empowering of parents and sees them as experts on defining their own needs. * It is critical that community- based centres make an explicit commitment to partnership with other community-based services. Making this commitment explicit gives a very clear message to other agencies about the value of partnership. * Some possible partners may need a more persistent approach, and some professional groups (e.g. general practitioners) may be particularly difficult to engage. No one agency can construct a partnership on its own. All the stakeholder agencies need to seize every opportunity for establishing and developing partnerships with each other. |
| *2) Targeting children's centre services on the most needy families. Local Government Education and Children’s Services Research Programme (2011)* |
| Robustness of study ✰✰✰✰✰ |
| This study comprised a literature review of 42 sources followed by 47 interviews in 6 local authority areas with local authority advisers, children’s centre leaders, other children’s centre staff and parents. |
| Identifying and targeting needs and services effectively can be challenging to achieve in practice. Children’s centres and local authorities said they developed effective services for those in greatest need through:   * Strategic decision making and panel discussions – with senior managers and heads of service. * Monitoring and reviewing their services – including monthly, quarterly and annual reviews. * Consulting with families – to determine their needs, the support required and their satisfaction with services. * Identifying facilitators and barriers (e.g. building on effective local partnerships, and overcoming barriers to data sharing). * Local authority support and challenge (e.g. providing relevant data, and using the annual conversation to examine the business plan and the Ofsted self-valuation form. * Assessing value for money, outcomes and impacts – using value for money exercises and toolkits to explore the costs of services, and evidencing outcomes through monitoring data and feedback. |

| *3) Barriers and facilitators to delivering injury prevention interventions in English children’s centres. Trudy Goodenough et al. (2016)* |
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| Robustness of study ✰✰✰✰✰ |
| 33 interviews with children’s centre staff from 16 centres across four study sites explored practitioners’ experience of factors that impact on their implementation of health promotion and injury prevention intervention. |
| Although this study looked specifically at the barriers and facilitators for delivery of injury prevention programmes in English children’s centres, it also identified a number of universal themes.  Facilitators included:   * Partnership working. * Effective parent engagement. * Employing specialist workers to engage specific groups, e.g. traveller communities, non-English speakers, and male workers to work with fathers. * Knowledge of policies and strategies in injury prevention. * Relevant and accessible training for staff.   Barriers included:   * Lack of engagement and difficulties reaching disengaged families. * Funding constraints. * Paucity of national and local injury data. |
| *4) Scrutiny Inquiry Report Children’s Centres. Leeds Council Scrutiny Board (Children and Families) (2017)* |
| Robustness of study ✰✰✰✰✰ |
| Based on interviews with practitioners/staff in four children’s centres visited as part of the Scrutiny Enquiry. |
| The scrutiny visits sought to identify how working in partnership is making a difference and the strength of links to clusters partnerships, GP’s, health services, primary schools and voluntary organisations. It found that the provision of services for families has been facilitated in general by developing partnership working with key partners. The most significant of these partnerships has been the integration of health visiting services and  children’s centre services into 25 cluster based Early Start Teams, which has impacted favourably on all children’s centres and health visiting services through improved information sharing, service monitoring and accessing support from other services.  All centres visited highlighted their Pregnancy, Birth and Beyond programme as an example of integrated working, where midwives provide support alongside health visitors and children’s centre staff. Family Outreach Workers contact parents prior to the sessions in order to engage them in activities initially: the importance of this role was highlighted as parents form strong and valued connections with their worker.  The enquiry found that all children’s centres had a commitment to sharing good practice and improving their services for the benefit of the children and families they support. |

## 5.5 Leadership and management

### 5.5.1 Conclusions

There were 6 research studies published looking at the leadership and management within children’s centres.

A number of common themes emerged from these studies around improving leadership or good leadership practices:

* Integrated and inter-disciplinary working, collaboration and accountability.
* Engaging responsively and effectively with families.
* Having access to data and using data, monitoring and evaluation to drive improvements in outcomes.
* Good communication and interpersonal skills.
* Motivating and empowering staff.
* Continuing learning and development, with appropriate resources and tools.

| *1) Leading and Managing in the Early Years: A Study of the Impact of a NCSL Programme on Children’s Centre Leaders’ Perceptions of Leadership and Practice. Lynn Ang (2011). Educational Management Administration & Leadership 40(3) 289–304.* |
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| Robustness of study ✰✰✰✰✰ |
| This study presents the key findings of a national evaluation of early years leadership across a range of children centres in England. The focus of the study is to explore children’s centre leaders’ perceptions of leadership, and the impact of their professional qualification - © - the National Professional Qualification in Integrated Centre Leadership (NPQICL)[[2]](#footnote-2) - on their professional practice.29 participants who graduated  from the NPQICL answered an electronic survey, followed up by 15 telephone interviews. |
| The findings reveal that integrated and multi-agency working, reflective learning and practice, as well as professional status and pay, are key factors that can significantly influence the role of children’s centre leaders and which in turn has a direct impact on their professional practice. |

| *2) Highly effective leadership in children’s centres. Caroline Sharp, Pippa Lord, Graham Handscomb, Shona Macleod, Clare Southcott, Nalia George and Jenny Jeffes (2012)* |
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| Robustness of study ✰✰✰✰✰ |
| This research involved a review of literature on early years’ leadership and the production of 25 case studies of leaders of ‘highly effective’ children’s centres with practitioner workshops to validate the findings. |
| The key behaviours that leaders of “highly effective” children’s centres utilised to address the main challenges facing them are:   * Having a clear vision to improve outcomes for children and families. * Engaging responsively with families. * Using evidence to drive improvements in outcomes. * Using business skills strategically. * Facilitating open communication. * Embracing integrated working. * Motivating and empowering staff. * Being committed to their own learning and development.   The key challenges centre leaders said they faced were:   * Leading in a time of intense change. * Maintaining high-quality services in the face of uncertainty and funding cuts. * Maintaining staff morale and motivation. * Keeping an appropriate balance between universal and targeted services. * Dealing with increasing numbers of vulnerable families, combined with fewer sources of support. * Managing limitations in the understanding by other agencies of the contribution made by children’s centres, combined with a perceived low status of early years’ professionals. * Tackling barriers to effective data-sharing between partner agencies. |
| *3) Leading an effective improvement and development programme for children’s centres. Gill Weston and Mary Tyler (2015)* |
| Robustness of study ✰✰✰✰✰ |
| Based on data collected during Ofsted inspections of 9 children’s centres between January 2011 and early autumn 2012 |
| There were a number of key themes within the inspection reports when areas for improvement were identified, including:   * Improving the use of data to ensure that families were tracked more systematically as they accessed services. * Increasing the accountability of key partners within the programme – these included health, social care, Jobcentre Plus and adult learning. * Ensuring that parents were included within the governance and decision-making process. * Developing a more rigorous approach to monitoring and evaluation, including at local authority level. |

| *4) System leadership development in Children’s Centres in the UK. Kaz Stuart and Megan Wilcox (2017)* |
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| Robustness of study ✰✰✰✰✰ |
| This study was based on interviews with 24 leaders of children’s centres across Hertfordshire. It aimed to establish the complex nature of leadership in children’s centres and demonstrate the value of system leadership as a vital concept for children’s centre leadership. |
| System leadership was relevant because these heads were leading across a new “system” of multiple centres where previously they had led only one. Evaluation found that the concept of system leadership was appropriate, supportive and validating for leaders of children’s centres; however, the concept needed support with further practical tools and resources. The implication of the study is that leaders of children’s centres could be supported to work more effectively with system leadership. When leaders of children’s centres feel effective, they have enhanced wellbeing and achieve more outcomes, which in turn enhances the wellbeing of the children and families that they serve.  Overall, the leaders perceived themselves to be skilled; however, system leadership and pedagogical leadership were the weak areas of leadership. Alongside these, a range of leadership and management sub-skills needed specific attention as shown by low scores on individual indicators. These included:   * Pedagogical innovations, 50%. * Funding and commissioning, 51%. * Andragogy, 53%. * Managing inter-professional teams, 55%. * Applying relevant leadership models and theories, 56%. * Fostering inter-professional learning, 56%. * Linking research and practice, 56%. * Managing change, 57%. * Developing strategic plans, 57%.   The heads of centres were also asked to name the leadership challenge that most worried them at the time. The following results corroborated the needs identified in the diagnostic and added more to the list. The areas of concern identified by more than one head included:   * Change management. * Resource management. * Time management. * Collaboration and networking. * Strategy; and delegation. |

| *5) Value-based relational leadership practice in Children's Centres: an action research project. Kaz Stuart (2018)* |
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| Robustness of study ✰✰✰✰✰ |
| This study was based on interviews with 24 leaders of children’s centres across Hertfordshire, using action research. |
| Leadership teams were made up of staff from a variety of professional backgrounds including education, health, social services, early years and the voluntary sector. Part of the team have a strategic focus and work across all the centres, while the other team members have a more operational focus for a group of children’s centres.  The data analysis by leaders and the researcher portrayed a highly value based and relational leadership practice in these children’s centres. Whether discussing leadership at an espoused level or practical level, whether talking strategy or daily problems, the leaders’ vocabulary remained consistently the same. Communication, dialogue, inclusivity, collaboration were central.  The leaders identified their key strengths as:   * Interpersonal skills (communication, relationships, honesty, funny, friendly, open, empathetic). * Developmental skills (supportive, empowering, team player, role model). * Problem solving skills (problem solver, resourceful, reflective, creative, proactive, detailed, multi tasker). * Positive attitude (strong, optimistic, enthusiastic, committed.   They also identified areas for development:   * Delegation. * Monitoring. * Patience. * Feeling confident. * Leading meetings. * Leading people. * Conducting appraisals. * Organisational skills. * Trusting intuition. * Looking after own wellbeing.   .  Leadership challenges were identified and coded into 12 categories:   * Doing too much too fast. * Using technology. * Using data. * Staying motivated. * Developing good partnerships. * Empowering staff. * Large team working. * Staff shortages. * Leading meetings. * Challenging people. * Time management. * Budgeting. |

