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

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EXECUTIVE SUMMARY

1. Introduction

Action for Children commissioned a research team at King's College London to evaluate the impact of *Action for Children* Children's Centres on outcomes for vulnerable children. The study took place during 2010-11. Within the wider context of early intervention to meet wider family support needs, the study also addressed key topics including health, inter-agency collaboration; access to services; and the role of outreach. The study period coincided with robust public and political debate around the allocation of public spending, alongside an extensive review of services and outcomes for children and young people, through five parallel reviews.[1]

Proposed developments in the configuration of community health services for children and their families, put a spotlight on the existing and potential contribution of Children's Centres to undertake the co-ordination of services, as well as have a positive impact on child outcomes, alongside supporting workforce recruitment and retention; and the enhancement of inter-agency collaboration.

2. Existing knowledge

Evaluations already commissioned by both central government and other bodies have consistently shown that Children's Centres can 'host' a set of services delivered by a complex mix of other agencies, including health, social work, early years and employment-related services. Recent research studies which have explored Centre-

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[1] http://www.education.gov.uk/munroreview/ (assessed 31/05/11)
[1] http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf
[1] http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf
[1] http://media.education.gov.uk/MediaFiles/B/1/5/%7BB15EFF0D-A4DF-4294-93A1-1E1B88C13F68%7DTickell%20review.pdf

based provision (including Tunstill et al 2007; Cameron et al 2009; Tunstill et al, 2009[2]) have highlighted the necessity for making available a continuum of support, with the capacity to meet specific needs at a particular time. These researchers highlight the vital importance of interagency collaboration in creating and sustaining provision, at the same time as ensuring good communication with families (Anning et al, 2006[3]). Evaluations of Sure Start Local Programmes/Children's Centres which have been completed, at both national[4] and local levels[5], have pointed to the advantages for children and families of delivering targeted services within a framework of universal services. It also maximises the effective management of resources. In addition *boundaries* related to geography or age have also been found to raise serious problems for children and families such as:

- failing to meet the needs, including health of children across their developmental life course, that is, beyond the age of 4 years;
- failing to maximise access to services; and
- Increasing the risk of a sense of stigma, which can deter people who need services from using them.

[2] Synergy Research and Consulting (2009) Evaluating the Delivery by Action for Children of Targeted Family Support. Available via: http://www.actionforchildren.org.uk/policy-research/research
[3] Anning, A. Cottrell, D., Frost, N., Green, J., Robinson, M. (2006) *Developing Multiprofessional team work for integrated children's services*. Maidenhead, Open University Press
[4] Belsky, J., Barnes, J., Melhuish, E. (eds) (2007) *The National Evaluation of Sure Start: Does Area-based Early Intervention Work*? Bristol. Policy Press; Melhuish, E., Belsky, J., Anning, A. et al (2007) Variation in Community Intervention Programmes and Consequences for Children and Families: the example of Sure Start Local Programmes. *J Child Psychology & Psychiatry.* 48: 543-51.
[5] Malin, N. & Morrow, J. (2008) *Evaluating Sure Start: inter-profesionalism and parental involvement in local programmes*. Chichester, Wiley

3. Project objectives

The research objectives were:

- Which models of joint working operate within the Sure Start Children's Centres (SSCCs)?
- To what extent do SSCCs succeed in co-ordinating different agencies within their areas?
- Do, and if so in what way, SSCCs improve outcomes for vulnerable children?
- What do SSCC outreach services achieve for children (outcomes) and what is the state of the evidence behind the skills' sets which are required to deliver positive outcomes for children?
- What do family support services achieve for children (outcomes)?
- How good are SSCCs at achieving health outcomes (and how do their outreach and family support services support health staff in SSCCs to achieve improved outcomes).
- What are the implications of the available data for the nature of future service developments in Action for Children policy and practice?

In addition the design of the data collection process has sought to illuminate the overall nature and impact of Action for Children's family support work, including the role of outreach activity in facilitating access to services.

4. Findings

4.1 How we carried out the study?
The team used a mix of quantitative and qualitative methods, including site visits and face to face interviews with stakeholders; and an analysis of policy documentation and of case records. This approach captured data from a sample of five Action for Children Children's Centres across England chosen to capture a range of demographic characteristics including socio-economic status and ethnicity. Data was collected on:

- Profile of children and families using services;

- Range of services delivered by the centre;

- Style and reach of service delivery (including outreach activity); and

- Services provided and outcomes achieved for a purposive sample of 53 cases drawn from the 5 centres (outcomes were assessed on a researcher rating scale developed for the study).

4.2 What did the data show?

The graph in Figure 1 (NB: analysis of cases allowed for the identification of more than one need) highlights the fact that in the majority of cases 'need was multiple' including parenting issues (94.3%) and family social issues (81.1%). However, it is also obvious that health-based needs, are widespread, e.g. mental health issues; general health issues; development issues; physical disability issues. At the complex end of the spectrum of health need, drug abuse featured in a significant minority of cases, and the behavioral and emotional issues identified, were themselves health related, even if less obviously so.

Unsurprisingly given this picture, referral routes included self referral as well as following a referral from another agency. Where parents came of their own volition this was frequently as a result of very positive "word of mouth" through their friends and neighbourhood networks.

Figure 1: What needs did the children and families bring to the centre?

Family needs

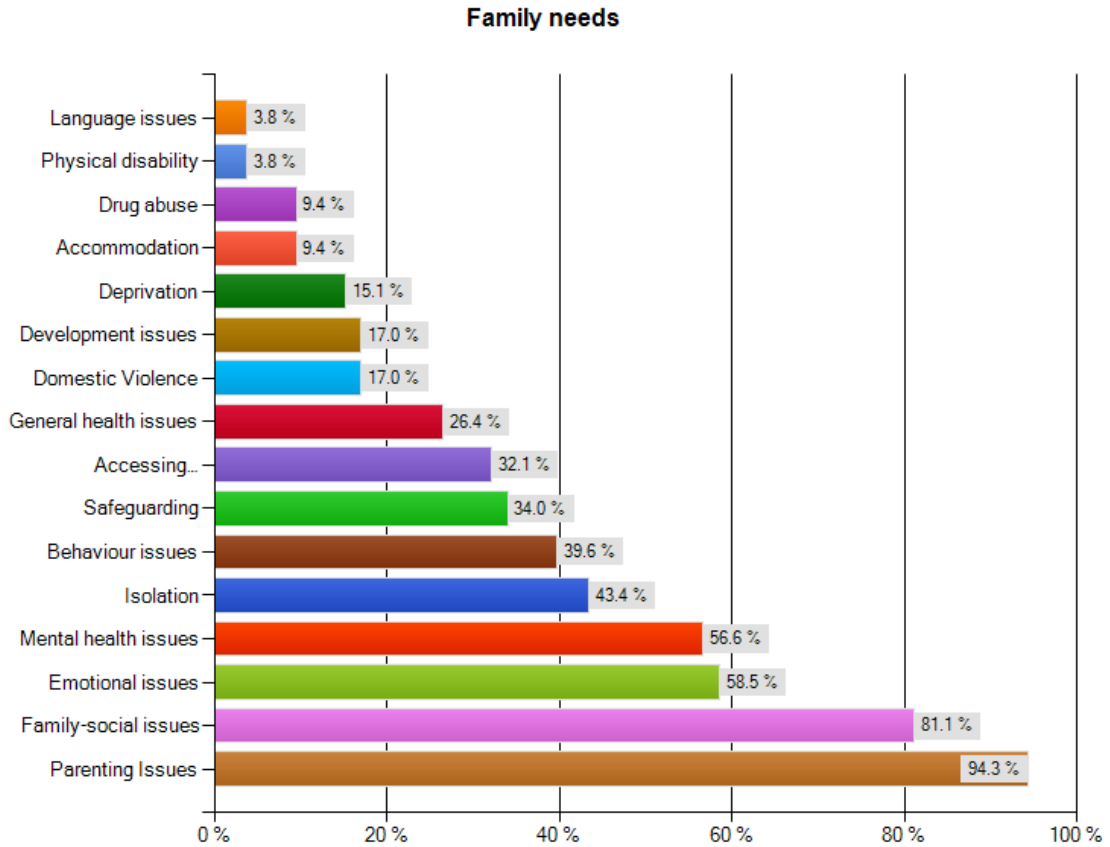| Need	Percentage
Language issues	3.8 %
Physical disability	3.8 %
Drug abuse	9.4 %
Accommodation	9.4 %
Deprivation	15.1 %
Development issues	17.0 %
Domestic Violence	17.0 %
General health issues	26.4 %
Accessing...	32.1 %
Safeguarding	34.0 %
Behaviour issues	39.6 %
Isolation	43.4 %
Mental health issues	56.6 %
Emotional issues	58.5 %
Family-social issues	81.1 %
Parenting Issues	94.3 %

Figure 2 provides a percentage breakdown of the types of services provided by the five centres. Over three quarters fell into the category of *family support* which itself underlines the multifaceted and inter-related nature of parenting need.

Figure 2: What services were delivered to the children and families by the centre?
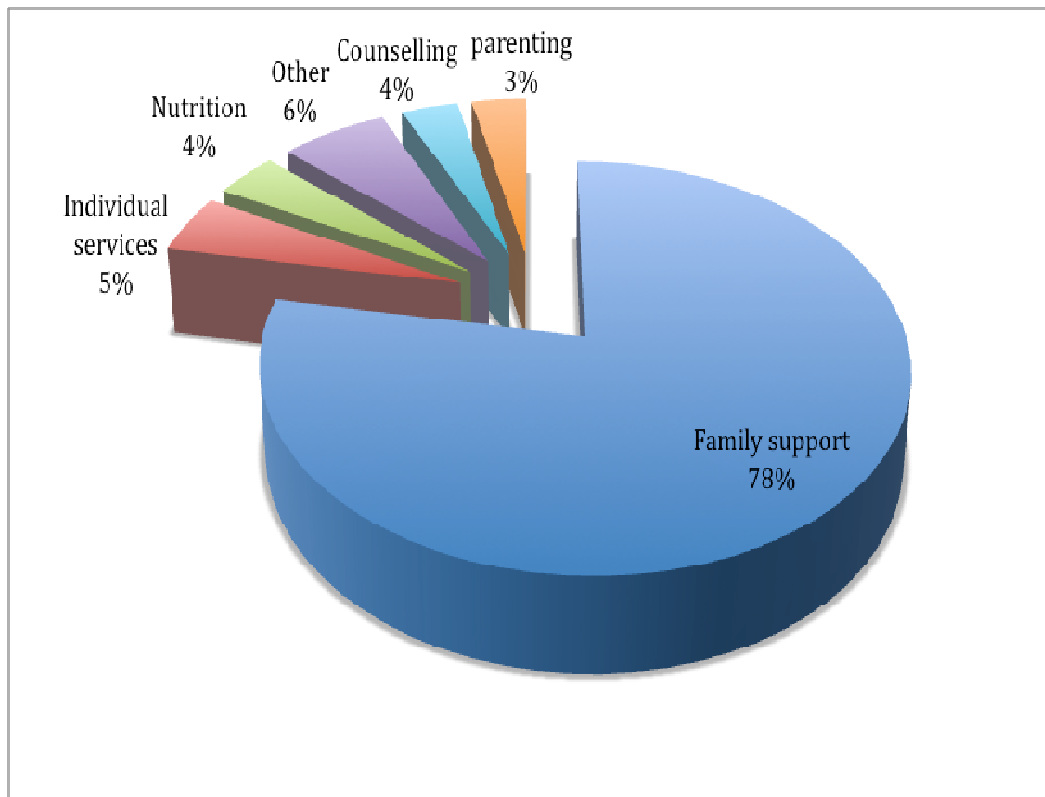
4.3 Focusing on outcomes

It is essential to acknowledge the complexity of measuring *outcomes* within the relatively short period of this study. In addition, in respect of a high proportion of the families whose service experience is reflected in Figure 3, the very maintenance of 'status quo' is itself a positive outcome. In terms of health outcomes, it is only realistic to expect very obvious measurable outcomes over a much longer period. This research reality underlines the validity of the concept of 'as long as it takes'.

