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

**(Overview Report)**

**January 2021**

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**Table of contents**

[1. Background 2](#_Toc58830888)

[2. Key Conclusions from Other Local Authorities 3](#_Toc58830889)

[3. Key Conclusions from Literature Review 4](#_Toc58830890)

[4. Summary of Findings from Other Local Authorities 5](#_Toc58830891)

[5. Summary of Findings from Literature Review 6](#_Toc58830892)

# Background

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.

# Key Conclusions from Other Local Authorities

**Lessons learnt while redesigning children’s centres:**

* Communicate and “*take your staff with you*”.
* Undertake a thorough consultation process, including engagement with staff, families and partners to get their buy-in. Co-production and the involvement of parents and families in developing services are very important.
* Follow a systematic planning process.
* Trialling the new model in one location was a very valuable learning opportunity for one authority.
* Do not underestimate the challenge in bringing together separate staff teams from multiple organisations (with quite significant differences in cultures, language and behaviours) to move forward as a single service.

**Other lessons of interest to policy makers are:**

* The value of community-based provision or children’s centre buildings being a hub for the wider community, and co-located teams/services.
* Parents are positive about and value children’s centres/hubs. Parent champions have been very effective in two local authority areas.
* The value of good partnership working and building relationships, and good communication between health services and the centres.
* The positive impact of learning from different types of professionals and their skillsets.
* Having a centre provider that is health led has led to the provision of other health services for families in the local community, generating significant savings and reducing the confusion for families.
* Moving to a whole family model has been positive for one local authority. An effective early intervention service (for 0-18s) has produced positive outcomes for another authority.
* Having a single email and IT system for children’s centres, social care and other local authority services has eliminated previous data sharing issues and improved information sharing. This has not affected data sharing with health though.

# 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.

# Summary of Findings from Other Local Authorities

There are a number of broad organisational models for children’s centres:

* Single site or standalone centres.
* Clustering.
* Hub and spoke.

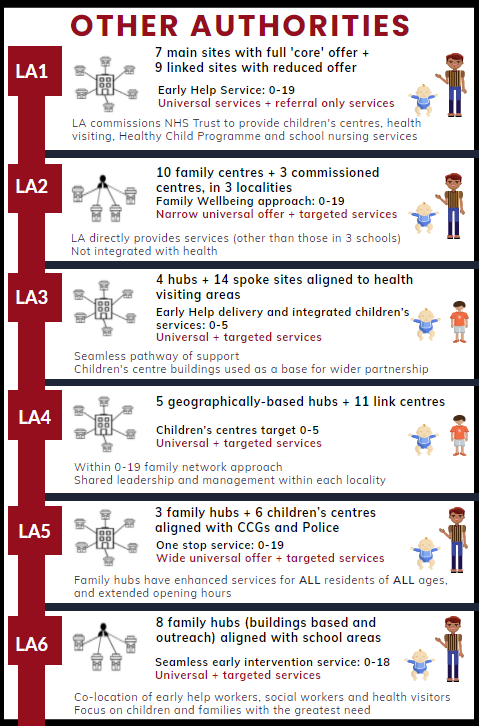
Some models also incorporate outreach work.

The 0-5 population in the six local authority areas ranges from just under 10,000 to nearly 27,000 (compared to around 13,500 in Southend).

**Comparison of spend per population and centre**

The spend per 0-5 population[[1]](#footnote-1) ranges from £71.31 to £309.97 (compared to £74.1 in Southend).

The spend per centre ranges from nearly £120,000 to just over £338,000 (compared to just over £110,000 in Southend).



## **4.1 Local Authority 1**



Children’s centres come under the early help strategy (Starting Well). This is an integrated 0-19 service to deliver effective prevention and early intervention = children’s centre ‘core offer’ for 0-5s + 0-5 Healthy Child Programme + 5-19 Health and Wellbeing Service

A single provider (an NHS Foundation Trust) is commissioned to provide children’s centre, health visitor/Healthy Child programme and school nursing services. The provider also delivers some traditionally health or hospital orientated services within the centres.

The main sites are situated in areas of highest deprivation and the linked sites are part of existing groupings near to the main centre. Services are open to all families, although there are some referral only services targeted at specific needs. The local authority does not commission any services from the voluntary sector within children’s centres, but centres do link up to community organisations (e.g. the food bank and schools for activities during summer holidays).

The new model was felt to be the best option to:

* Help mitigate potential children’s centre closure/de-registration.
* Maximise limited resources.
* Enable the local authority’s early support service to target support for families with complex and multiple needs.
* Enable collaborative working with health partners.

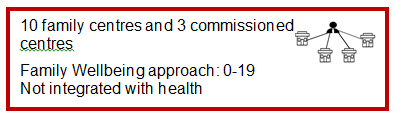
**Positives from the new model**

* Being ‘joined up’ and part of a wider children’s services system.
* Commitment to personal development for staff within the new provider.
* Excellent performance by the provider in statutory social care support.
* Having a provider that is health led has led to the provision of other health services for families in their local community, generating significant savings and reducing the confusion for families.
* Single point of contact for more complex families.