| *6) Using practice development methodology to develop children’s centre teams: Ideas for the future. Dr Ann Hemingway (2009)* |
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| Robustness of study ✰✰✰✰✰ |
| This evaluation of a two-year project to develop inter-agency public health teams within children’s centres is based on interviews and an action learning set to develop practice. |
| Members of the team included a health visitor, a health promotion officer, a school nurse, a social worker and a primary mental health worker. Representatives from education – i.e. a local head and deputy head teacher – also attended meetings regularly. Other  practitioners included staff from the youth advisory centre and representatives from the local authority, which supported the development of the local strategic partnership.  Practice development methods enable teams to work together in new ways, embracing engagement, empowerment, evaluation and evolution. The evaluation showed that practice development methods can enable successful team development and showed that through effective facilitation, teams can change their practice to focus on areas of local need. The team came up with their own process to develop a strategy for their locality.  Findings showed that effectively changing how people practise requires the following:   * Practitioners need to feel that working together differently is essential to improving outcomes for residents/clients. * They need to feel supported in making changes. * Institutions need to recognize this need and that resources/organisation of work may need to change. * Local practitioners need access to relevant local health needs data and information across agencies in an accessible format.   Providing services in a different way and dealing with areas of conflict between agencies, some of which are historical in origin, requires honest dialogue and effective facilitation. Involving a “third party” (in this case a local public health academic) has been shown to be useful where these conflict areas are deeply entrenched. Setting ground rules within teams is part of the process of managing conflict and change as issues arise. The team could also reflect on its achievements in this development context and the project clearly identified that there were no other mechanisms for team members to express concerns or reflect on positive developments together across different agencies. |

# Children’s Centres in Other Countries

## 6.1 Australia

### 6.1.1 Background

A 2004 Ministerial Inquiry into Early Childhood Services in **South Australia** recommended the building of an integrated early childhood service system based on the development of a new concept of child and family centres. The South Australian Government established an initial 20 children’s centres, mostly located on primary school sites, increasing to 47 by mid-2018. The aims of these centres were to ensure that:

* Children have optimal health, development and learning.
* Children learn to play together, building social skills and wellbeing.
* Children receive specialist services when health or learning concerns are identified.
* Aboriginal children are safe, healthy, culturally strong and confident.
* Parents provide strong foundations for their children’s healthy development and wellbeing.
* Families find it easier to use health, child care, education and family support services.
* Families have more child care and early learning options.
* Families link up with other families with young children.
* Families get information about parenting and young children’s learning and healthy development.
* Families get help from staff if concerned about their child’s health or learning needs.
* Families have options to consider a return to school, further study or employment.

In the state of **Tasmania** (which has a population of 515,000 people) child and family centres were adopted in 2009 as a government initiative to provide a single entry point to early years’ services for families of children from pregnancy to age 5. At the heart of the model is a concerted approach to addressing systematic barriers to access and participation in early years and parent/family support services. Tasmanian children live in the most disadvantaged communities in Australia, have the lowest living standards and experience the highest levels of social exclusion. Compared to other states and territories, they also have the worst education and health outcomes in adult life. From 2011 to 2014, 12 centres opened across Tasmania.

The children’s centres’ vision is that all Tasmanian children have the best possible start in life. The four priority areas for centres are

* To provide high quality learning, health and wellbeing programmes that support children and families to learn and thrive.
* To build each community’s sense of belonging with their centre as a place of importance.
* To create and maintain strong and flexible partnerships between everyone involved in each centre’s community
* To develop tools that will show the difference the centres are making to the lives of children, their families, support services and the community.

### 6.1.2 Model of service provision in South Australia

The children’s centres were broadly modelled on the UK Sure Start programme. Centres were located in areas of community need to enable the provision of high quality services, especially to children and families who may not otherwise have access to these supports. The child and family centres are based on a model of integrated practice and provide a ‘one-stop shop’ by bringing together a range of services for children (from birth to 8 years) and their families. These services include:

* Early education and care for children from birth through to early years of school.
* Child health information.
* Family support.
* Playgroups and play activities.
* Early assessment of children’s learning needs and intervention programmes.
* Community development activities.

Some centres with particular needs also have health services such as hearing and eye tests, immunisation, health promotion (with a particular focus on Aboriginal children) and specialised support such as speech pathology and occupational therapy, plus specialist support for children with disabilities/high support needs and families experiencing disadvantages, parenting difficulties and child development issues.

### 6.1.3 Model of service provision in Tasmania

Tasmania’s child and family centres provide a single entry point to early years’ services for children and families living in amongst the most disadvantaged communities in Australia. This place-based early years’ model provides a single entry point to comprehensive, complementary and coordinated universal, targeted and specialist services tailored to the specific needs of a community.

Children’s centres offer:

* Universal services (e.g. Child Health and Parenting Service)
* Progressive universal services (e.g. Launching into Learning)
* Targeted services (e.g. nurse home visiting for first-time young parents)
* Specialist services (e.g. Disability Services)
* Services for parents (e.g. counselling, Vocational Education and Training)
* Services and supports tailored to the specific needs of a community.

Services are available on an appointment and drop-in basis. Working with families at the centres is guided by the five best-practice principles stated in the Early Years Learning Framework for Australia. These principles are:

1. Secure, respectful and reciprocal relationships.
2. Partnerships.
3. High expectations and equity.
4. Respect for diversity.
5. Ongoing learning and reflective practice.

Each centre has two paid staff - a centre leader and a Community Inclusion Worker. Services and supports are provided by government (e.g. Child Health and Parenting Service, Launching into Learning), non-government organisations (e.g. playgroups, childcare) and by the community (e.g. toddler’s haircuts, garden maintenance).

### 6.1.4 Evaluation of Children’s Centres

| 1. *Harman-Smith, Y., Brinkman, S, Gregory, T., Brushe, M., &. Herreen, D. (2016).*   *Evaluation of Children’s Centres in South Australia: a report on the measurement of*  *process and impacts. Government Report. Department for Education and Child*  *Development. Adelaide.* |
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| Robustness of study ✰✰✰✰✰ |
| The evaluation uses three data sets: survey data (39 parents, 129 children’s centre staff and service providers and 26 directors and heads of school early years); de-identified Family and Community Programmes data from children’s centres, and de-identified 2015 Australian Early Development Census data linked to SA Government pre-school data. |
| There was a great deal of variation in the range and number of services and supports available across centres. The most commonly available supports were:   * Parenting support services (e.g., parenting programmes, domestic violence support) * Family support (e.g., Family Service Coordinator consultations) * Supported playgroups (e.g., Learning Together, facilitated playgroups, allied health playgroups, Save the Children) * Community groups (e.g., cooking/art/craft/music groups, cultural parent groups, yoga) * Health services (e.g., maternal child health, health information sessions, allied health).   Although children’s centres are located in areas of higher need, and thus attract families from suburbs with greater socio-economic disadvantage, additional support in centres tended to be utilised more heavily by families from less disadvantaged communities. There was increased service use in centres for children aged 0 to 2 years where there was a Child and Family Health Service or an antenatal service onsite.  Although centres were not reported to be reducing duplication of services in their area, they were reported to be helping to improve referral pathways in the broader community. This included:   * Achieving earlier identification of vulnerable children and families. * Providing new knowledge or skills for team members. * Improving the capacity to reach more children and families. * Providing a clearer pathway for families to the supports and services. * Improving access to specialist services and preschool programmes.   The vast majority of parents reported that services and supports available to them met their needs and that staff in centres provided well-informed support and referrals, were committed to helping them, and were approachable.  Few parents reported that there were services they were not able to access. When parents reported not being able to access services and supports, barriers to access tended to be cost, wait times, or a lack of available services. Families with additional needs tended to report greater difficulty accessing services. |

| On the whole, parents using children’s centres reported high levels of wellbeing, social connectedness and positive parenting practices, although families who had additional support needs reported less favourable outcomes.  Leadership was rated highly in around two thirds of sites. Where leadership was not rated highly, integrated service delivery was also rated as less functional.  The professional development programme for children’s centres was valued by the leadership and used to enhance their knowledge about providing integrated services. Professional support from the Early Childhood Development Strategy team was also rated highly. |
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| *2) Ian McShane (2016) ‘Educare’ in Australia: analysing policy mobility and transformation, Educational Research, 58:2, 179-194.* |
| Robustness of study ✰✰✰✰✰ |
| The research involved analysis of policy and project-related documents, plus 30 interviews in Derrimut (a suburb of 8,000 residents near central Melbourne) with educational officers, school staff, local government officials and staff involved in on-site partnerships with the school. The evaluation focuses on the children’s centre created in Derimut located within the community centre next to the primary school. |
| Key positives from the findings were:   * The co-location of early learning and primary schooling provided opportunities to establish a shared educational vision and manage practical issues such as school readiness and transition. * The community centre is used for after school hours care, although space constraints mean the programme is conducted in the ‘community’ section of the building, requiring a high level of staff vigilance over safety and food allergy issues, highlighting tensions arising from the hybrid setting. * The maternal and child health service in the centre was quickly and heavily utilised. * Setting up diverse recreation programmes was welcomed in a suburb with relatively few recreation options.   Less successful were:   * A room equipped with computers had little use due to the lack of staff resources. * Funding constraints prevented the centre from opening at weekends. * Concerns were raised by incidents when male ex-partners engaged in threatening behaviour. * Some residents perceived that the facilities were only available to childcare clients. * Aspirations for community participation in the governance of the centre were slow to be realised. |