Taking account of this challenge we devised a study-specific rating scale, including health related indicators:

THIS RATING SCALE WAS DEVELOPED SPECIFICALLY FOR THIS STUDY TO MEASURE OUTCOMES FOR THE CHILDREN, INCLUDING HEALTH OUTCOMES

A rating of 4 will reflect 'progression' in scenarios such as these typified below:

- Safeguarding concerns raised with regard to a young parent shortly after the birth - with intensive, support these concerns subsequently diminished.

- A family with very long-term concerns around the developmental delay associated with long-standing neglect remained fully engaged with the project over a long period, and in regular contact with the centre health visitor.

- The youngest child with a serious physical disability condition (cerebral palsy) the family came into local authority care. However this was done in a planned way, with the maintenance of close links with both birth family and the centre.

A rating of 3 will reflect progression in scenarios such as these typified below:

- Progress had been very fragile for a family where a parent had a mental health difficulty and was still in an unstable situation. There may have been progress with the children; there were some setbacks, including a disruptive hospital admission, but this established an on-going link with the practice nurse in the GP practice, who linked with a family support worker in the centre.

- A parent struggled in their relationship with a teenage child, but the family still access services and remain engaged, albeit with frequent crises.

A rating of 2 will reflect progression in scenarios such as those typified below:

- A young, new, mother was overcoming serious drug misuse problems, and working with the centre midwife to establish a healthy nutrition plan for herself, and persist with breast feeding. Significant problems remained.

- Parents of a young child had struggled with a volatile adolescent who continued to experience frequent crises but the centre were still able to periodically engage and make some progress. A link was made to the local CAMHS service, and the parents attended behavior management sessions. However the young person refused to engage and is currently excluded from school.

A rating of 1 will reflect progression in scenarios such as those typified below. :

- A family with concerns around neglect where problems had increased with no significant progress and parents had disengaged entirely.

- A family had begun to attend the centre but after a brief involvement in a parent education class, had stopped. There were concerns regarding domestic violence, and at present the father made threats to staff and the father in a family he knew who were using the centre.

Figure 3: An overview of outcomes at point of referral (T1) and point of data collection (T2, i.e. either case closure – four fifths, or open at file analysis – one fifth)
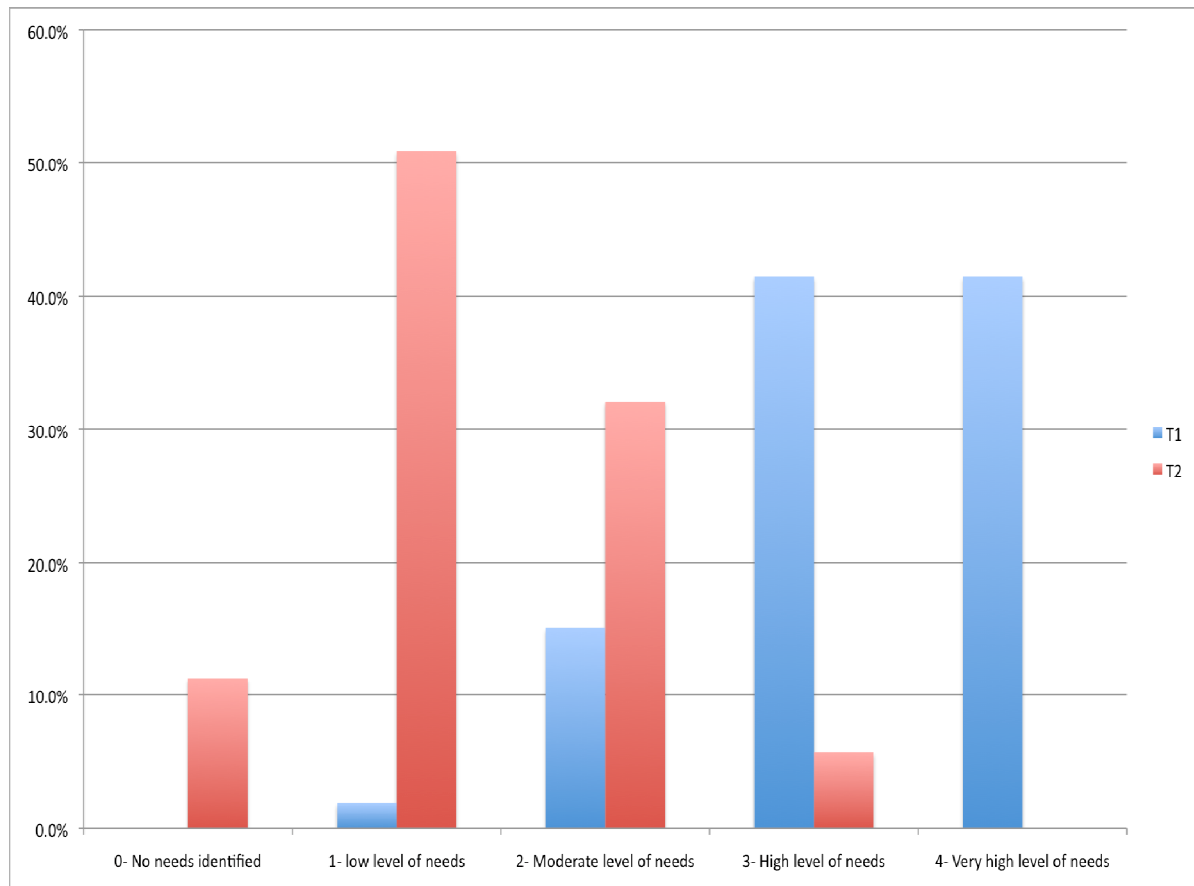
Figure 3 illustrates that overall families came to the centres with relatively high levels of need in respect of their children (blue bars). At the point the data was analysed to produce this table (red bars) the majority were considered to have lower of need with a minority (11%) having no needs and just under a third having a moderate level of need.

In other words the data provides an overall picture of '*children doing better'* in open cases *after the beginning*, and in closed cases *by the end*, of their contact with the centre staff and the services on offer.

5. Key Messages

5.1 Maximising Reach

Action for Children Children's Centres have evolved a sophisticated range of mechanisms to maximize "reach" in even the most challenging circumstances. The Action for Children agency *partnership style*, working with other local agencies, and crucially health, maximizes service responsiveness for families and can help protect local family support capacity by engaging with small/medium sized agencies.

5.2 Partnerships with health services and NHS professionals

The study has identified the potential role for Children's Centres to offer commissioners of health and children's services a joined-up service that achieves positive outcomes for children and adds value to their investment in respective services. Children's Centres offer centre-based opportunities for local health professionals to engage with parents in a family-focused setting; they seem to have had particular success in meeting health-related need through the engagement of community-based midwives and health visitors and the potential to consolidate links with GPs.

5.3 Maximising investment at the same time as building community capacity

Children's Centres offer a wide range of 'volunteer opportunities' for members of the local community. These are beneficial to users of their services and are also are helpful in enabling parents and members of local communities to share in support for families. While some volunteers may use this as a stepping stone into employment, others may find it useful in developing social and community capital.

5.4 Access and acceptability for all parents

There is a strong sense that Children's Centres have been able to roll back a long history of perceived threat to families from well-meaning professionals and charities. Centres have been sensitive to the wariness of parents and have made efforts to reduce the risk of stigma. This will be a challenge if they are to become more targeted. A key part of Children's Centres' work has been that while they have stressed

accessibility they have also engaged in outreach. It is this that may reverse disengagement and may strengthen the link to parents who are most isolated and vulnerable and least able to meet the health needs of their children. They also work with many children with disabilities and long-term health conditions. It is possible that their work with ill and disabled children will intensify, and they are in a strong position to respond to the many challenges involved.

5.5 Meeting some needs for *most* children to ensure that the needs of *vulnerable* children are identified and met

Action for Children Children's Centres can deliver a range of preventative services which make a major contribution to the range of outcomes for children - including health outcomes; behavioural outcomes; and developmental outcomes, all of which contribute short-term and life-long benefits, including the enhancement of school readiness. This breadth of early intervention applies as importantly both to children whose various special needs have already been identified; and to families who struggle with the challenges posed by the task of parenting, and who may need short periods of support in order to weather crisis or change.

A number of the children they work with have raised child protection concerns, although levels of risk vary. In a small but significant number of cases the Centres are part of a web of support for very vulnerable children.

6. Final word

Action for Children Children's Centres have the potential to act as a gateway, and in some cases one-stop-shop, for the early intervention which we know from the international and national evidence base, can improve outcomes, and especially health outcomes for children, both during their childhood and through to later life. Our findings highlight the value of the policy and practice approaches we found in the Children's Centres and would suggest that the Action for Children *service style* constitutes a very timely and effective way of delivering services in a period of particular resource

challenge. For families the Children's Centres constitute a non-stigmatising and popular route into services; for service agencies and professionals they provide a crucial resource to help them co-ordinate their work to the benefit of children, at the same time as reducing inefficiency and lack of co-ordination.

1. Introduction

The project described in this report has been commissioned by Action for Children to provide feedback on the existing work of its Children's Centres, taking account of current policy requirements and the new challenges which face the commissioners and providers of services for children and their families.

The overall aim of the evaluation has been to investigate the impact that Action for Children Sure Start Children's Centres (SSCCs) have on outcomes for vulnerable children. It has sought to answer a number of specific objectives:

- Which models of joint working operate within the SSCCs?

- To what extent do SSCCs succeed in co-ordinating different agencies within their areas?

- Do, and if so in what way, SSCCs improve outcomes for vulnerable children?

- What do SSCC outreach services achieve for children (outcomes) and what is the state of the evidence behind the skills' sets which are required to deliver positive outcomes for children?

- What do family support services achieve for children (outcomes)?