**Challenges for the new provider**

* Bringing together three separate staff teams from three different organisations (with quite significant differences in cultures, language and behaviours) plus quantifying and clarifying how they moved forward as a single service.
* As an NHS health organisation, the new provider lacked somewhat in experience of an early years’ element.
* Getting used to the monitoring data required for reach and contractual key performance indicators.
* Reluctance to follow the Early Help assessment process for families who do not meet the threshold for children’s social care but have two or more needs.

## 4.2 Local Authority 2



There are 10 family wellbeing centres and 3 commissioned centres, split into three localities. The range of service provision has been extended to cover 0-19 years, with a focus on prevention. Management oversight of all family wellbeing centres moved to sit within local authority control. The local authority directly provides services except for three which are commissioned with the school where the centre is located. They are not integrated with health services.

The centres provide a universal service, although more recently the offer has become more targeted. Staff are now called early help workers and focus on level 3 cases with some level 4 work.

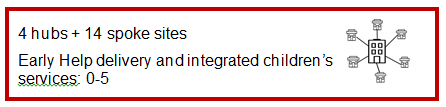
**Positives from the new model**

* The move to a whole family model
* Being based in the community, and the decision not to close buildings was more palatable to service users.
* Learning skillsets from each other and distributing that knowledge across teams.
* Identifying gaps and planning services around them.
* Having a thorough public consultation.

**Challenges for the new model**

* The implementation of changes could have been more planned and systematic, which would have better supported staff morale and ‘buy in’.
* Low staff morale: the changes followed a major restructure where many staff had lost their jobs and the redesign was not felt to have been handled particularly sensitively, with poor communication.
* Bringing staff together from multiple services with different backgrounds when also trying to shape the family wellbeing offer.
* Staff believed they were moving into an early intervention and prevention service, however, the reality was that statutory children’s social care work took precedence, which resulted in some frustration.
* Family wellbeing centres have seen a massive increase in demand across Early Help and Children’s Social Care, particularly since the pandemic, meaning they cannot always undertake which threatens the degree of early help work that can be completed.
* Partnerships were difficult to maintain whilst in the midst of change, especially relationships with health visitors and schools.
* Some intervention programmes that children’s centre staff had been trained in were initially suspended or ceased. Likewise, some public health initiatives are not given the same priority as before.
* Ensuring data systems were compatible and the lack of baseline data were problematic.

## 4.3 Local Authority 3



The local authority directly provides children’s centre services via 4 hubs and 14 linked sites. Some services are offered in venues such as libraries and community centres. 9 of the 18 children’s centres are located on school sites.

Early Help children’s centre service delivery has been integrated with the 0-19 Children’s Public Health Nursing team. The local authority has also moved towards a more integrated approach to delivering services for children and families by establishing a seamless ‘pathway of support’ from pregnancy to age 5. Children’s centre buildings are also a base for the wider partnership, including; midwifery, health visitors, day care provision, adult learning and community/voluntary provision.

The local authority’s Early Help team offers a range of open access and targeted provision. Health visiting teams and midwives are co-located with Early Help teams in the office spaces within children’s centres, and staff work closely with schools to identify families who need additional support.

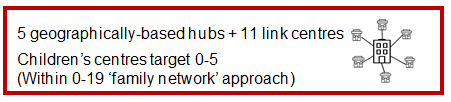
**Positives from new model**

* Greater emphasis on children’s centre buildings being a hub for the wider partnership delivery of services for children aged 0-5 and their family. This offer includes universal provision and a more targeted offer , and where needs cannot be met through Early Intervention, specialist services can be engaged at an early stage.
* Co-location of Early Help staff, health visitors and midwives has improved communication to identify any emerging needs.
* Data shows an increased engagement with the area’s more vulnerable families and improved outcomes for their children.
* Keeping the focus on the child at the heart of all the local authority’s work ensures that everyone works to the same clearly identified vision.
* Increased understanding of the importance of co-production with a commitment to involving parents and carers in developments to services.

**Challenges for the new model**

* As with any time of change, some professionals and families find those changes easy, whilst others find them more challenging.
* The Early Help Service has identified a slight decrease in attendance scores following a reduction in open access play sessions.

## 4.4 Local Authority 4



The local authority has prioritised and maintained its children’s centre provision. It has 5 localities each having a hub plus linked centres, with shared leadership and management across all sites. Children’s centres predominantly work with the pre-birth to five age group. The authority discontinued the previous external commissioning arrangements and assumed direct management of centres and staff. The health visiting service is commissioned by the local authority but run by an NHS Trust.

Children’s centres are a free universal service (although the universal offer has declined) with an additional targeted remit for families identified as needing support. The health visiting service predominantly delivers a large number of their universal offer through the children’s centre programme. There is no direct delivery by the voluntary sector within children’s centres.