| *3) Catherine L. Taylor, Kim Jose, Wietse I. van de Lageweg & Daniel Christensen (2017) Tasmania’s child and family centres: a place-based early childhood services model for families and children from pregnancy to age five, Early Child Development and Care, 187:10, 1496-1510.* |
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| Robustness of study ✰✰✰✰✰ |
| Methods included a survey, focus groups and interviews. The 247 survey respondents included parents who were eligible but did not necessarily use the centre in their community along with centre users. The focus groups and interviews with 24 parents were conducted with centre users only. The focus group and interviews complemented the survey by allowing more in-depth exploration of the lived experience of centre users. |
| This study investigated the impact of children’s centres on parents’ use and experiences of early year’s services. Key findings were that:   * Centre users made more use of early years’ services than did non-users. * Centre users rated their experiences of these services more positively than non-users. * Centre users were more likely to report that early years’ services were convenient and close, committed to helping, and worked closely with one another. * Parents identified centres as informal, accessible, flexible, responsive, neutral, non-judgemental and supportive places where they felt valued, respected and safe. Parents said that these qualities made the critical difference to their engagement and positive experiences of services and supports in centres, in contrast to some of their experiences in the past. * The neutral, non-judgemental and supportive approach to engaging with families was important to parents who did not feel judged about their parenting practices, resulting in positive interactions with centre staff and service providers and increased confidence in parenting. * Parents felt centres were welcoming places that were helping them to develop positive child, family, school and community connections. * Centres were places where parents felt they could go at any time, even when ‘at their worst’, and where parents felt safe and confident to ask for help and support if needed. * There was a strong sense of community ownership of centres, with users reporting being asked to make suggestions about what programmes the centres offered, discussions about how centres ‘belonged’ to parents and centre users considered them places they could invite other parents to join. * Parents reported that involvement in training and learning opportunities through the centres had led to increased confidence, skills and knowledge; and education and employment opportunities. For some, involvement in training and learning at the centre had led to re-engagement with formal education.   Centres have overcome barriers to parental engagement in early years’ services in a number of ways:   * Parents reported that the provision of a range of health, education and other support services in their local community had facilitated greater access and engagement with services and supports. * Many said that the time and organisation required to attend centralised services via public transport, often with more than one child, had acted as barriers in the past, impacting on their engagement with health and education services. Some said that they would have missed appointments in the past because of the challenges involved in getting to them. |

| * Co-location of services enabled some parents to access services and supports without having to disclose their use to family and friends. This ability to maintain privacy and confidentiality about services used meant that some participants were now accessing child and family services such as counselling and legal advice that they may not have under different circumstances. * The single entry point facilitated ‘soft contact’ with service providers by parents and families through drop-in sessions, which then led to engagement with more targeted services and supports where necessary. |
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### 6.1.5 What makes a user-friendly centre?

| *4) Weeks, W. (2004). Creating attractive services which citizens want to attend. Australian Social Work, 57(4), 319–30.* |
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| Robustness of study ✰✰✰✰✰ |
| Literature review on the importance of the physical environment in integrated service centres. |
| The author developed a framework of elements for creating user-friendly human services:   * **Accessibility** is a key principle and includes geographical, physical and psychological accessibility. * A **‘neutral’ doorway**, meaning an entry which is non-stigmatising. * **Single-doorway services** are particularly valuable for families facing social and emotional difficulties. They are able to become familiar with the location and to attend different services which might address their needs. The neutral nature of the centre operates to increase privacy and reduce stigma. * A **welcoming entry**, including ease of access, presentation of the waiting room, and practices of reception. * The **provision of information** on services and resources, which might be readily available in the waiting area. * **Cultural diversity** in environmental design: racism and ignorance about the cultural practices of others is reflected and embedded in individual workers’ practices, as well as systemic arrangements. * **Availability of outdoor space**. * **Safety** is an issue which provides a challenge to avoid resorting to security guards and electronic barriers. One entry gate and door is necessary, and reception staff require a mechanism, such as a counter bell or buzzer, to alert others to assist in the event of a violent incident. Reception staff may need a call system to local police as extra protection. Services also need a safe place for locked records. * **Community and group work space** (associated with the principle of service user participation). Services need meeting space and open space for activity sessions, community meetings and lunches, and space in which to run groups. Opportunities for community food sharing can assist participation. Using the service as a site for community meetings increases community ownership, an essential precursor to citizens feeling that this service belongs to them. * **Co-location of interrelated services** can be a very useful resource to service users, without the difficulties of amalgamation of services. |

## 6.2 Canada

### 6. 2.1 Background

Toronto First Duty (TFD) began in 2001 as a demonstration project testing an ambitious model of service integration across early childhood programmes of child care, kindergarten and family support in school-based hubs. Other services such as public health were also part of the service mix. The goal was to develop a universally-accessible service model that promotes the healthy development of children from conception through primary school, while at the same time facilitating parents’ work or study and offering support to their parenting roles.

Phase 1 of TFD, with implementation of the model in five community sites, concluded in 2005. Phase 2 (2006 to 2008) focused on knowledge mobilisation, policy change, and further development of the TFD model in one of the original five sites. Phase 3 of TFD (up to 2011) focused research on integrated staff teams and learning environments in full day early learning programmes, and additional studies on integration of community services for children under four.

### 6.2.2 Model of service provision

In this delivery model, a professional team of kindergarten teachers, early childhood educators, family support staff and teaching assistants plan and deliver the programme. Space and resources are combined. There is a single intake procedure and flexible enrolment options. Children and families are linked to specialised resources as required.

The Toronto First Duty project operated in five sites in Toronto, and provided a comprehensive continuum of supports and services, including:

* An **integrated early years learning environment** blending the three streams of kindergarten, child care/early childhood education and parenting. This included shared space, resources and approaches.
* An **early childhood team** integrating staff from the three early years’ streams, with each member delivering core aspects of early years’ support.
* An **integrated governance model**, a consolidated structure with control over a pooled budget and accountability to provide management, planning and administration and ensure the delivery of comprehensive services and supports. This included joint programme planning, administration, financial management and programme evaluation.
* **Seamless access** to services and facilitated access to other services. This included common referral to the TFD project and integrated client information/data collection.
* **Parent involvement** with the aim of increasing the participation of parents/carers in governance, programme and planning.

### 6.2.3 Evaluation of family hubs

| 1. *Carl Corter et al. (2006). Toronto First Duty: Phase 1 Report.* 2. *Carl Corter et al. (2009). Toronto First Duty: Phase 2 Report.* 3. *Carl Corter, Zeenat Janmohamed, Janette Pelletier (2012). Toronto First Duty: Phase 3 Report.* |
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| Robustness of studies ✰✰✰✰✰ |
| The evidence gathered included data sets on child and programme observations, key informant interviews, focus groups and assessment tools that measured the quality and integration level of the programme. The child data was provided by the Toronto District School Board and from participation data available through an intake and tracking system which provided continuous quantitative and qualitative data over three years on 2,643 children and their parents who participated across the five TFD sites. |
| Key findings included:   * Children benefited socially and emotionally, and developed pre-academic skills. * Parents whose children attended TFD programmes reported being more involved in their children’s early learning (parent involvement is an important factor in school success). * Parents expressed high levels of satisfaction with TFD programmes. Parents felt more confident in helping their children learn. Programme hours and participants increased at all of the sites. Access to programmes allowed parents to achieve goals, such as helping children learn and meeting other parents. * TFD achieved the goal of equitable access for all families. * Participation levels predicted children’s physical health and well-being, language and cognitive development, and communication and general knowledge, after taking into account demographic, parenting and site factors – i.e. more intense use (number of hours) increased children’s cognitive and language development. * The quality of non-parental care services is the central and most consistent factor that determines the effects of those services on children. Quality in TFD programmes compared to their non-integrated counterparts was higher. Moreover, quality continued to improve throughout the term of the project. The sharing of the quality assessments with staff was a motivator for further improvements. * Staff had strong positive opinions of the professional benefits from integration. These evolved from the beginning stage when there was considerable angst over turf and status, to the redefining of roles and responsibilities brought about by strong leadership, professional development and programme supports.   The evidence illustrates that wide scale integration and improvement of early childhood services will require organisational and policy change beyond individual sites and beyond the local level. Factors facilitating higher levels of integration included:   * Strong leadership, with shared resolve and problem solving. * Opportunities for staff time to meet. * Common beliefs and an articulated site vision. * Monitoring of integration and quality using measurement tools. * Teamwork that aims at children’s development but which also includes respect among blended professionals. * Common professional development. * Using the common curriculum principles provided. * School space for co-location of care with kindergarten and other services. |

## 6.3 Germany

### 6.3.1 Background

National legislation provides guidelines for the support for children, young people and their families. The aim is preventative, to stimulate their individual and social development, to further the creation of good living conditions and to protect them as well as to provide support for parents. National law offers a framework for provision but the implementation is undertaken by local rather than federal authorities. It is important to note that it is the parents’ principal right to make decisions about their children’s education: this ‘parental priority’ principle is the reason why many programmes in Germany are aimed at strengthening parents’ own ability to support their children.

In Germany, childcare centres are part of the welfare system; they are not linked to the school system and they have their own pedagogical concepts that target social education rather than school instruction.

In 2006, the federal state of North Rhine-Westphalia agreed to develop around one-third of its 9,000 childcare centres into certified family centres by 2013.