- How good are SSCCs at achieving health outcomes (and how do their outreach and family support services support health staff in SSCCs to achieve improved outcomes).

- What are the implications of the available data for the nature of future service developments in Action for Children policy and practice?

In addition the design of the data collection process has sought to illuminate the overall nature and impact of Action for Children's family support work, including the role of outreach activity in facilitating access to services.

The study design takes account of the specific goals set out by Action for Children, which it refers to as the **five pillars,** described fully in Action for Children's strategic plan[6]. Fundamental to these is the principle of inclusion, with a specific commitment to undertake work with fathers; work with children with disabilities; work with ethnic minorities; and work with 'hard to reach/engage' parents; as well as to facilitate parental participation and involvement in service design.

The Action for Children approach to families highlights a whole family approach, a focus on early intervention, and the determination to provide a continuum of support through service user involvement, relationships, and the delivery of Parenting Programmes to improve outcomes for children and young people.

In the context of health focused work the Children's Centres seek to:

> *…address local health targets and inequalities; early intervention & prevention; promotion of nutrition, hygiene, increasing service- user knowledge & choice regarding healthy eating/healthy lifestyles; joint work with health visitors and PCTs.*

This project was commissioned in 2010 by Action for Children to evaluate the role and outcomes for children of the Children's Centres which they run in England. Action for Children attaches priority to ensuring that its services demonstrate impact on the lives of children, young people and their families. The charity produces an annual review of its effectiveness impact and each of its services is now beginning to complete report cards to demonstrate key messages clearly. Action for Children collects and analyses both quantitative and qualitative information available in order to understand and

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[6] Action for Children (2010) *Supporting Families Priorities 2009-2011.*

demonstrate the impact of a range of its services. This research has been designed to inform the understanding of impact.

Alongside its own internal evaluation mechanisms, Action for Children commissioned this study in the context of a particularly challenging policy time. Its timing coincided with a robust public and political debate around the allocation of public spending including the publication of the 2010 Comprehensive Spending Review (CSR). (The interim report on early findings was produced at this stage). The range of themes which that first report identified and discussed continues to underpin debate and decision making about the direction of national and local policy making about provision for children and their families.[7]

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[7] Action for Children (2010) *The role of Action for Children children's centres in the local service system for children and their families: interim report.*

2.   The Structure of this report

This report is organised in the following five further sections:

- Section 3 provides a brief overview of research knowledge in respect of Centre-based services for children and their families
- Section 4 describes the current policy context of the evaluation
- Section 5 describes the methodology used by the project team
- Section 6 reports the findings, across the related areas of service inputs; service outputs; and child-level outcomes.
- Section 7, the concluding section, identifies and explores potential implications of the data for the design of future services, taking account of current and future challenges for both commissioners and service providers.

It has long been acknowledged by researchers that in any evaluation of service delivery it is important to recognise the inter-relationship between policy; research methodology; and conceptions of what constitutes *good practice*.[8] For example, there is an overlap between the ostensibly discrete topic of *research and its methodology* and the dominant *policy culture* (in this study, we have therefore taken account of current debates around the *place of experimental methods*; and the *policy emerging around payment by results*). Given this caveat, there is a substantial knowledge base which is accessible to the providers and evaluators of children's services in the community, and in particular, services delivered from a *Centre-base*.

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[8] Tunstill, J. (2003) 'Evaluating Family Support: Political and Technical Issues' in Pinkerton, J. & Katz, I. (eds) *Evaluating Family Support*, Chichester. Wiley
Rutter, M. (2007) 'Sure Start Local Programmes: An Outsider's Perspective' in Belsky, J, Barnes, J, Melhuish, E. (eds) 'The National Evaluation of Sure Start. Does area based intervention really work?' Bristol. Policy Press.

3.   The research knowledge context for understanding *Centre-based services for children and their families*

Two consistent challenges feature strongly in the research literature over at least two decades. These have dominated debate on how to achieve the 'best' configuration and delivery mode for effective children's services. One such challenge is to find a sensitive, yet cost-effective solution to the enduring problem of facilitating access to services at a timely and early enough point. The second is the need to support the building of sound partnerships between agencies so they can ensure their services help improve outcomes for children and their parents. The current emphasis of the Coalition Government on *local* as opposed to *national* service responsiveness gives these enduring challenges a new urgency, and shines a particularly bright spotlight on the positive existing contribution and potential future role of Children's Centres.

The Audit Commission acknowledged, as far back as 1994[9], that *Centre-based services* occupy a unique place within a wider network of agencies, both inside and beyond their immediate communities, and are well placed to address and meet both of these challenges by acting as a gateway or one-stop shop for a wide range of services for children and their families:

> *Social Services support is focused too narrowly at present … an investment in more proactive services should improve the possibility of reducing the need for crisis intervention… the idea of a 'primary resource' or the one stop shop centre could act as a single point of entry to a range of multi-agency support services.*

The Munro Review of 2011 prompts a further re–acknowledgement of the crucial role of Children's Centres in helping agencies to remain vigilant in avoiding organisational models which can *narrow the gateway to entitlement* and result in a *destructive impact*

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[9] Audit Commission (1994) *Seen But Not Heard: Developing and Co-ordinating Community Child Health Services for Children in Need.* London HMSO, p.46.

of high thresholds.[10] A central theme emerges across all of the Munro Review's conclusions so far, around the importance of being able to operate on the front-line, not merely as identifiers and assessors of children's needs, but as workforce members engaged in service delivery. Indeed, Munro singles out Children's Centres as an example of agencies currently not reaching their potential. She argues that universal services, such as Children's Centres, do not currently offer comprehensive early specialist support to vulnerable children, young people and families because professional and specialist family support capacity and expertise have not been developed in those services.

However, while this criticism may be true of *some* providers who have constructed Children's Centres in line with a very narrow 'early years' brief (which, it could be argued, reflected initial New Labour guidance on Centres), many accounts of family support services indicate that this is *not a given.* Where agencies have made a conscious decision to incorporate the four levels of need in their Centre-based provision there is evidence that they have the capacity to meet need across the continuum.[11] However, Munro raises an important question as to how far the term "Children's Centres" has itself, unintentionally perhaps, precluded a wider commitment to meet the needs of the child within her or his own family. Research literature has captured several examples of Centre-based services delivering a wide range of services though not necessarily badged as children's services. Conversely, some Centre-based services, such as Children's Centres, have met the challenge.

In particular, given the focus of the Munro Review, two very helpful key characteristics can be identified which distinguish Children's Centres from other office-based practice. Warren and Lightburn [12] argue that Centre-based care can "deliver mixed services, melding the *informal* with the *formal* and inter-agency and inter-disciplinary practice".

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[10]Munro, E. (2010) *Safeguarding and Social Work Reform; a review of child protection.* London, DFE
[11] Tunstill, J. et al (2005) *Implementing Sure Start Local Programmes: An Integrated Overview of the First Four Years* http://www.ness.bbk.ac.uk/implementation/documents/1185.pdf
[12]Warren-Adamson, C. & Lightburn, A. (2010) Family Centres: protection and promotion at the heart of the Children Act 1989, *Journal of Children's Services* 5 (3) pp 25-37.

Many studies have shown that Centres possess the potential to act as a *one stop shop.*[13] Their location within a complex matrix of community stakeholders, including individuals, services and other agencies, places them at the potential heart of any local service configuration. Even the most imaginative day care setting would not have the potential to offer the same wide-ranging package of services as a Children's Centre or indeed some Family Centres. All research studies which have explored Centre-based provision (including Tunstill et al 2007; Cameron et al 2009; Warren-Adamson & Lightburn 2010), have highlighted the necessity for making available a continuum of support, with the capacity to meet specific needs at a particular time. These researchers, as well as Anning et al[14], highlight the particular fact that the task of creating and sustaining such provision requires considerable interagency collaboration, as well as good communication with families.

Children's Centres have been shown to possess the ability to combine different forms and styles of work in a single Centre, such as nursery provision for children with intensive social work support for families; a range of groups and activities; adult education; schemes run by parents; family therapy; and community development approaches which seek to address the relationship between the Centre and its neighbourhood, and build social and economic capacity at the local level.[15] Then, as now, it is the location of Centres which may have a major positive or, indeed, negative impact on access to services. The task of facilitating accessibility depends on close liaison and co-operation between a range of community stakeholders, including individuals, services, agencies and projects.

Secondly, Children's Centres have a vital role to play in ensuring the delivery of high quality child protection and safeguarding services in a way which avoids the *gate-keeping dangers* highlighted by Munro. As the National Evaluation of Sure Start (NESS)

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[13] Hill, N. (2004) The one-stop family shop. *Children Now* (24 Mar) pp20-21
[14] Anning, A. Cottrell, D., Frost, N., Green, J., Robinson, M. (2006) *Developing Multiprofessional team work for integrated children's services*. Maidenhead, Open University Press
[15] Cameron, C. et al. (2009) *Working together in extended schools and Children's Centres: a study of inter-professional activity in England and Sweden.* London: Department for Children, Schools and Families. (DCSF-RBX-09-10)

showed[16], Sure Start Children's Centres were in a position to make a major contribution to the task of safeguarding, and enabled Centre staff across a range of disciplines to see the concept of safeguarding as '*everyone's business'* and develop new frameworks within which all the agencies could develop collaborations and overcome barriers. These findings have been consistently echoed in a number of other studies, all of which have highlighted the role of community based services in facilitating the early recognition of 'child protection problems'[17], which role is inextricably linked to facilitating parental access to and usage of community-based services.[18]

In many ways therefore, current knowledge serves to *validate* the nature of the above challenges rather than to provide easy answers to any or all of them. Most of what we know has been derived from the evaluations of Sure Start Local Programmes (SSLPs) which were commissioned at national and local level, and developed into Children's Centres with expanded area coverage, numbers and extended service ranges from 2002. A feature of the large scale National Evaluation of Sure Start (NESS) study was the 'Sure Start-blind' nature of the standardised research instruments. The study design focussed on measuring a range of outcomes, but was designed to eliminate questions about specific service usage. As a result, many of the 'why and how' questions in relation to achieving improved outcomes remain unanswerable at other than an area level.

Evaluations of SSLPs /Children's Centres which have been completed, at both national[19] and local levels[20], have pointed to the advantages of delivering services on a

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[16] Tunstill, J., Allnock, D. and the National Evaluation of Sure Start Team, Birbkeck College (2007) *Understanding the Contribution of Sure Start Local Programmes to the Task of Safeguarding Children's Welfare.* London. DCSF

[17] Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., Macmillan, H. (2009) Recognising and responding to child maltreatment. *The Lancet.* 373. (9658) 167-180

[18] Garbers, C., Tunstill J., Allnock, D. and others (2006) Facilitating access to services for children and families: lessons from Sure Start local programmes. *Child & Family Social Work.*11 (4) pp287-296.