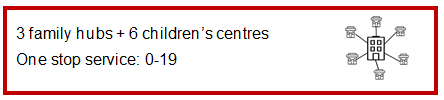
**Positives from the new model**

* Centres now work much more collectively and cohesively so are able to provide a more even offer, using buildings more effectively.
* The authority understands more about its communities and can respond better to their needs. It has reduced ‘serial attenders’.
* Good partnership working and good communication between health and the centres. This has built on the existing good practice of working with families in a shared way via health input plus family support.
* Children’s centres are an excellent resource for health services, especially following the reduction of health visitor numbers and a very restrictive and tightly commissioned service.
* Ability to refer or advise families to access a centre that is near to them, which makes services accessible. Families consequently develop very good relationships with centres.
* Having a single email system and children’s centre database, which is the same as the social care system, has eliminated the previous data sharing issues between different providers and improved information sharing.

**Lessons learnt and challenges for the new model**

* The key lesson learnt was about communication with staff and “*taking them with you on the journey*”, and being as open and transparent as possible with partners, families and staff. Regular updates are vital, even if there is nothing to update on.
* It is important to engage with partners in the planning stages to discuss and think through key ways in which they can work collectively.
* Continuing issues around sharing data between health services and the local authority, and access to data due to different governance arrangements, (although the health visiting service lead felt that they “*make it work*” with good communication links.
* The borough is seeing far greater need now, but centres may not be able to address central issues such as housing, poverty and domestic violence.

## 4.5 Local Authority 5



There are 3 family hubs, which have enhanced services for all residents of all ages and extended opening hours, plus 6 children’s outreach centres based in schools, which deliver activities co-ordinated by the hubs and delivered by partner organisations. The three localities are aligned with the clinical commissioning group neighbourhood model and place-based policing.

In the 18 months prior to the redesign, the authority trialled an all age approach within one hub. The local authority has worked with its partners to extend children’s centre services through the new one stop hubs, making more services available in local communities. The new model supports older children, their parents, families and the wider community. Centres now offer a broad range of services, activities and support beyond the pre-school age group.

A range of teams are based in the hubs, which also provide hot desks, network access and printing for local authority staff and partners who are not based at the hubs.

The health visiting service across the borough was transformed a year before the redesign of children’s centres.

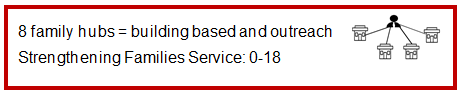
**Positives from the new model**

* Strong partnership working and relationships where the local authority has built up trust with parenters.
* The hub trial increased access rates to children’s centres, including wider access beyond the under fives. For example, a six month pilot which saw the birth Registrar located in the trial family hub substantially increased participation by parents in the hub’s activities.
* Do Not Access (DNA) rates for the speech and language drop-in sesssions have fallen because they are in a more convenient place for families.
* The take up rate for mental health and wellbeing support for young people has increased since this has started to be delivered from the centres.

**Challenges for the new model**

* Getting the right buy-in from the right partners is essential, as is strong support from across the local authority.
* The HR process was difficult as there were multiple schools and academies involved and it took time to obtain consensus from each organisation and the different unions.

## 4.6 Local Authority 6



The 0-18 family-centred model has 8 locality based ‘Strengthening Families hubs’, aligned with schools. The model includes universal and targeted services for families from priority groups, and focusses on both outreach and building-based provision.

The Strengthening Families Teams are located in the hubs alongside social workers and health visitor teams which facilitates joint working and the sharing of expertise. Partners also form part of the offer, including around 80 parent champions who encourage families to engage with services.

The principles of the service include a focus on children and families with the greatest need and the distribution of resources firmly aligned to analysis of local need. It also embeds the authority’s Troubled Families programme. The local authority has aimed to create a “seamless” early intervention service for families, who can move from universal services to a more targeted service where higher needs are identified. Partnership forums in each locality include schools, health and voluntary organisations and discuss emerging issues within that locality with a small budget to address local issues arising.

**Positives from the new model**

* Feedback on the redesign was positive and highlighted the importance of Early Help services to families.
* The early intervention service has been successful, including avoiding a spike in demand during COVID and reductions in the rates of children in care, Child Protection and Children in Need.
* Being locality-based has made a huge difference to the early intervention work.
* The co-location of staff has improved partner relationships.
* The parent champion initiative has been very positive.
* Good evidence-based suite of interventions used..

**Challenges for the new model**

* Initially, health visitors had difficulties after moving into the hubs, including issues around hot desking, that health staff were not used to working in a “mobile” way with technology, and the need to accommodate multiple filing cabinets with paper records.
* Lack of space in some of the hub buildings, especially where rooms in which activities used to be run are now used for office space.
* Different working practices over the Christmas period for health visitors and local authority staff and the closure of hub buildings during the lockdown, with very little notice.

# Summary of Findings from Literature Review

## 5.1 Evaluation of children’s centres in England

### 5.1.1 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.

### 5.1.2 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 to.

### 5.1.3 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.

### 5.1.4 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.

## 5.2 Children’s centres in other countries

### 5.2.1 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.

### 5.2.2 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.

### 5.2.3 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.

### 5.2.4 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.

### 5.2.5 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.

### 5.2.6 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.

### 5.2.7 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.

**5.3 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.)

**5.3.1 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.

**5.3.2 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.

**5.3.3 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.

1. The offer for LA areas 1, 2, 5 and 6 is 0-19 while the offer for LA areas 3 and 4 is 0-5. [↑](#footnote-ref-1)