### 6.3.2 Model of service provision

Family centres are designed to bring together services for families in the local community, and are a universal service with an additional special focus on specific target groups such as immigrant or educationally deprived families. They collaborate with family education and advice services to make these services accessible to a larger number of families. Their offer includes placements and skills-training for childminders and services for reconciling family and work.

Acting as a ‘hub’ of a network of family and child welfare services, family centres are supposed to offer parents and their children advice, information and assistance in all stages of the early years. A large part of these services are not offered by the staff of the family centres themselves but by local partners or other professionals. The criteria for the certification of family centres focus on cooperation - family centres are asked to conclude cooperation contracts with different partners in order to establish a cooperation that should be clear and reliable.

The programmes offered in the family centres are very different according to the needs of the local families, but include:

* Health promotion.
* Language courses in German.
* Cultural and creative activities
* Family education.
* Family counselling/psychologist services.
* Information on childminders.
* Space provided to childminders when the family centre is closed (most day care centres close by 5 pm so childminders look after children from 5 pm onwards for parents who need to work longer.

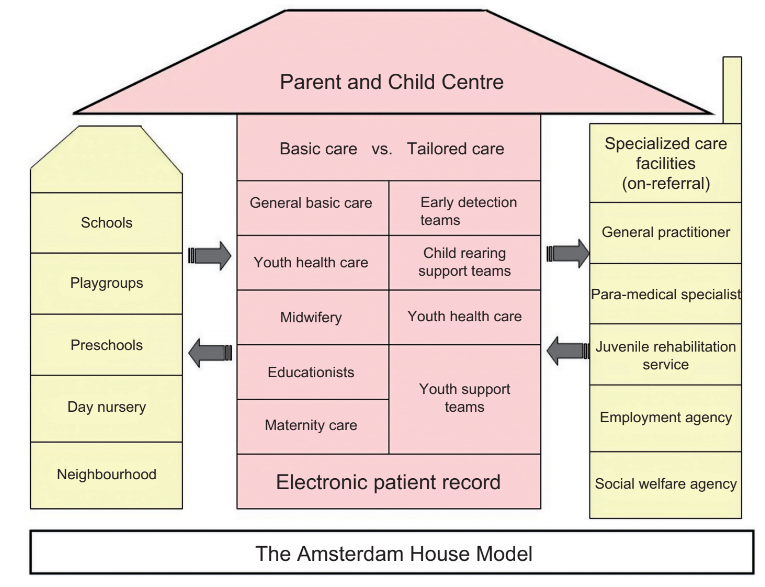
### 6.3.3 Evaluation of family hubs

| *1) Stöbe-Blossey, S. Implementation of integrated services – the example of family centres in North Rhine-Westphalia. Early Years Volume 33, 2013 - Issue 4: Integrated Children's Services: Re-thinking Research, Policy and Practice.* |
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| Robustness of studies ✰✰✰✰✰ |
| This study draws on empirical data collected during the scientific evaluation programme (2007/2008), the analysis of the results of external evaluations concerning the certificate of quality (2007–2012), a qualitative survey of 23 centre leaders (2011) and surveys of other professionals (2008). |
| * The implementation of family centres led to a high-acceptance rate and local youth offices consider them as an important element of their policy. * Centres have succeeded in reaching families more easily in their neighbourhood. * The transparent standards offered by the certificate seem to be a factor in this success. The experiences concerning external and intermediate elements of governance are rather positive: the certification process proved to be an appropriate way to build up family centres, to control their development and to link central standards and decentralized needs. Cooperation led to qualitative improvements and to decentralized services. * The cooperation between family centres and counselling agencies was seen as a very positive element by both the family centres and also the counselling agencies (86% of family counselling professionals saw better opportunities for preventive work through cooperation with family centres, 82% considered that barriers for parents were reduced and 75% said that they had gained better access to families who are difficult to reach). * The local youth office is an important partner for the development of family centres (85% of the directors of family centres said there was good cooperation). * Resources have been shown to be a restraining factor. Even if cooperation is considered to have positive effects, it is time consuming for the family centres as well as for their partners. * Not every family centre is able to offer all the activities that are needed, due to funding constraints of both the centre and the local partners, which means that resources often appear to be a restraining factor for the implementation of integrated services. For example, there are not as many family counselling agencies as would be needed by the family centres, especially in rural regions. * Management aspects need more attention as most of the centre directors said that they would need more time for managerial tasks and better support for team building. |

## 6.4 Netherlands

### 6.4.1 Model of service provision

Parent and Child Centres (PCCs) are family health care service centres. Doctors, nurses, midwives, maternity help professionals and educationists are integrated into multi-disciplinary teams in these neighbourhood-based centres. The professions of youth health nurses, youth health doctors, educationists, midwives and maternity help professionals together form the basic core of the PCCs. Although being part of the same multi-disciplinary team, midwives and maternity help professionals do not operate from the same building as the other core partners but operate from private, independent organisations often working from the client’s home. They are therefore often affiliated with multiple PCCs or are not affiliated with any PCC at all.



PCCs are the first contact that new parents in the Netherlands have with the supporting health and social care system. The centres’ aims are to:

* Support better parenting.
* Strengthen parenting competencies.
* Identify social and health risks at an early stage.
* Offer early interventions in case of problems with developments or parenting of children.

Amsterdam’s professionals and managers often refer to the PCC as the **spider in the web of information, care, and early identification of problems and professional referrals**.

The PCCs are located in the former well-baby clinics, since these clinics were already a low-threshold place for families to visit regarding issues concerning health, child development and parenting, offering parents support and education through pregnancy, childbirth and the postnatal period.

The PCCs were developed bottom-up by professionals and they offer general advice and parenting support as well as tailored help, specialised referrals to secondary care services, consultations with special education and with general practitioners. Services include:

* Regular health check-ups
* Midwife consultations
* Parenting advice
* Child vaccinations

### 6.4.2 Evaluation of Parent and Child Centres

| *1) Vincent Busch, Henk Van Stel, Johannes De Leeuw, Edward Melhuish and Augustinus Schrijvers (2013) Multidisciplinary integrated Parent and Child Centres in Amsterdam: a qualitative study. Volume 13, 12 April 2013 of Int J Integr Care 2013; Apr–Jun, URN:NBN:NL:UI:10-1-114418* |
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| Robustness of study ✰✰✰✰✰ |
| The study analysed 91 published documents on the origin and organization of the PCCs and the results from interviews with PCC experts and with PCC professionals, plus structured interviews with PCC-professionals (67 health care professionals, 12 PCC managers and 12 PCC-experts) in Amsterdam. |
| Advantages of PCCs:   * Easily accessible place for parents to visit. * More continuity of care. * Better collaboration since working from the same building/workplace leads to more smooth and frequent inter-professional contact. * Short communication lines with low-threshold contact between professionals. * Easier contact between professionals. * Speeding up collaboration efforts.   Challenges facing PCCs:   * No uniform set of multi-disciplinary protocols and work procedures for their daily practices, with organisational structures not being adapted to the multidisciplinary functional practices. * Not one front desk employee to refer clients to the appropriate service(s. * No standardised procedures to collect and store information. * Delay in communication between hospital, midwives and PCC. * Housing guidelines not in line with integration. * Differing expectations regarding the PCC-manager role among PCC-partners. * The danger of PCCs being dominated by professionals and not by the client. |

## 6.5 Northern Ireland

### 6.5.1 Background

The Sure Start Programme in Northern Ireland was introduced in 2000/2001 by the Department of Health, Social Services and Public Safety. Policy responsibility for Sure Start transferred to the Department of Education in 2006. Sure Start is therefore now funded by the Department of Education and administered by the Health and Social Care Board.

As Sure Start originated as a health and social care programme, it was in the beginning strongly focused on health and wellbeing outcomes. However with the move to the Department of Education, the focus has widened to also include education outcomes.

Sure Start is currently provided in the top 20% most deprived wards in Northern Ireland and the Department of Education is in the process of expanding this provision to the 25% most deprived wards. In total, 39 projects have been established across Northern Ireland, enabling the provision of support to around 43,450 children under 4 and their families.

### 6.5.2 Model of service provision

Sure Start in Northern Ireland focuses on improving the social, emotional and cognitive development of children or their literacy and numeracy skills, which are the outcomes required by government policy in this area. Each Sure Start project varies in its size and the services it offers, which are delivered by a variety of different staff, including health visitors, midwives, early years/family support workers and speech and language therapists. In addition a number of Sure Starts use volunteers to deliver activities such as providing crèche services and/or transporting children with disabilities.

Sure Start in Northern Ireland is one of a number of interventions and services that are delivered through statutory and voluntary and community sectors which are aimed at addressing the needs of children and young people in disadvantaged areas. However, Sure Start is the only universal early years’ intervention in Northern Ireland focused on the needs of children and parents/families that live in disadvantaged areas. Other early years’ programmes and services complement the work of Sure Start through increasing awareness of Sure Start services, referring families that could benefit from Sure Start and providing additional support to particular target groups (such as teenage mothers).

The services being delivered by Sure Start focus on a range of needs including:

* Childhood development, through the Developmental Programme for 2-3 Year Olds speech and language support and learning through play.
* Health and wellbeing such as services aimed at increased dental registration and immunisation rates and healthy eating.
* Parental support, including parenting classes, home visits, social support, etc..
* Services targeted towards specific vulnerable groups, such as Travellers or migrant/newcomer families.

The total budget allocation to deliver Sure Start in 2014/15 was just over £24m per annum, equating to around £620,000 per Sure Start per annum. Sure Start project budgets for 2014-15 varied from £231k (employing 3 FTEs with 517 registered users) to a budget of over £1m (employing 33 FTEs with 2,643 registered users).

The average cost per child was £658 (ranging from £441 to £1,112). This compares favourably to the average cost of Sure Start in England of around £1,300 per eligible child per year (2009-10) and the Welsh Flying Start Programme of £2,000.