[19] Belsky, J., Barnes, J., Melhuish, E. (eds) (2007) *The National Evaluation of Sure Start: Does Area-based Early Intervention Work?* Bristol. Policy Press; Melhuish, E., Belsky, J., Anning, A. et al (2007) Variation in Community Intervention Programmes and Consequences for Children and Families: the example of Sure Start Local Programmes. *J Child Psychology & Psychiatry.* 48: 543-51.

universal basis for children and families as well as for the optimum management of resources. Designing services on the basis of *boundaries* (i.e. geography or age) has been found to raise serious problems for children and families such as:

- failing to meet the needs of children across their developmental life course, that is, beyond the age of 4 years;
- failing to maximise access to services; and
- increasing the risk of a sense of stigma, which can deter people who need services from using them.

In the last session (under the previous government) of the House of Commons Select Committee on Children, Schools and Families in March 2010, having focussed on Children's Centres and taken extensive evidence from researchers, the Committee concluded:

> *Sure Start has been one of the most ambitious government initiatives of recent decades and its aims and principles have commanded widespread support. Children's Centres have been based on research evidence and a sound rationale, but have not yet decisively shown the hoped for impact …….*
> *The unambiguous belief of those who work in the sector is that Children's Centres are bearing fruit in a way that is demonstrated by the experiences of individual families who use them. However there is also a proper and necessary awareness that evidence about outcomes must be collected more systematically and rigorously, a process hampered in many areas by lack of data ……*

However, as the Committee itself stressed, '*this should not be a cause for panic'.* [21]

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[20] Malin, N. & Morrow, J. (2008) *Evaluating Sure Start: inter-profesionalism and parental involvement in local programmes*. Chichester, Wiley
[21] House of Commons Select Committee on Children, Schools and Families (2010) *Fifth Report of Session 2009-10. Summary,* London TSO

Its overall judgement represents an acknowledgement that, on the basis of the data collected, both quantitatively as well as qualitatively, a positive *direction of travel* in respect of outcomes can be identified in the contribution by Children's Centres to *better child outcomes*.

An earlier study was commissioned in 2008 by Action for Children to evaluate the delivery of targeted family support centres across England, Wales and Scotland.[22] This review took account of the research literature, and on the basis of a methodology using both quantitative and qualitative methods, identified a set of key messages including the following:

- Intensive support can make a positive difference to the lives of children and their families in even the most challenging circumstances. Targeted support is not seen as stigmatising by parents and young people who welcome a personalised approach to their problems in order to produce personalised outcomes

- There is a vital need to ensure that bridges to service access are constructed between different levels of need. Robust outreach, whereby project staff make individual contact with families in the community (in their own homes in the first instance), is essential to make a reality of access for those families who are seen as being the most hard to reach

- Workers with a wide range of skills and professional backgrounds can work together to deliver a high quality family support service

- Intensive family support based on sustained professional relationships is particularly effective in cases of neglect

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[22] Synergy Research and Consulting (2009) Evaluating the Delivery by Action for Children of Targeted Family Support. Available via: http://www.actionforchildren.org.uk/policy-research/research

- Effective family support encompasses services which deliver both practical help and emotional support

- The measurement of an individual child level outcome needs to allow for the concept of added value, given the complex needs of many families in receipt of targeted services. A genuinely preventive approach seeks (at every point) to prevent something worse happening, whatever that may be

- It is a mistake to interpret repeated access to services, through the traditionally negative concept of a *revolving door*. Such "episodic access" is often used to exemplify service deficits or failures, when in fact the reverse is true. Indeed ensuring continuing access to services through an open door approach is a sound way of providing the sort of long term support to families, which can both promote and safeguard the welfare of children. There are sound empirically as well as entitlement- based reasons for sustaining such an open door approach across projects.

In particular that study took the opportunity to look in detail at the day to day activity of Sure Start Children Centres run by Action for Children. The Action for Children centre in Exeter provided a powerful case study example of the approach predominantly adopted by Action for Children, where it had been commissioned to deliver this part of local children's services (see Figure 1).
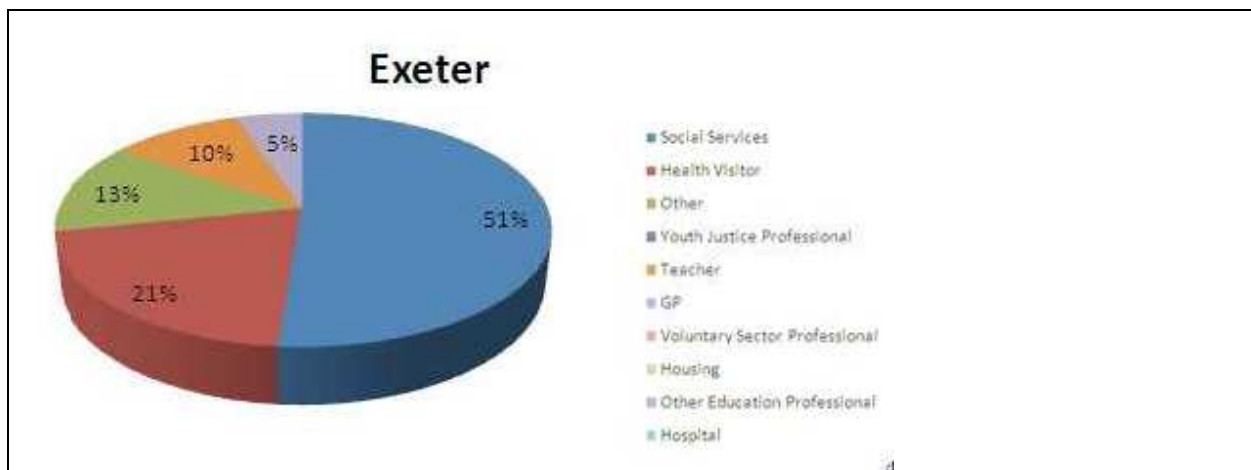
Figure 1: The Action for Children Sure Start Children's Centre in Exeter: A snapshot of referral sources

Delivering services: the work of the Action for Children Exeter Children's Centre

The Exeter project, located in brand new purpose-built children' s centre premises, was able to able to offer a much wider 'menu' of universal and targeted services, alongside the intensive case work provided by the project social workers. This range meant staff could work purposively to ensure families were offered and took up, access to services at different Tiers. Study families who might be finding their parenting role particularly challenging, or where there were safeguarding concerns identified, could be 'bridged' into the universal parenting groups for example, as well as receiving a tailored case work response. The resulting "diversity of parenting group membership" was achieved without any apparent evidence of a sense of stigma being experienced by any of the participants. Group members to whom we spoke characterised their parenting capacity in very similar terms and nobody described themselves, nor was described by anyone else, as "a problem parent".

In **Exeter** the proportion of families using the centre and in receipt of a targeted support service (approx 10% of the total) were achieving high level outcomes associated with the service mix across the universal and targeted services which the centre could offer.

Exeter

- Social Services — 51%
- Health Visitor — 21%
- Other — 13%
- Youth Justice Professional — 10%
- Teacher — 5%
- GP
- Voluntary Sector Professional
- Housing
- Other Education Professional
- Hospital

3.1 What can be deduced from research-based knowledge?

- Longstanding research findings emphasise the value of a Centre-based approach to delivering services for children and families which are effective and provide value for money.

- New developments in the configuration of community health services for children and their families put a premium on the contribution of Children's Centres to undertake the co-ordination of services, as well as to support workforce retention, and have a positive impact on recruitment.

- Children's Centres can 'host' a set of services delivered by a complex mix of other agencies, including those, such as employment-related services, that in stand-alone settings, may be seen as stigmatising or struggle to access their intended recipients.

In considerable part as a result of the evaluations commissioned by both central government and other bodies, Sure Start Children's Centres now constitute a recurrent topic in debates about children's services, and they have had a consistently high profile in Government statements. There would appear to be an emerging consensus as to their overall considerable achievements, with the points of disagreement focussing on issues such as targeting and eligibility. As Barry Sheerman MP (Chairman of the House of Commons Select Committee for Children, Schools and Families from 2007) commented recently in a Parliamentary debate (Hansard 27/4/2011):

> *"One of the wonderful things about our Sure Start and Children's Centres ….is they represent the end of looking at children in bits. …In a Sure Start centre, for the first time , the assessment of all sorts of bits of their needs were brought together in one place, so that a child, for whom there might be a lot of pressures and challenges, was looked at holistically. The children's centre was a one-stop shop where the child was evaluated and got the proper help….It is a matter of outreach, finding out which child needs the help, and giving it."*

In the same House of Commons debate on SSCCs, Tim Loughton MP, Parliamentary Under-Secretary of State for Education, concluded by stating:

> *"We want children's centres to provide the foundation for stronger earlier support, retaining a network of children's centres that offers universal services that are accessible to all families, but with targeted support for those families who are in greatest need."*

In reaching these conclusions the Minister could draw on the emerging findings of a number of inter-related enquiries commissioned by the Coalition Government. These five substantial pieces of work are beginning to indicate the nature of the policy 'road map' which will inform the activity of commissioners and service providers in the next five years.[23]

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[23] See Munro, Tickell as cited

4. The current policy context

The identification of key components in the current policy context, of most relevance to the project reported here has of necessity requires a seriously rigorous, if not ruthless eye. In essence there are two major areas of policy development, which, at the time of writing, are still in train, firstly the nature of NHS structures; and secondly the aspiration towards 'cohesive inter-agency and multi-disciplinary working'. The final shape of the overall system is yet to emerge, and the reshaping of heath structures and systems is of particular interest in the context of Sure Start Children's Centres. (This evaluation has sought to highlight the particular relationship between the health needs of children and their families, and the extent to which Sure Start Children's Centres can and do make a contribution to meeting those needs).

A dominant theme articulated by the Coalition Government is the need for sharing responsibility for addressing child and family needs across professions, agencies and sectors. Indeed the fact that Government has, in a short period of time, commissioned five parallel enquiries reflects the energy that Ministers and their advisers are applying to the mapping and analysis of current systemic achievements and challenges. These reviews span areas including early years, family justice and child protection.

The Coalition Government has made the elimination of the budget deficit within the life span of this Parliament its primary economic objective. This has led to a challenging Comprehensive Spending Review (CSR) and financial settlement for local government and, in turn, for their voluntary sector partners. Furthermore, in order to ensure these financial targets are realised the budget reductions have been front loaded into the first two years of the administration and so the years 2010-12 look set to be the most challenging. At a local authority level many have experienced budget reductions of over 25 per cent.

The Government however has wider policy ambitions than simply overseeing budget cuts. In its first year it has promoted the idea of localism and the associated idea of the

"Big Society".[24] The belief underlying much new policy development has been that greater power needs to be devolved to local government and indeed to frontline practitioners. It is proposed that there needs to be less regulation and prescription from central government and a relaxation of the performance management culture. Alongside the Localism Bill (introduced December 2010) there is an ongoing review of the current legislative framework for local authorities. Already the requirement for Children's Plans has been removed as well as prescribed organisational structures such as Children's Trusts. This vision reflects many of the themes of the recently published Munro Review of child protection.[25] It proposes a vision for services based less on prescriptive procedures with a greater emphasis on professional discretion and judgement and on local decision making. These themes are also reflected in the Health and Social Care Bill, which will be discussed further below.

The implications for commissioners and service providers are that this is not a period when the sector can expect large scale national programmes with prescribed, target driven detailed procedures. Instead we may expect government to set out a framework within which local decisions and policy makers, commissioners and managers will be expected to implement, using their own judgement as to what fits local circumstances most appropriately.

This approach is reflected in five coordinated policy reviews of which the Munro Review is only one. Together these five reviews represent an important part of the process of realising the Coalition's vision for child welfare. The other reviews are in relation to early intervention (Allen)[26], tackling Poverty (Field)[27], early years (Tickell)[28] and family justice

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[24] http://www.communities.gov.uk/localgovernment/decentralisation/localismbill/ (assessed 31/05/11)
[25] http://www.education.gov.uk/munroreview/ (assessed 31/05/11)
[26]
http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf
[27]
http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf
[28] http://media.education.gov.uk/MediaFiles/B/1/5/%7BB15EFF0D-A4DF-4294-93A1-1E1B88C13F68%7DTickell%20review.pdf

(Norgrove).[29] While the reviews are at different stages of the reporting process, collectively alongside other reforms they begin to suggest that services may well be delivered in a very different environment in the coming years. That is, a less proceduralised system which nevertheless will make greater demands in terms of practitioners using their discretion and judgement and that they may well be working in very different organisational contexts which will require the capacity to work flexibly and in innovative ways.

An indication of the extent to which these five reviews seek to be mutually complementary - where appropriate - is provided by the following conclusion from the Munro Review in calling for a "Sharing of responsibility for the provision of early help"[30]:

Through the lens of Munro….

Like the reviews led by Graham Allen MP, Dame Clare Tickell, and Rt Hon Frank Field MP, this review has noted the growing body of evidence of the effectiveness of early intervention with children and families and shares their view on the importance of providing such help. Preventative services can do more to reduce abuse and neglect than reactive services. Many services and professions help children and families so co-ordinating their work is important to reduce inefficiencies and omissions. The review is recommending the Government place a duty on local authorities and their statutory partners to secure the sufficient provision of local early help services for children, young and people and families. This should lead to the identification of the early help that is needed by a particular child and their family and to the provision of an offer of help where their needs do not match the criteria for receiving children's social care services.
Within preventative and other services good mechanisms are needed to help identify those children and young people who are suffering, or likely to suffer, harm from abuse or neglect and who need referral to children's social care…."
(Munro, 2011: 7)

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[29] http://www.justice.gov.uk/downloads/publications/policy/moj/family-justice-review-interim-rep.pdf
[30] Executive summary, page 7, Munro 2011

This economic and policy context has both a direct and indirect impact on the provision of Centre-based support. The Coalition Government has stated that it values Children's Centres and the contribution they make to child welfare. Reference has been made to protected budgets but within a more localised decision making system the extent to which this area of provision is protected from cuts will vary from area to area. Nevertheless, the Government has stated that it wishes Children's Centres to return to their original focus of working with the most vulnerable. It has also proposed a move toward payment by results, although what this means in the day to day reality of Centre-based provision is still evolving. More generally, the review of early years, the desire to address worklessness and the commitment to early intervention will all play variable roles in shaping Centre-based services. This might be, for example, in the greater and more creative use of volunteers or the re-shaping of the balance between targeted and open access services.

4.1 Community Health Policy

Awareness of the importance of the early years has grown within the health sector, along with an exponential growth in the scientific evidence over the last decade. At the dawn of the 21st century, 'Neurons to Neighborhoods[31]' was a massive, seminal report that synthesised new knowledge about neurobiology and genetic development in the foetus and early years. It drew attention to the importance of critical periods for development during this time, along with the significant impact of interpersonal relationships, particularly between mother and infant, and the interconnectedness of all these factors with local communities. Harvard University has continued the task of incorporating new evidence into scientific and policy briefings, noting (page 6) that a:

> *'remarkable convergence of new knowledge about the developing brain, the*
> *human genome, molecular biology, and the interdependence of cognitive, social,*

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[31] National Research Council and Institute of Medicine (2000) From neurons to neighborhoods: the science of early child development. Committee on integrating the science of early childhood development. J. P. Shonkoff and D. Phillips, (eds.) *Board on Children, Youth and Families, Commission on Behavioural and Social Sciences and Education.* Washington DC: National Academy Press

and emotional development offers scientists and policymakers an exceptional
opportunity that did not exist a decade ago'[32]

and it has periodically updated the public health and paediatric communities through
further monographs and briefings.[33]

In the same time period, the World Health Organisation (WHO) reported on the
significance of maternal and child health [34], violence and health (including interpersonal
violence such as domestic and child abuse)[35] and the social determinants of health.[36]
These reports all emphasised the interconnectedness of health, social, educational and
community issues. One research synthesis, prepared for the Commission on the Social
Determinants of Health (CSDH), indicated that early childhood development should, in
itself, be considered a determinant of later health and inequalities.[37] Early Child
Development, in that report, is defined as occurring between conception and the age of
eight years. Internationally, the authors suggest, the health sector is usually best placed
to engage families with children in this age range, because of the frequency with which
mothers and young children visit their doctors, although in England this is the age range
most often encompassed by Children's Centres.

This international literature has been picked up and used in England, most notably
within the expanded Child Health Promotion Programme (now the Healthy Child

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[32] Center on the Developing Child at Harvard University (2007) *A Science-Based Framework for Early
Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable
Children.* http://www.developingchild.harvard.edu (accessed 07-06-10)
[33] Center on the Developing Child at Harvard University (2007) *Early Childhood Program Effectiveness*
www.*developingchild.harvard.edu/content/publications.html* (accessed 07-06-10)
Center on the Developing Child at Harvard University (2010) *The Foundations of Lifelong Health Are Built
in Early Childhood.* 2010 http://www.developingchild.harvard.edu (accessed 22-05-11)
[34] WHO (2005) *The World Health Report: make every mother and child count.* Geneva, World Health
Organization (WHO).
[35] Krug, E. G. et al., eds. (2002) *World report on violence and health.* Geneva, WHO.
[36] CSDH. (2008) *Closing the gap in a generation: health equity through action on the social determinants
of health. Final Report of the Commission on Social Determinants of Health.* Geneva, WHO.
[37] Irwin, L., Siddiqi, A., Hertzman, C. (2007) *Early Child Development: A Powerful Equalizer. Final Report
for the World Health Organization's Commission on the Social Determinants of Health.* University of
British Columbia, Vancouver.

Programme[38]), which used the current evidence, drawn together in a substantial review of reviews about which interventions would best help promote child health[39], and in considering health inequalities.[40] Sir Michael Marmot, who chaired the CSDH, went on to develop recommendations about how best to address the persistent health inequalities in England.[41] He proposed a life course approach, quoting evidence to justify placing the highest priority on the early years, although he noted:

> *'A key challenge is the recruitment of appropriately skilled and qualified staff in the context of critical shortages of some professionals, such as health visitors.'* (page 97)

Indeed, the need to act on the amassed evidence of a need to focus upon early years, using a holistic, preventive approach that encompasses children, families and the communities in which they live, seemed to almost bypass the NHS, as it focused increasingly upon clinical concerns and waiting lists following the reorganisations and targets introduced by the former New Labour government. Public health emphasis upon the social determinants of health was considered to be the remit of local government, whilst services for children and the early years were co-ordinated through the former Department of Children, Schools and Families. There was a specific duty on local government to develop Children and Young People's Plans (CYPPs) in conjunction with the health sector, but this did not always happen as effectively as envisaged, with one review of CYPPs revealing very limited reference to either children under the age of three years, or to health professionals.[42] In due course, a Parliamentary Health Committee Inquiry looking specifically at the role of the NHS in relation to health

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[38] Department of Health, Department for Children, Schools and Families. *Health Child Programme. Pregnancy and the first five years*. Gateway ref: 12793, London, Department of Health

[39] Barlow, J., Schrader Macmillan, A., Kirkpatrick, S., Ghate, D., Smith, M., Barnes, J. (2008) *Health-led parenting interventions in pregnancy and the early years*. London, Department for Children, Schools and Families

[40] Strategic Review of Health Inequalities in England post 2010 (2010). *Fair society, healthy lives.* London: The Marmot Review. 2010. www.ucl.ac.uk/marmotreview (accessed 15-02-10)

[41] ibid (Marmot Review)

[42] Cowley, S., Dowling, S., Caan, W. (2009) Too little for early interventions? Examining the policy-practice gap in English health visiting services and organisation. *Primary Health Care Research and Development*. 10: 130–142

inequalities[43] commented:

> 'We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families, at the same time as the Government reiterates its commitments to early-years services.' (page 7)

The shortage of midwives, and most particularly, of health visitors was unfortunate in this context, since these two professions share a professional ethos that focuses upon 'positive health' and social well-being, rather than upon illness, pathology and the more clinically oriented interests that characterise much of the NHS. However, staff shortages in these two fields hampered their full engagement in the last government's agenda for integrated children's services in many areas. Indeed, the number of health visitors in post fell by 19.1% (from 10,047 to 8,125 full time equivalent) between September 2000 and 2010, compared with an increase of 17.7% among midwives and an increase of 32.9% in NHS staff overall in the same period.[44] An increase of 52% in the health visiting establishment would, therefore, be needed to bring them in line with the rest of the NHS. Similar staff increases had occurred in Sure Start local programmes and in Children's Centres after 2005.[45]

By 2009, the staffing situation had become so acute, that the Chief Nurse was charged with establishing an 'Action on Health Visiting' programme, which (jointly with the profession's union, Unite/CPHVA -the Community Practitioners' and Health Visitors'

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[43] House of Commons Health Committee (2009) *Health Inequalities. Third report of session 2008-09, Volume 1.* HC 286-I. London: TSO, 2009
[44] NHS Information Centre for Health and Social Care. NHS Workforce: Summary of staff in the NHS: Results from September 2010 Census www.ic.nhs.uk accessed 17-05-11
[45] Audit Commission (2010) *Giving Children a Healthy Start,* London, Audit Commission.

Association) began the process of redeveloping the service.[46] At the same time, the (then) opposition Conservative party had begun to formulate its plans for 'helping new families' [47], with a major emphasis upon redeveloping the health visiting profession. This policy led to a manifesto commitment, subsequently confirmed by the Coalition Government, to employ 4200 more health visitors, which will boost this workforce by almost the 50% needed. Early in 2011, a 'health visitor implementation plan[48] was released, with accompanying governance arrangements, details of numbers needed in each local Strategic Health Authority area and how these staff were to be recruited[49] (mainly through new entrants completing health visitor training, but with some 'returning to practice') over the period of 2011-2015. The new service vision was set out in the implementation plan and in further detail in an accompanying paper.[50] This vision (see figures two, three, four and five below) aims to build on the tradition of health visitors providing health advice and support to families in their homes, as well as in health centres and clinics, serving as a bridge or connection between local services such as those provided in general practice and Children's Centres. The question of exactly where health visitors are best located is seen as best left to local determination, given that premises vary considerably in their suitability and accessibility to the population served by health visitors (i.e. families with young children).