The greatest proportion of costs was staff costs, accounting for on average 74% of the total budget. There was no significant variation in the average staff costs per FTE post which ranged from £24, 477 to £28,334.

### 6.5.3 Evaluation of Sure Start centres

| *1) Department of Education Independent Review of the Sure Start Programme (2015).*  *Final Report.* |
| --- |
| Robustness of studies ✰✰✰✰✰ |
| The review included desk research, stakeholder consultations, interviews with primary schools and pre-schools, focus groups with hard to reach/non-users of centres. |
| Strengths highlighted were:   * Health professional input in identifying families who may require additional support after a baby is born and referring them to services as soon as possible. * Partnership working was seen as strong by both Sure Start managers and the HSC interviewees. * Sure Start Projects located next to nurseries, highlighted closer relationships and better partnership working than those that didn’t. * Location assisted partnership working with voluntary and community sector organisations, for example several Sure Start projects noted that because they shared premises with healthy living centres or community groups they got to know each other and as a result they worked effectively together. * Organisations represented on Management Committees tended to have better/closer working relationships than those who were not represented.   The review highlighted a number of issues:   * Lack of consistency in the resources used within each project and a risk that not all projects were utilising all staff efficiently: The roles of managers and staffing within Sure Start projects varied significantly across Northern Ireland, depending on the activities being delivered. The job titles and the job descriptions vary across staff as they are developed locally, even for the same types of services. * Shortage of health visitors, midwives and speech and language therapists across Northern Ireland. * The lack of a professional framework for home visitors. * Since Sure Start projects work in different ways, the quality of partnership working varied. * Inconsistent access to live birth data. * The majority of non-users of Sure Start did not have a good understanding of the services Sure Start delivers - the most common barrier to using projects was a lack of awareness. * Some projects do not have an educational representative on their Management Committees. |
| *2) Education and Training Inspectorate (2019). Second Sure Start Evaluation Report.* |
| Robustness of studies ✰✰✰✰✰ |
| These evaluation findings are based on first hand evidence gathered by the ETI inspection teams during two day visits to five individual Sure Start projects between November 2018 and  April 2019. |
| Strengths identified were:   * The high quality age appropriate interaction of most staff with the children, which is reflective of the high level of ongoing quality training they received. * Parents with a very complex range of needs can make progress when provided with the relevant support and the time required. * The wide range of high quality programmes, information and support provided for parents contribute to improved emotional wellbeing for parents and improvements in the home learning environment. * Parental participation is maximised when appropriately high expectations of participation is core to the vision of the project. * Midwives and health visitors play an important role in often being the first early point of contact for mothers and in contributing to the effective multi-disciplinary and collaborative approach with other Sure Start staff. * Pre-school settings report consistently on improvements in the children’s settled behaviours, attention and listening skills. Most pre-schools acknowledge the benefits of Sure Start and would like to develop closer working relationships for the benefit of children and families. * An enabling culture is being developed across all services that recognises that speech is “everybody’s business” and not just that of an individual specialist speech and language therapist or individually targeted support. * The increasing contribution of the speech and language therapists to the planning process in collaboration with childcare staff is having a positive impact on the quality of the support being provided to meet children’s individual language needs. * The business planning process implemented is shifting more effectively from an emphasis on collecting mainly quantitative data to one which focuses more clearly on analysing a range of data to measure the impact and outcomes of the work of Sure Start work for families and children.   Areas for further development identified were:   * Recording relevant assessment information of the children’s progress. * Systematic and effective self-evaluation, monitoring and evaluation. * Insufficient consideration given to preparing parents for when their child is deregistered at age 4 years so that gains made are built upon. * Increases in parent participation and retention rates. * Evaluation of the lasting impact of programmes on changes made within the home learning environment is too limited in many projects. * Insufficient consultation with under-represented groups to identify the barriers to participation and plan for improvement. * Improvements to be made is not monitored and measured sufficiently. * Too much variation in the frequency and range of contact between pre-schools and their local Sure Start resulting in insufficient information being shared to ensure that the children’s progress and parents’ participation is sustained and built upon. |
| *3) Education and Training Inspectorate (2020). An evaluation of Improving Practice in Sure Start.* |
| Robustness of studies ✰✰✰✰✰ |
| The findings of this third evaluation are based on evaluative visits to 11 Sure Start projects to evaluate a selection of self-nominated case studies of improving practice. |
| Key strengths identified were:   * The projects are developing a more consistent and effective culture of reflection and self-evaluation combined with external evaluation as a means to bring about continuous improvement in the best interests of the children and parents. * A combination of qualitative and quantitative data is used to track the engagement and progress of children and parents and to demonstrate the positive impact of the services and programmes being provided. * The highly effective practitioners, from varying professional disciplines, engage in continuous professional development and training which is cascaded to staff to enhance their delivery of programmes and services. * The programme support specialists for the Developmental Programme for 2-3 Year Olds provide effective feedback to staff and disseminate best practice among the groups which promotes quality learning experiences for the children. * There is effective inter-disciplinary team collaboration and sharing of information to identify and follow up on the needs of families and children at the earliest stage. * Partnerships with local pre-schools are improving and developing further to promote smooth transitions and build on each stage of learning and development for the child and parent. * The project staff interweave health and education messages in an effective and holistic manner as they implement a wide range of high quality programmes and services. * The resources used to deliver programmes and services to the children and the parents are of a high quality and are used effectively to engage children and parents during sessions.   Areas for improvement identified were:   * The processes for monitoring and evaluation within projects do not consistently include sufficient emphasis on direct observation of practice to evaluate the effective implementation of programmes. * There continues to be too much variation in the expectation and effectiveness in the involvement of parents in the Developmental Programme for 2-3 Year Olds across projects. * Where there are service level agreements to deliver programmes the lines of accountability for monitoring and evaluating quality are not always clear enough. * The project leaders, who are under increasing pressure to balance the need for the management of complex staff structures, monitoring and evaluation of provision and outcomes and the associated range of documentation requirements, need simplified systems of reporting. |

## 6.6 Norway

### 6.6.1 Background

A pilot project initiated by the Norwegian Health Authorities as part of the national plan for advancing mental health care established the first family’s houses in 2002- 2004. The pilot was developed on the basis of the Swedish Family Centre Model and adapted to the Norwegian context. After the pilot, health authorities recommended that the municipalities should further explore the model: by 2012, 150 centres had been set up throughout the country. The houses were meant to provide better-coordinated services that supported the whole family. The goal of the work was to promote wellbeing and good health amongst children, adolescents and their families and to improve conditions for children and young people.

### 6.6.2 Model of service provision

Family centres – known as family’s houses - have been defined as a complete range of services based in the same premises with a health centre that provides antenatal care, preventive child welfare services, educational-psychological services and open daycare for children. The family’s houses are centres that provide interdisciplinary services for children, adolescents and their families in the municipalities. Both health and social services are located together.

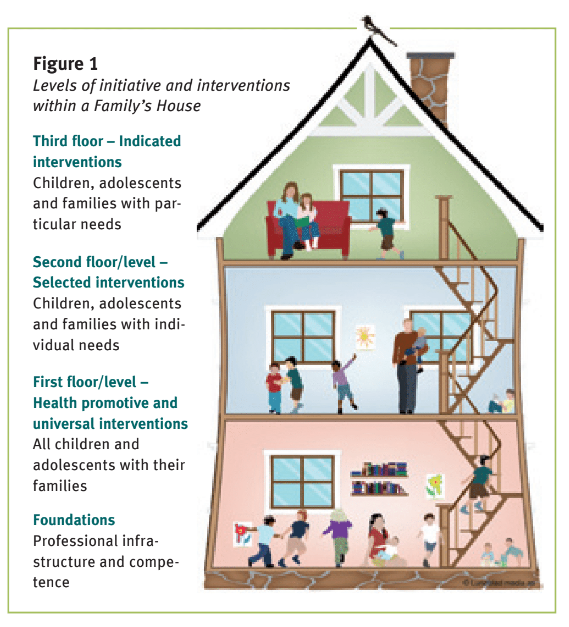
Universal intervention or low-threshold services in the family’s houses comprise:

* **Open kindergarten** where children up to the age of six and their parents or carers attend together. They can come and go during hours. The activities are similar to regular kindergartens but in addition, they can meet different professionals from other services in the centre.
* **Preventive family team** is an interdisciplinary team that provides counselling for parents with children aged 0-5 years. Parents and professionals can contact the team. The team collaborates with the kindergartens and health care for children.
* **Universal parenting training programme** (the incredible years) focusing on strengthening parenting competence. The course is a universal prevention intervention and is offered to parents with children aged 2-6 years without known risk factors.
* **The Norwegian café** is a drop-in language course for immigrants with limited skills in Norwegian. The café collaborates with a part-time kindergarten specialising in language and social skills; parents can attend the café, while the children are at the kindergarten.

More targeted interventions and services include:

* Healthcare services for children.
* Pregnancy care.
* Preventive child welfare services.
* Pedagogical-psychological services.

The term family’s house implies a tangible building and is also a metaphor for how the services are organized, connected and placed within the model.



### 6.6.3 Evaluation of family centres

| *Ingunn Skjesol Bulling (2009) Stepping through the door – exploring low threshold services in Norwegian family centres* |
| --- |
| Robustness of study ✰✰✰✰✰ |
| This paper is based on a study of 3 Norwegian family centres providing different forms of low-threshold services. The methods for generating data in this study were participatory observation and 8 focus groups plus 13 individual interviews (52 professionals in total). |
| Key findings were:   * Location in the centre of the community is important for participation. Parents said that walking distance made it easy to combine visits to the centre with their daily routines. Others travelling by car or public transport appreciated the fact that they could combine the trip with other tasks. * Other families were excluded by the distance. Living expenses in the countryside are lower than in the cities, and families with low income can afford better housing in the rural areas. The challenge is often transportation, because many cannot afford a second car and public transportation is often scarce. * Co-location with other services was seen as an advantage, e.g. parents being able to combine a visit to open kindergarten with consultations in the healthcare centre. Professionals described contact with other services in the same building as being more frequent than with services located elsewhere. * Services being free of charge was seen as important to keep the threshold for participation low, especially for families with low incomes. No entrance fee and a free cup of coffee were also important for the parents attending the open kindergarten. * Centres provided the opportunity to meet other adults and receive social support in parenting, and everyday life, in addition to being an arena for the children to develop new skills, meet other children and play. Parents valued being able to ‘just drop by’, and the flexibility of services led parents (especially those with very young children) to make frequent use of the services. * Professionals felt that positive impact with early intervention came from being able to make direct contact with services without a referral from a specialist, short waiting times and the provision of rapid support when needed. * Professionals described the centres as an arena where everybody is welcome, and one that would include families that would not receive help from the system ‘because it is not serious enough, or it is the early stages of a developing issue’. * Continuity of contact with the same professionals was important for all parents. * In addition to answering questions, the professionals in the open kindergartens facilitated conversations and guided families seeking more extensive help. Some of the parents were in contact with the family centre for several years and described the professionals as ‘door openers’ to other public services and central to the parents’ motivation to seek further support for their families. |

## 6.7 Sweden

### 6.7.1 Background

The objective of Swedish public health policy is to create social conditions ensuring good health on equal terms for the entire population. The comprehensive Swedish welfare system is almost entirely decentralised to 20 county councils and 290 municipalities. The Västra Götaland region in Sweden has a population of 1.5 million people. Public health there is the province of the Public Health Committee whose policy is directed towards promoting health. Child wellbeing is been high on the policy agenda and aims to support good parenthood as well as child welfare and development. Region Västra Götaland works together with the local authorities, non-profit associations, and government authorities and agencies.

### 6.7.2 Model of service provision

All children resident in Sweden are entitled to free health and dental care. In the majority of Swedish families both parents work outside the home and children are entitled to full-time subsidised pre-school from the age of 12 months. The municipalities are obligated to provide pre-school services for children from 12 months up to 60 months of age. These include:

* **Open pre-school** is a staffed informal meeting place for children up to the age of 6 years and their parents, for play, pedagogical activities and social exchanges. Visitors are not registered and decide themselves how often they want to participate. The open pre-school is free of charge.
* **Maternity healthcare centres** provide services for pregnancy testing, contraception, pregnancy monitoring, birthing classes, parenting classes, check-ups and can provide counselling with psychologists. These services are free of charge.
* **Child health centres** are specialised health centres for newborn and younger children. Staffed with paediatricians, paediatric nurses and psychologists, they provide not only regular check-ups for height and weight development as well as mental and motor development, but also counselling and parenting classes. The child health centres also administer the Swedish vaccination programmes. These services are free of charge.

**Family centres** are fully integrated with maternity healthcare, child health services, open pre-school and social welfare activities and operations. The Swedish National Institute of Public Health has defined the family centre as a complete range of services which are fully co-located, covering maternal healthcare, child healthcare, open early childhood education and care and the preventive work carried out by the social services. The definition assumes that the four basic services operate from the same premises. By locating services in one place, at the family centre, it is hoped to facilitate collaboration and increase accessibility for children and parents. The family centres in Region Västra are administered jointly by local municipalities and the healthcare in the area.

### 6.7.3 Evaluation of family centres

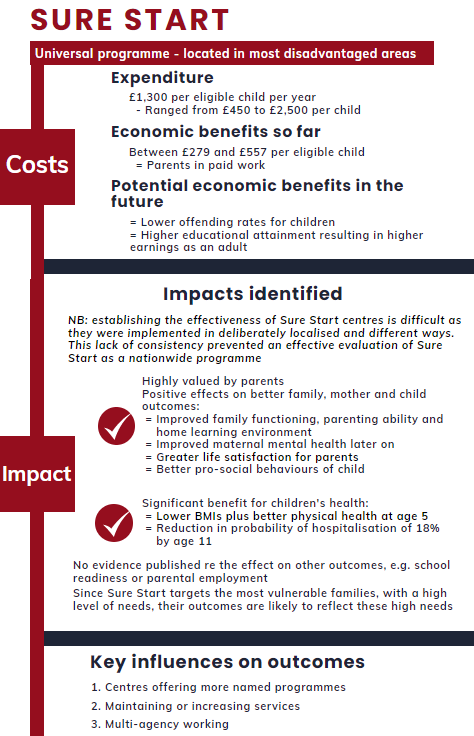
| *1) Agneta Abrahamsson, Vibeke Bing, Mikael Löfström (2009). An Evaluation of Family Centres in Region Västra Götaland, Sweden.* |
| --- |
| Robustness of study ✰✰✰✰✰ |
| This evaluation of family centres compiled experience and results of the work done by the family centres to create a base for further developments. The main study of the evaluation included 16 family centres. Six of these had also participated in a deep study. Altogether 470 parents, over 600 children and 185 members of staff, managers and politicians have contributed data for this evaluation. |
| The key benefits from family centres were:   * Open pre-schools at family centres can contribute to greater equity in health among different social groups and can be a powerful factor in public health care. * Grouping services in family centres can potentially increase health promotion and contribute to evening out health inequality among families with children. * Family centres are flexible and dynamic facilitating: social interaction; personal development; and learning. * Families who visit the open pre-schools at the family centres studied accurately reflect the socioeconomic profile of the catchment areas. * Parents visit the open pre-schools primarily for the sake of their children, but also in order to meet other people, exchange experiences and find help and support. * Parents need to feel confident that extra support is at hand when and if needed, and that they have access to all the competence available at the family centre. * The open pre-school is of considerable importance as a meeting place for immigrant parents living in the suburbs. This is where they meet Swedish people and learn Swedish, while immigrants living in smaller towns do not share this perception of the open pre-schools to the same extent. * Most staff report that the family centres have led to changes in how they work, which in turn increases the quality of interaction with the families. They can devote themselves to what they have been trained to work with and leave other tasks to colleagues with appropriate qualifications and training.   Success factors for family centres were:   * Creating a framework for child centred social intercourse and a good atmosphere where parents support one another. * Greeting visitors so that they are unafraid to cross the threshold. * Furthering parent-child bonding. * Supplying service and social counselling. * Creating an opportunity for conversation and active listening to promote growth as a parent.   The extent to which the open pre-schools and the family centres are able to reach the most disadvantaged groups is related to how closely their resources correspond to the target group and their needs. If the socio-economic strongest groups in society are not to benefit at the cost of disadvantaged groups, it is essential that the resources of the open pre-school - such as staffing, opening hours and size of premises - correspond to the numbers of children and the social status of the catchment area. How services are adjusted and dimensioned in relation to the size and socio-economic conditions of the target group determines whether families who are disadvantaged, shy, have lots of children or poor language skills, will be included or left out.  The dedication and enthusiasm of staff and management are essential to the functioning of family centres. The professions involved belong to a common field of service and this facilitates collaboration within family centres and amongst staff. Developing collaboration within centres depends on how the service is structured and managed. The service concept needs to determine the staffing and management of family centres in order to be able to contribute to reducing health gaps among families with children.  An agreed budget, guaranteeing staff from different authorities time to collaborate, benefits collaboration in the family centres. There must be common, measurable operating targets for the family centres, which are continuously monitored.  It is important to implement a clear management structure including a steering group. The steering group should have three central tasks:   * To assume responsibility for the family centres as a part of each respective authority’s operations so that the family centres become integrated in the surrounding operations. * To assist in coordinating managers at different levels in respective authorities. * To assume responsibility for supporting and managing the work and staff of family centres.   The role of coordinator also falls under the management function. To successfully accomplish these tasks the coordinator must be given clear task descriptions, a defined authorization and designated working hours. The coordinator will also have the task of representing the family centre, as well as monitoring and attending to collaboration issues for the centre, but will not be solely responsible for implementing collaboration. |
| *2) Wells, M. and Sarkadi, A. (2012). Do Father-Friendly Policies Promote Father-Friendly Child-Rearing Practices? A Review of Swedish Parental Leave and Child Health Centres* |
| Robustness of study ✰✰✰✰✰ |
| Findings from a literature review |
| The research into fathers’ involvement in child health centres found two main barriers:   * The centres’ hours of operation as most are only open during normal working hours, when most fathers are also working. * The child health nurses’ attitudes as they are doing little to directly encourage active participation from fathers during a child’s first year of life.   However, when fathers’ active participation is sought out, fathers do become actively engaged in their child’s health care. Directly communicating with the father, encouraging his participation for the sake of his child, and requiring commitment for certain programmes or sessions have been effective in increasing fathers’ participation in child health services. The child health nurses need to have positive interactions with both parents in order to fully support their parenting styles and offer continuous guidance.  The use of the internet can also encourage father participation, e.g. through online parent support groups. The research found that fathers enjoyed sharing and hearing about other perspectives on fatherhood from other fathers. Fathers wanted to continue having parent group meetings throughout the entire childhood period, not just during their child’s first year of life. |

# Evidence from Sure Start Local Programmes

This section looks at the published evidence about Sure Start local programmes and their impact up until the more generic form of children’s centres were launched in

2002.