[46] Department of Health and Unite the Union. (2009) *Getting it right for children and families. Maximising the contribution of the health visiting team 'Ambition, Action, Achievement'* Gateway ref: 12735. London Department of Health.

[47] Conservative Research Department (2008) *Helping new families: Support in the early years through universal health visiting.* London. Conservative Party,

[48] Department of Health (2011) *Health Visitor Implementation Plan 2011-2015: A Call to Action*, Gateway ref. 15182, London: Department of Health.

[49] Dear Colleague letter (2011) *Government commitment on health visiting: NHS Operating Framework and assurance: for action.* Gateway reference 15182. London, Department of Health.

[50] Department of Health (2010). *Service vision for health visiting in England,* London: Department of Health

Figure 2: Achieving better health for children, families and communities

**Achieving better health for children, families and communities:
the health visiting contribution**

DH) Department of Health

Improving public health
(*Best health outcomes)

Developing community resources
(*Community capacity/Big society)

Maximising family resources
(*Supporting families)

Bridging family and services and primary health care services
(*General practice focus for health)

Accessing Specialist Services

Population

Community

Family

Child

Health visiting services
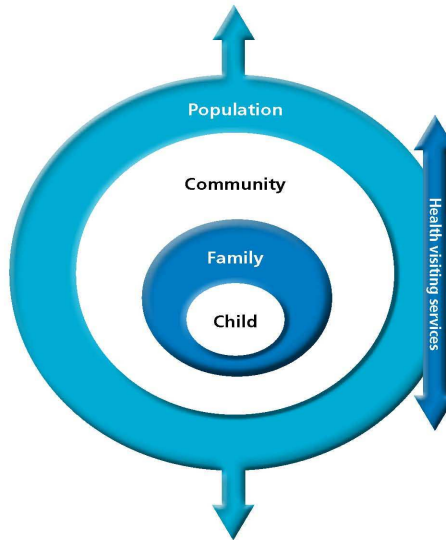
Health Visitors
(*empowered professionals with more autonomy)

Health Visitors: skilled to improve health outcomes by:

- **Providing family health services – more contacts and extended range care packages**

- **Champion of wider health and wellbeing, prevention and public health, building family and community capacity**

- **Utilising resource – leading teams delegating and referring**

Figure 3: The Service Vision

The Service Vision

DH) Department of Health

Community and Public Health

Individual Health

Local people and commmunity groups

All families
Universal HCP Service offer
(with increased contacts)

Some families – some of the time
Specific additional care packages

Some families all of the time
Ongoing additional support

A few families
Intensive multi agency care package

Building and using community capacity to improve health outcomes

Leading and delivering healthy child programme
Lead Health Visitor and Health Visitor in Sure Start Health Teams

Vulnerable children and families

Safeguarding protecting children

Figure 4: Five levels of service provision in the new vision, what it means for families

> **Interactions at community level**: building capacity and using that capacity to improve health outcomes and **leading the Healthy Child Programme for a population**.

> **Universal services for all families**: working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families. Leading the Healthy Child Programme for families with children under the age of 5.

> Additional services that **any family may need some of the time**, for example care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the health visitor may provide, delegate or refer. Intervening early to prevent problems developing or worsening.

> Additional services for **vulnerable families requiring ongoing additional support** for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

> Making sure the appropriate health visiting services form part of the high intensity multi agency services for families where there are **safeguarding and child protection concerns**.

Figure 5: The universal prevention and early intervention pathway from pregnancy to 5 years
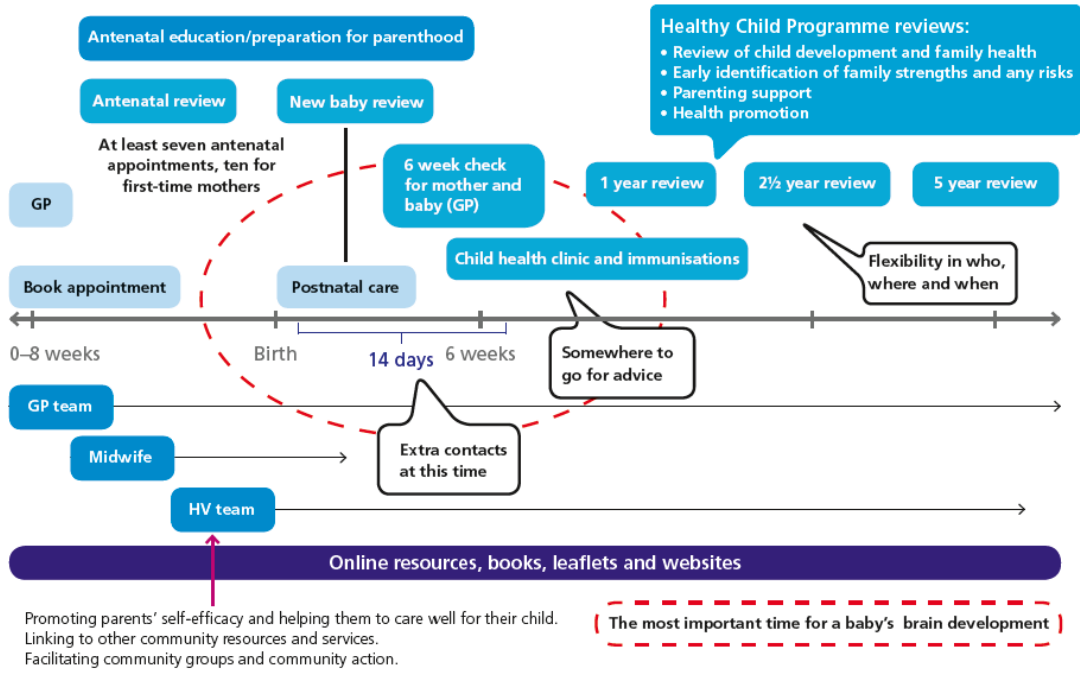
5.   The design of the present study

The project we have described in this report has been commissioned specifically to address the need for timely feedback on the existing work of Action for Children Children's Centres; and, as importantly, on their unique ability to meet the challenges outlined above.

The present externally conducted evaluation has been designed to capture data which can:

a) be linked with the experience of specific service episodes;
b) take account of the often under-estimated impact on service access of outreach work by staff; and
c) illuminate the nature and impact of family support work.

In other words, the research team has sought to identify those key service components which impact on children and their families, in order to demonstrate the difference that they may make to the lives of children in terms of improved health, education and safeguarding outcomes.

5.1 Objectives
The overall aim of the evaluation is to investigate the impact that Action for Children Sure Start Children's Centres (SSCCs) have on outcomes for vulnerable children. The following five questions were prioritised:

- How good is Action for Children at co-ordinating different agencies within their SSCC and how does this improve outcomes for vulnerable children?
- What do Action for Children outreach services achieve for children (outcomes) and what can be said about the evidence behind the skills sets which are required to deliver outcomes for children?

- What do Action for Children family support services achieve for children (outcomes)?

- How good is Action for Children at achieving health outcomes and how do its outreach and family support services support health staff in SSCC to achieve improved outcomes?

- To draw conclusions on ideas as to future service developments that Action for Children can consider.

5.2 Method

In order to capture a *meaningful* picture of impact on children's outcomes, it has been important to understand the context, the design, and the delivery style of the services and interventions being provided to deliver that impact. The study therefore incorporates both quantitative and qualitative components, with three closely inter-related key elements:

a) **An *audit of input*** – e.g. what are the organisational systems in place in Children's Centres?; What services are being delivered?; What are the workforce characteristics?; and, how do Centres interact with other statutory and/or voluntary sector agencies? Data has been collected from a range of sources including a documentary analysis of Self Evaluation Forms by the Children's Centres; supplemented by qualitative data gleaned in face-to-face interviews by the research team with Centre stakeholders.

   This data underpinned the collection of data in the following phases which seek to capture *output* and *outcome* (these are two concepts often confused with each other, and can helpfully be understood through the lens of ***service based**/output*; and ***client based**/outcome* (see for example Tunstill 2003, p39[51]).

b) **An *overview of output*** - e.g. an aggregate description of Children's Centre use, paying particular attention to reach within the Centre areas, including the nature

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[51] Tunstill, J. (2003) Evaluating Family Support; political and technical issues, in *Evaluating Family Support: thinking internationally; thinking critically*. Chichester, Wiley.

of need being presented; and the characteristics of those using services, and where possible the identification of those sections of the community who may be distinguished by their "failure" to use the services on offer.

c) **A <u>child/family outcome</u> measurement phase** - for this we used a well tried method of file study and outcome ratings generated by the research team, on the basis of the relevant research literature on child outcomes. A researcher rating of outcomes was made for children and their families, in respect of a purposive sample, which was planned to comprise 10 cases selected from each of the six Children's Centres. In the event the sample size was 53, drawn from five centres.

The rating system we used acknowledges the complexity of measuring interim outcomes. In other words, although some outcomes (e.g. attaining 5 GCSEs; remaining in a stable placement over a certain period of time) are relatively easily quantified, some less obvious outcomes often prove to be less easily measurable. In the context of family circumstances those *less obvious d*evelopments may be as important to the ultimate well-being of an individual child as the 'easily recorded' ones.

5.3 The study approach to understanding outcomes

The approach echoed the method used by two of the present team members in an earlier evaluation of the delivery of targeted family support through Action for Children children's centres.[52] In the Synergy study the following four-point scale was designed to analyse the data on outcomes for children, and in particular to allow for measuring progress '<u>towards</u> an outcome'. In this earlier study a, rating of **4** may therefore reflect any of the following types of scenarios:

- Safeguarding concerns were raised with regard to a young parent shortly after the birth of a child - with intensive support these concerns subsequently diminished.

- A family with very long-term concerns around neglect remained fully

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[52] Synergy Research and Consulting Ltd. (2009) The Effectiveness of Delivering Targeted Family Support through Children's Centres.

engaged with the project and made some small but significant progress, such as increased school attendance

- Older children came into the care of the local authority in a planned way, maintaining close links with both birth family and the Centre

A rating of **3** may reflect scenarios such as the following:

- Progress had been very fragile for a family where a parent had a mental health difficulty and was still in an unstable situation. There may have been progress with the children; there may also have been some setbacks such as regular and/or disruptive hospital admissions

- A parent struggling in their relationship with a teenage child. Although the family attend services and remain engaged there are frequent crises

A rating of **2** may reflect the following scenarios:

- A young mother with serious drug misuse problems where engagement had only been very partial and significant problems remain

- Parents struggled with a volatile adolescent who continued to experience frequent crises but the Centre was still able to periodically engage and make some progress. Parents attended sessions but the young person refused to attend and was excluded from school

A rating of **1** may reflect the following scenarios:

- A family with concerns around neglect where problems had increased with no significant progress and parents had disengaged

- A family where there were concerns regarding domestic violence but engagement was only very partial and inconclusive. Father made threats to staff.