It should be noted that establishing the effectiveness of Sure Start children’s centres has proved difficult because they were implemented in deliberately localised and different ways. There has never been a single model of what a Sure Start children’s centre should look like on the ground and the shifting policy directives have, over time, lead to centres altering both their structure and their offer to local communities. This lack of consistency prevented the use of experimental research designs for the effective evaluation of Sure Start as a nationwide programme.



## 7.1 Financial cost and economic benefits

There was 1 research study identified looking at the financial costs and economic benefits of sure Start local programmes.

### 7.1.1 Conclusions

On average, Sure Start local programmes cost around £1,300 per eligible child per year (at 2009-10 prices), varying from £450 to £2,500 per eligible child.

By the time children reached five years old, Sure Start had delivered economic benefits of between £279 and £557 per eligible child, due to parents moving into paid work more quickly than parents in comparison areas. Several other outcomes have the potential to generate economic benefits in the future: lower offending rates for children; and higher educational attainment resulting in higher earnings as an adult.

Source is:

| Robustness of study ✰✰✰✰✰ |
| --- |
| *1) National Evaluation of Sure Start local programmes: An Economic Perspective. Economic perspectives on the impact of Sure Start local programmes up to when the children were five years old (DfE Research Report DFE-RR073, 2011)* |

### 7.1.2 Cost of Sure Start

On average, Sure Start local programmes **cost around £1,300 per eligible child[[3]](#footnote-3) per year** at 2009-10 prices (or £4,860 per eligible child over the period from birth to the age of four). There was substantial variation, from around £450 per eligible child to around £2,500.

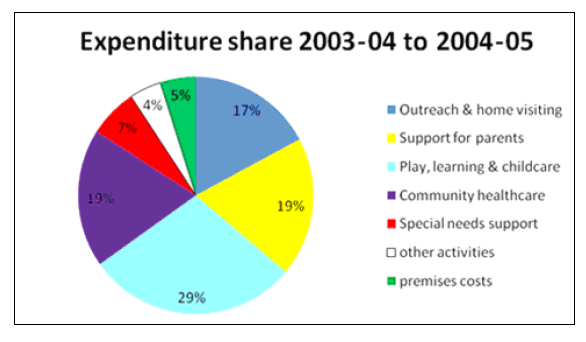
The share of expenditure (average between 2003-04 and 2004-05) was:

**29%** on play, learning and childcare services[[4]](#footnote-4)

**19%** on support for parents

**19%** on community healthcare[[5]](#footnote-5)

**17%** on outreach and home visiting



### 7.1.3 Economic benefits

The economic benefits of early childhood interventions can be high (and much higher than for interventions with similar levels of expenditure on adults), but they typically do not emerge until at least 15 years after the intervention begins.

By the time children reached the age of five, Sure Start had already delivered economic benefits of **between £279 and £557 per eligible child**.

* Due to parents living in Sure Start areas moving into paid work more quickly than parents in comparison areas. (Two-thirds of the value of these benefits is received by families in the form of higher incomes and one-third by taxpayers in terms of higher tax receipts and lower benefit payments.)
* Several other outcomes by the age of five have the potential to generate economic benefits in the future:

| * less harsh discipline in the home * lower rates of family chaos | ⇨ | linked to negative behaviour in children and adolescents, which is in turn associated with higher rates of offending and poor educational attainment |
| --- | --- | --- |
| * a richer home learning environment | ⇨ | associated with better educational attainment, which in turn is associated with higher earnings in adult life |

* There was also one potential source of negative economic impact: mothers living in SSLP areas reported higher rates of depression. Maternal depression is associated with children developing behavioural problems and with lower school attainment.

## 7.2 Impact and outcomes

There were 6 research studies identified looking at the impact and outcomes from Sure Start local programmes.

### 7.2.1 Conclusions

Available research suggests the sure start programme was highly valued by parents and has had positive effects in promoting better family, mother and child outcomes. These positive effects included:

* Improved family functioning, parenting ability and home learning environment.
* Improved maternal mental health later on.
* Better pro-social behaviours of the child.
* Lower BMIs and better physical health for children at age 5.
* An 18% lower probability of children being hospitalised by age 11.
* Greater life satisfaction for parents.

The negative effects were that mothers experienced more depressive symptoms and parents in Sure Start areas were less likely to attend school meetings.

Sure Start local programmes may have different effects on other outcomes, such as children’s school readiness or parents’ employment decisions, but there is no evidence available for these domains.

Sources are:

| Robustness of studies ✰✰✰✰✰ |
| --- |
| *1) The impact of Sure Start Local Programmes on five year olds and their families. The National Evaluation of Sure Start (NESS) Team Institute for the Study of Children, Families and Social Issues, Birkbeck University of London. (Research Report DFE-RR067, 2010).* |
| *2) The impact of Sure Start Local Programmes on seven year olds and their families. The National Evaluation of Sure Start (NESS) Team Institute for the Study of Children, Families and Social Issues, Birkbeck University of London. (Research Report DFE-RR220, 2012)* |
| *3) Evaluation of Children's Centres in England (ECCE) Strand 3: Parenting Services in Children’s Centres Research Report (DfE Research Report DFF-RR368, 2014)* |
| *4) The impact of children’s centres: studying the effects of children's centres in promoting better outcomes for young children and their families. (Evaluation of Children’s Centres in England for DfE, Strand 4, 2015)[[6]](#footnote-6)* |
| *5) The health effects of Sure Start. (Institute for Fiscal Studies, 2019)* |
| *6) Relationships between families’ use of Sure Start Children’s Centres, changes in home learning environments, and preschool behavioural disorders. (Hall et al, 2019)* |

### 7.2.2 Aim of Sure Start children’s centres

Sure Start local programmes (SSLPs) were intended to promote positive change in outcomes for families, parents, and children and to enhance the life chances for young children growing up in disadvantaged neighbourhoods.

The underlying rationale for the introduction of Sure Start was to support all children and families living in particular disadvantaged areas by providing a wide range of services tailored to local conditions and needs. Children in these communities are at risk of doing poorly at school, having trouble with peers and agents of authority (i.e. parents, teachers), and ultimately experiencing compromised life chances (e.g. early school leaving, unemployment, limited longevity). The centres therefore focused on parenting and early years’ home learning environments, which may have potential to improve behavioural outcomes for young children. SSLPs not only aimed to enhance health and wellbeing during the early years, but to increase the chances that children would enter school ready to learn, be academically successful in school, socially successful in their communities and occupationally successful when adult.

The original intention of Sure Start local programmes was to maximise reach, and many services were intended to be available to all families with young children who were living in such neighbourhoods. SSLPs would thereby have an inclusive purpose rather than being available to only those families regarded as the ‘most needy’. Thus, potential users would not be stigmatised by attendance because at least some services were open to all families and children.

A key point to note is that SSLPs were actively encouraged to focus their efforts on identifying and targeting the most vulnerable at risk families and to try to engage with them to meet their needs. However, families with poorer family functioning and mothers with poor mental health show more problems and their negative outcomes are likely to reflect their difficulties. They have greater contact with health visitors or outreach workers, suggesting that the neediest families are maintaining contact with SSLPs long term and make more use of services.

### 7.2.3 Sure Start impacts on child outcomes

* **More favourable outcomes in** **pro-social behaviour** were identified for children whose families were registered at ‘standalone’ one centre units, school-led centres, centres with higher numbers of named programmes for families running, and those with higher levels of partner-agency resourcing.
* Children whose families used services showed **lower levels of later** **behaviours related to conduct problems and hyperactivity** at age 3 years plus.
* Children growing up in Sure Start areas had **lower BMIs** at age 5 than children in non-Sure Start areas.
* Children growing up in Sure Start areas experienced **better physical health** at age 5 than children in non-Sure Start areas.
* Sure Start **reduced the likelihood of hospitalisation** among children of primary school age. By age 11, greater Sure Start programme coverage reduced the probability by 18%:
* This is equivalent to averting 5,500 hospitalisations of 11-year-olds each year.
* A simple cost–benefit analysis shows that the benefits from hospitalisations are able to offset approximately 6% of the programme costs.
* At younger ages, a reduction in infection-related hospitalisations plays a big role in driving these effects. At older ages, the biggest impacts are felt in admissions for injuries.
* Sure Start benefits children living in disadvantaged areas most: the poorest 30% of areas saw the probability of any hospitalisation fall by 19% at age 11, compared to almost no impact in the richest 30% of neighbourhoods.

### 7.2.4 Sure Start impacts on maternal outcomes

* Using Sure Start services in a directed way (rather than inconsistently) **improved mental health outcomes for mothers later on**.
* Mothers in Sure Start areas reported **more depressive symptoms**. Long term use of the registered children’s centre was associated with poorer mental health for mothers from highly disadvantaged families: these mothers showed more mental health problems at baseline which may be difficult to support appropriately in a children’s centre setting.
* Fewer impacts were evident for mothers’ physical health but being registered at a centre with a high health emphasis led to mothers **moving out of poor health status**.
* All mothers in Sure Start areas reported **greater life satisfaction** at age 5. Mothers in lone parent and workless households reported greater life satisfaction at age 7.
* Parents in Sure Start areas were **less likely to visit their child’s school** for parent/ teacher meetings or other arranged visits.

Health status included parent reported health problems, diet, injuries and developmental issues (so includes some aspects of health that are less open to influence by children’s centres than other outcomes). Change into poorer health status was associated with greater levels of childcare, greater levels of Stay and Play and attending centres with home-based outreach services. This may well reflect greater contact with trained staff leading to the identification of previously undetected health problems or an increased awareness of health problems when parents are able to make comparisons with other children of a similar age.

Extended contact with health visitors/midwife services was associated with negative effects indicating poorer functioning for many outcomes and most likely indicating higher and persisting or emerging needs for those families. The authors interpret this as evidence of impact as reach. This is because health visitors/midwives are a special kind of service (compared to others such as Stay and Play, for example) that aims to target and work long-term with those families showing persisting needs. When additional family characteristics measuring need (adverse life events such as bereavement/divorce or problems of drug/alcohol abuse etc) were taken into account, the negative associations between mother or family outcomes and extent of engagement with health visitor/midwife visits were no longer statistically significant.

### 7.2.5 Sure Start impacts on family outcomes

The positive effects associated with Sure Start local programmes for maternal wellbeing and family functioning, in comparison with those in non-Sure Start areas were that:

* Mothers in Sure Start areas reported a **greater improvement in the home learning environment** and providing a **more cognitively stimulating home learning environment** for their children at ages 5 and 7.
* Mothers in Sure Start areas reported providing a **less chaotic home environment** for their children at age 5 and for boys at age 7 (it was not significant for girls at age 7).
* Mothers in Sure Start areas reported engaging in **less harsh discipline** at ages 5 and 7.
* There was a **greater decrease in workless household status** for families in Sure Start areas.

Families’ engagement with children’s centres and use of their services showed:

* Positive effects on family functioning and the early home learning environment.
* Reductions in in parents’ self-reported levels of distress in everyday life and child rearing, relationships and perceived parenting ability.

Families registered at centres where the number of named programmes for families had increased showed:

* Improvements in the early home learning environment.
* Improved perceptions of closeness between parent and child, levels of positive interaction and child positivity.

Families registered at centres not experiencing cuts to budgets/services showed:

* Reductions in the level of confusion and disorganization in the child’s home environment.
* Reductions in parents’ self-reported levels of distress in everyday life and child rearing, relationships and perceived parenting ability.
* Improved perceptions of closeness between parent and child, levels of positive interaction and child positivity.
* Improvements in the early home learning environment.

Centres with mixed leadership predicted better outcomes for:

* Parents’ self-reported levels of distress in everyday life and child rearing, relationships and perceived parenting ability
* Perceptions of closeness between parent and child, levels of positive interaction and child positivity.

Mixed leadership may be more likely to enhance multi-agency working and this may provide more specialist experience to support parenting, and the emotional needs of parents.

### 7.2.6 Benefits to parents and children identified by staff

Interviews with Sure Start staff in 2013 suggested that children and adults attending ‘Play and Learning’ activities received a number of benefits as a result of their participation.

* **Children were reported to develop skills** which supported their ‘Personal, Social and Emotional Development’, ‘Physical Development’, and ‘Understanding of the World’; as well as school readiness and social interaction.
* Adults were reported to benefit from **improved parenting skills, greater knowledge of child development, and increased confidence in parenting**, as well as receiving more general support for their personal needs.

Parents attending the Sure Start local programmes in 2013 gave similar examples of perceived benefits:

* Their **children showed improvements in** ‘Personal, Social, and Emotional Development’, as well as improved ‘Physical Development’.
* There were **high levels of satisfaction**, with the vast majority of interviewed parents (92%) indicating that they were “very happy” with the services that they received.

### 7.2.7 Differences in service use

Overall, findings show that different services can have different effects for different user groups. It is important to consider the dynamic nature of Sure Start service use by families over time (different combinations of services used and how use may change over time) and the effects of services used elsewhere.

There were differences between financially disadvantaged families and other families in certain patterns of service use:

1. High disadvantage families were more likely to use the registered children’s centre long term (5 months longer than low disadvantage families), and for more hours in total (38 hours more than low disadvantage families).
2. High disadvantage families were more likely to access specialist services aimed primarily at parents and families (e.g. family support, employment, and education) than other families, but less likely to engage in organised activities at the registered children’s centre.
3. High disadvantage families were less likely to focus on specific services (either health or family services) than other families when their child was very young (9-18 months), showing a less consistent pattern of service use at this time point.
4. High disadvantage families were less likely to use services outside the registered children’s centre than other families, especially organised activities.

## 7.3 Good practice

There were 3 research studies identified looking at working practices within Sure Start local programmes.

### 7.3.1 Conclusions

The characteristics and processes that promote better child, mother and family outcomes are offering a greater number of named programmes, maintaining or increasing services and multi-agency working. The effective integration of services had a positive impact in terms of support for children and parents.

Outreach is used as a means of reaching out to and supporting families, including those who are hard to reach and affected by a range of issues. Parents value the support they receive and see benefits for their children and for themselves. Professionals feel that effective outreach requires particular skills and experience as well as commitment and that it works best where it is supported by good multi-agency partnerships and, in particular, by data-sharing.

Sources are:

| Robustness of studies ✰✰✰✰✰ |
| --- |
| *1) The impact of Sure Start Local Programmes on five year olds and their families. The National Evaluation of Sure Start (NESS) Team Institute for the Study of Children, Families and Social Issues, Birkbeck University of London. (Research Report DFE-RR067, 2010).* |
| *2) Outreach to Children and Families - A Scoping Study. Outreach to Children and Families*  *(DCSF Research Report DCSF-RR116, 2009)* |
| *3) The impact of integrated services on children and their families in Sure Start children’s centres. Ofsted (2009)* |

### 7.3.2 What Sure Start children’s centre features influence families’ outcomes?

The impact evaluation provided evidence on a number of Sure Start children’s centre characteristics and processes that promote better child, mother and family outcomes. The results do not show one simple pattern of associations, but instead point to various features that predict specific outcomes; albeit with communalities observable in these features and effects. Three in particular stand out:

**1. Named programmes**

Offering a greater number of named programmes for families at a children’s centre (or increasing the numbers of named programmes offered) predicted better outcomes for child behaviour and family outcomes that involve parent-child interactions.

**2. Maintaining or increasing services**

Centres that were maintaining or increasing services rather than experiencing cuts and restructuring had better outcomes for mothers and family in:

* Maternal mental health
* The level of confusion and disorganization in the child’s home environment.
* The early home learning environment
* Parents’ self-reported levels of distress in everyday life and child rearing, relationships and perceived parenting ability.
* Perceptions of closeness between parent and child, levels of positive interaction and child positivity).

**3. Multi-agency working**

Multi-agency working appears to be beneficial for some child and family outcomes:

* Child’s pro-social skills.
* Child’s non-verbal reasoning.
* Parents’ self-reported levels of distress in everyday life and child rearing, relationships and perceived parenting ability.
* Perceptions of closeness between parent and child, levels of positive interaction and child positivity).

### 7.3.3 Integrated services

The effective integration of services had a positive impact in terms of support for children and parents in over half of the 20 centres visited between June and December 2008. Three centres were judged as making an outstanding difference. Challenges remained with onward links with primary schools, in reaching the most vulnerable families and in developing data on outcomes for parents and children. The least effective partnership working seen was between the children’s centres and Jobcentre Plus.

The schools reported that children’s improving attitudes to learning and social development were easing their transition into primary school. Children with learning difficulties and disabilities and those with developmental delay gained much from the close working of professionals from each service. Children from vulnerable families also gained significantly from their parents’ contact with children’s centres.

Parents from all social backgrounds were positive about the integrated services provided within their communities. They particularly appreciated being able to access a range of professional support and guidance under one roof. They reported clear gains in their parenting skills and enjoyment of their children. The successful integration of services had made life-changing differences to some parents and their children.

### 7.3.4 Outreach services

The study aimed to capture a broad spectrum of approaches to outreach, the outcomes which are thought to be achieved and the associated attitudes, beliefs and values which underpin this work. Key findings were:

* Outreach was used as a means of reaching out to and supporting families, making them aware of activities which can help them and providing some of these activities in the home.
* Children’s centres and schools successfully engaged families who were among those who are considered to be hard-to-reach, including families affected by poverty, poor living environments, health problems and other features of social exclusion.
* Those leading and managing the work were committed to supporting families across a wide range of issues, helping parents to deal with problems which may be complex and resistant to solution.
* Parents valued the support they receive and are able to describe the benefits for their children and for themselves. A number believed that the experience of family outreach has set their lives on an entirely new track.
* Among professionals, there was a consensus that effective outreach requires particular skills and experience as well as commitment and that it works best where it is supported by good multi-agency partnerships and in particular, by data-sharing. There was also agreement that effective outreach needs to be underpinned by clear aims and measurable outcomes, but the ways in which outcomes were conceptualised varied from setting to setting.
* There was general support for the idea of a framework of qualifications relating to outreach. In certain circumstances and with appropriate training and support, parent volunteers mad very good outreach workers.
* Children’s centres and schools offering extended services had a key role in addressing child poverty. With additional support and guidance, this role could be enhanced.

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1. Data comes from a survey of leaders in children’s centres in deprived areas in the summer/autumn of 2011. [↑](#footnote-ref-1)
2. Introduced by the National College for Leadership of Schools and Children’s Services in 2005, the NPQICL was developed to support the professional needs of children’s centre leaders, especially in the role they play in meeting the Every Child Matters (2003) outcomes for all young children. [↑](#footnote-ref-2)
3. SSLPs were an area-based programme so that all children in the relevant age group living within a designated area were eligible for services, whether or not they received them. [↑](#footnote-ref-3)
4. This excludes early years education for three- and four-year old children that was funded separately [↑](#footnote-ref-4)
5. This would normally be funding for provision which would not be available as part of mainstream health services, or to which access might be limited to more severe problems, for example speech and language therapy or postnatal depression services over and above those available through local NHS provision. [↑](#footnote-ref-5)
6. The six year Evaluation of Children’s Centres in England (ECCE) study was conducted between 2009 and 2015. These evaluation findings focused on children's centres that were set up under Phase 1 and 2 of the programme - phases which targeted the most disadvantaged areas, so have been included within the Sure Start section of this report. [↑](#footnote-ref-6)