In the present study we drew on the same approach, and generated a number of study-specific indicators, which are exemplified later in the report on page 65.

Whilst acknowledging that the centre and child sample size in the study is a small one, the team concluded that the incorporation of both qualitative and quantitative elements in the study method, enabled cautious conclusions to be reached as to the contribution of key centre/agency characteristics to the delivery of outcomes at the child level. It also

allowed for the exploration of consistency of service design and quality across the five centres.

6.   Study Findings

This section presents the findings on three inter-related topics:

- the characteristics of the centres and their mode and range of service delivery, in other words the <u>service inputs;</u>

- the contact/s they made with children and families in the community, in other words 'their outputs, and crucially their *reach*';

- the child level outcomes we identified for a sample of individual children, which were selected by the five centres.

6.1 Understanding the nature of service design and delivery: understanding the inputs

This section presents the picture that we obtained from the data covering child and family characteristics; the nature and range of child and family need; and the relationship between that need and access to / service usage in the five Action for Children Centres studied. We provide an initial overview of demographic characteristics before describing the *circumstances* and the professional contacts which brought children and their families to the Centres.

We then outline the range and nature of the inputs currently being provided by Action for Children Children's Centres and their stakeholders. The data describes both *service identity* and *service style*. We have sought to capture the identity, range and quality of services across the sample of Centres in the study, and in order to do so, we have drawn on our knowledge of the extensive literature on what makes for 'good practice'.[53] This has enabled us to identify the following indicators of good practice; these six widely

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[53] Including: Anning, A., and others (2010) *Developing multi-professional teamwork for integrated children's services.* 2nd ed. Maidenhead: Open University Press.; Broadhead, P., Meleady, C. & Delgado, M. (2008) *Children, families and communities: creating and sustaining integrated services.* Maidenhead: Open University Press.; Capacity (2009) *Outreach to children and families: a scoping study.* London: Department for Children, Schools and Families. (DCSF research report; RR116); Cummings, A. (2008) *Only connect: using a critical incident tool to develop multi-agency* collaboration in two Children's Centres. Nottingham: National College for School *Leadership;* Allnock, D., Akhurst, S., Tunstill, J. and NESS Research Team (2006). *Constructing and sustaining Sure Start Local Programme partnerships: lessons for future inter-agency collaborations'. Journal of Children's Services.* 1(3), pp.29-39.

acknowledged indicators of Children's Centres' quality and practice can be seen in the research literature to be associated with maximum service reach; and with the demonstration of 'better' intermediate outcomes for children and families.

6.2 The demographic characteristics of children using the Centres

Five of the six selected Action for Children Centres provided the researchers with a total of 53 individual detailed case files. These were analysed and coded for further comparative quantitative analysis. Table 1, shows that 59 per cent of the cases referred to boys, and the mean age of the children in this sample was 2.7 years. Of the 53 children, 21 percent (n=11) were reported to be members of black and minority ethnic (BME) groups.

Table 1 Gender of child in a selected sample of referral cases in five Action for Children Centres

Child's gender	Response Percent	Response Count
Boy	58.5%	31
Girl	39.6%	21
Not recorded	1.9%	1
Number of cases		53

6.3 What brought the families to the Centres?

We wanted to know *what sort of needs* lay behind the decision by the families, or where appropriate, their referrers to access the Centres. We have presented the data in the following three tables in order to help understand the similarity and/or variation in the needs identified for the child – as opposed to the needs which have been identified for the families. As shown, there is a similar pattern in respect of several needs, especially, for example in the context of family and social issues; emotional issues; and behaviour issues. Whilst it is inappropriate to draw too far-reaching conclusions from a small sample, this 'overlap in data' can be seen to underline the relevance of meeting child level need in the family (and community context). To *exclude* the needs of parents/carers will be likely to hamper the process of meeting child level need in this

age group, and the high percentage of family need recorded as parenting issues underlines this inter-relationship.

Poverty makes it hard to have a good childhood, but a lack of poverty does not equate to happiness. Twenty per cent of British children have mental health problems at some point and ten per cent have a recognisable clinical mental health problem. One in 12 children self-harm.[54] The UK is 21st of 25 European countries in terms of child wellbeing, scoring particularly badly on indicators for children's relationships with parents and peers, child health, relative poverty/deprivation, risky behaviour and subjective wellbeing.[55] Children in the 30 per cent most disadvantaged local authorities remain far less likely to be developing well than children in other areas at the age of 5 (39% compared to 55%).[56] The lower a child's socio-economic group at birth, the greater the probability of the child experiencing multiple deprivation in adulthood (Feinstein et al 2007).[57]

The following Figures (Figure 6 and 7) depict the identified needs by child and by family according to a detailed analysis of the 53 individual cases. This is followed by a pictorial breakdown of needs overall (Figure 8). The vast majority of children had family or social problems including experience of domestic violence; parents with mental health problems, alcohol misuse and so on. This was followed by parenting issues identified as a clear challenge faced by of one or both of the parents in providing basic parenting. These were usually a result of social, economic and mental problems faced by the parents and were considered to have direct implication on the child concerned. Figure 6 shows a wide range of needs with many overlaps meaning that most of the children had multiple needs.

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[54] Good Childhood Inquiry Launch Report (2006) www.goodchildhood.org.uk (see also Layard, R. & Dunn, J. (2009) *A good childhood: searching for values in a competitive age.* London, Penguin Books)
[55] Bradshaw, J. Hoelscher, P. & Richardson, D. (2007) An Index of Child Well-Being in the European Union, *Social Indicators Research*, 80: 133–177
[56] HM Government (2009) *New opportunities: fair chances for the future.* London: TSO. (Cm 7533).
[57] Feinstein, L., Hearn, B. and Renton, Z. (2007) *Reducing inequalities: realising the talents of all.* London: NCB.

. **Figure 6: Children's needs by percentages (n=53)**

Child's needs

Need	Percentage
Language issues	3.8 %
Mental health issues	3.8 %
Physical disability	3.8 %
Looked after	7.5 %
Isolation	15.1 %
General health issues	18.9 %
Development issues	24.5 %
Safeguarding	35.8 %
Behaviour issues	49.1 %
Emotional issues	60.4 %
Parenting Issues	66.0 %
Family-social issues	69.8 %
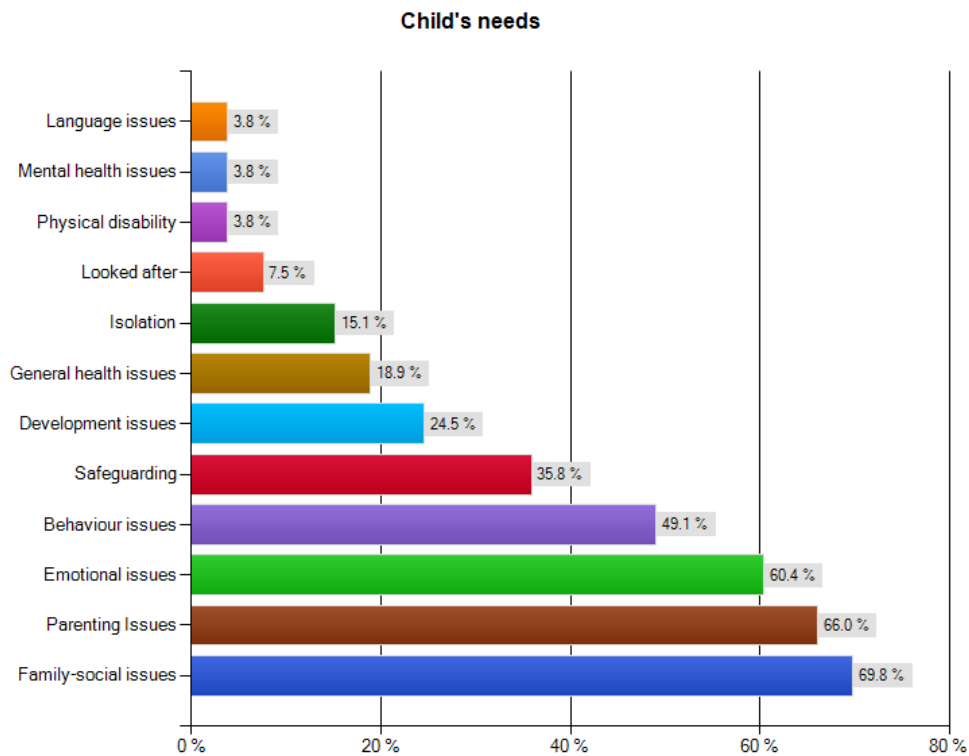
Physical disability

There are increasing numbers of children with special and complex needs, including physical and learning disabilities. The number of disabled children in England is estimated to be between 288,000 and 513,000, that is between 3.0% and 5.4% of all children under 18. The prevalence of disability is higher among boys than girls and lowest among children under 5 years of age (Mooney 2008).[58]

Mental health and social isolation

There is very little information about the mental health of pre-school children, as difficulties tend to be counted as either behaviour problems, linked with parental/social issues, or maternal mental health problems. Even so, as mental health problems persist

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[58] Mooney, A., Owen, C. and Statham, J. (2008) *Disabled children: numbers, characteristics and local service provision.* London: Department for Children, Schools and Families.

from childhood into adulthood in 30% of cases[59], pre-school children are unlikely to be completely exempt. An assessment of over 18,000 British children aged 5-15 in 1999 and 2004 found the overall prevalence of childhood mental disorders stood at 9.5%, with children of lone parents being twice as likely to be affected as those living with married couples.[60]

The number of mothers experiencing post-natal depression or other mental health problems is rising and often worsened by social isolation and lack of social capital in an area. In turn, this is linked with a lack of childhood wellbeing, which focuses attention on the need for group and centre activities.[61]

Diet/obesity

The already high rates of obesity amongst British children are continuing to increase (Association of Public Health Observatories [APHO] 2006). By the time they start school, 13% of children are overweight and 10% obese and by the end of primary school 14% are overweight and 17% obese. It is clear that most excess weight before puberty is gained before the age of 5 years. This is largely attributed to parenting styles and food behaviour.[62]

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[59] Goodyer, I. (2008) *Mental capital and wellbeing: making the most of ourselves in the 21st century. Depression in childhood and adolescence.* London: Government Office for Science. (State of science review D15). http://www.bis.gov.uk/assets/bispartners/foresight/docs/mental-capital/sr-d15_mcw.pdf accessed 28-05-11

[60] Meltzer, H. (2007) Childhood mental disorders in Great Britain: an epidemiological perspective, *Child Care in Practice*, 13: 4, 313-26.

[61] Gaynes, B.N., Gavin, N., Meltzer-Brody, S., Lohr, K.N., Swinson, T., Gartlehner, G. et al. (2005) Perinatal depression: prevalence, screening accuracy, and screening outcomes. *Evidence Reports: Technology Assessment*; 19 AHRQ Publication No. 05-E006-2

[62] Rudolph, M. (2010) *Tackling obesity through the healthy child programme: a framework for action.* Leeds, University of Leeds. www.noo.org.uk

Figure 7: Family needs (including parents and siblings) by percentages (n=53)

Family needs

Category	Percentage
Language issues	3.8 %
Physical disability	3.8 %
Drug abuse	9.4 %
Accommodation	9.4 %
Deprivation	15.1 %
Development issues	17.0 %
Domestic Violence	17.0 %
General health issues	26.4 %
Accessing…	32.1 %
Safeguarding	34.0 %
Behaviour issues	39.6 %
Isolation	43.4 %
Mental health issues	56.6 %
Emotional issues	58.5 %
Family-social issues	81.1 %
Parenting Issues	94.3 %
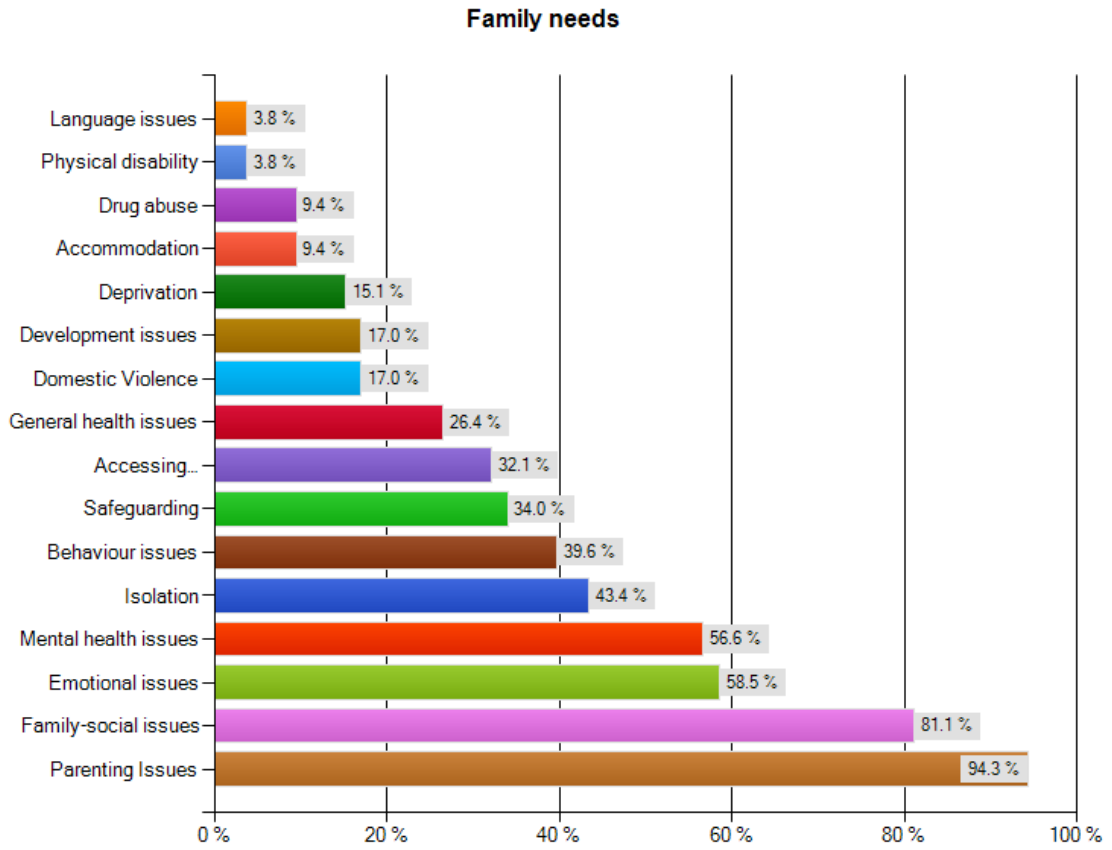
Figure 8: Categories of need as identified by the Centres by percentages (n=53)

Category of need

- Vulnerable with additional needs — 71.7 %
- Child protection — 11.3 %
- Child in need — 7.5 %
- Looked after — 5.7 %
- None of the above — 3.8 %
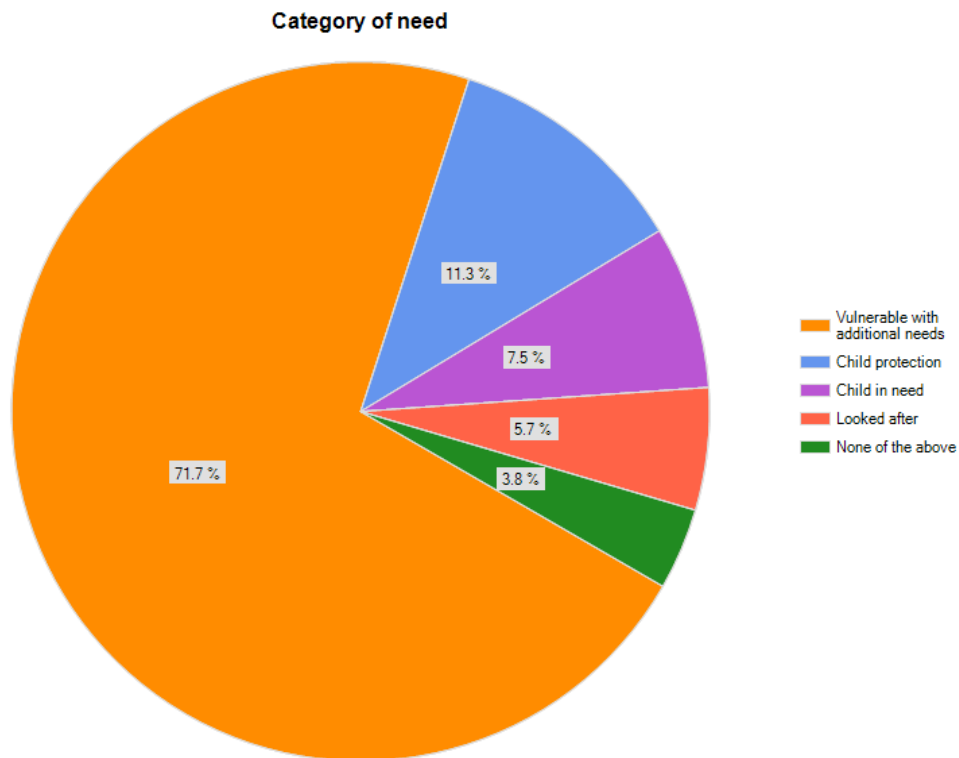
6.4 How did the Centres respond to this need?

We wanted to understand what services and more particularly *how* these services were delivered in response to the needs which are reported above. Analysis of the qualitative self report data was complemented by data collected by members of the research team at five sites. This enabled the team to provide a "more rounded" view of day-to-day activity than the quantitative analysis *alone*, would have been able to reflect. This mix of methods has allowed us to generate insights into the operational decisions made by managers in respect of service configurations. While in reality many of the examples described below illuminate more than one dimension of quality we have organised them (to some extent artificially) to exemplify each of the six indicators.

Figure 9: Types of services provided in the six selected sites to the sample of 53 cases
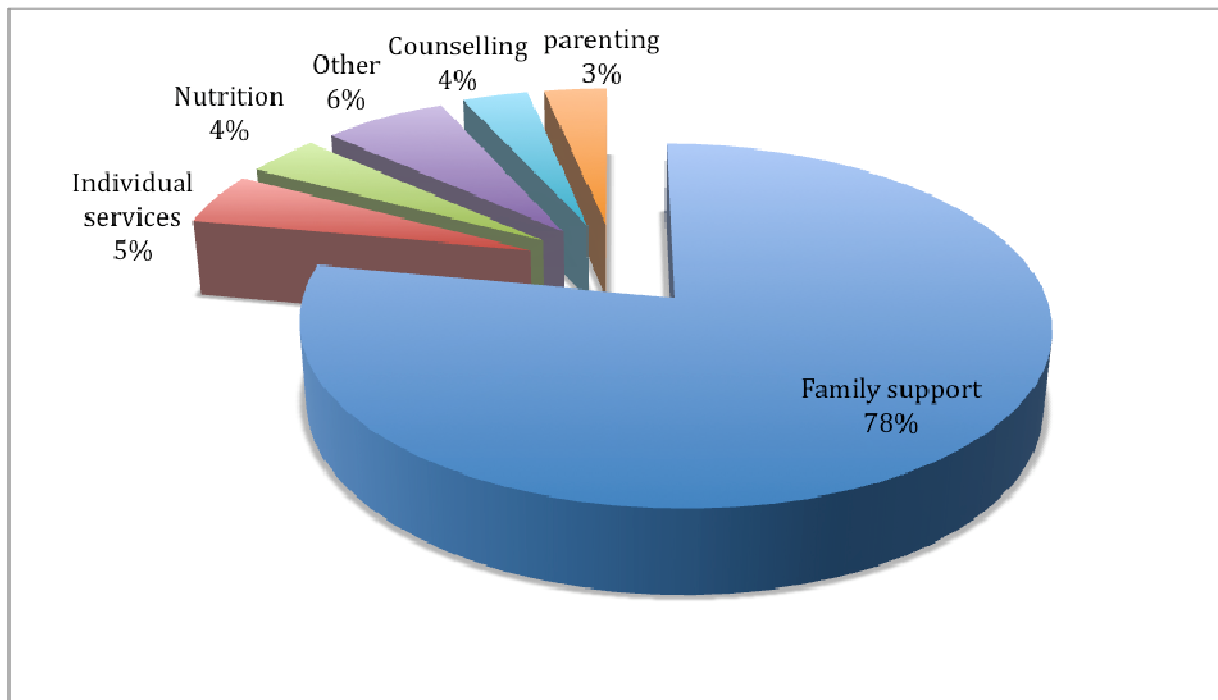
We can see from the pie chart above (Figure 9) that the great majority, over three quarters, of the services which were provided to the referred cases, can be categorised as "family support". Given the pattern of family and child level need which is reflected in Figures 6 and 7 this is unsurprising. It is important to recognise that the inclusive implications of the term family support are very positive and they directly relate to the achievement of better outcomes for the children themselves. It also underlines the multi-faceted and inter-related nature of need. In other words, as we know from the literature[63], there exists a close relationship between general parental stress and subsequent more acute/discrete problematic behaviours, such as alcohol and substance abuse, which can seriously impact on the well-being of children.

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[63] Blewett, J. & Tunstill, J. (2011)

6.5 Why these six indicators of Centre quality and practice at the *input level*, were identified as being most likely to have a positive impact on outcomes for children

We have chosen these six dimensions on the basis of both the extensive empirical literature, as well as to reflect the current requirements of Ofsted's inspection framework.[64] Within the existing body of research knowledge, there is a clear consensus as to the necessity for ensuring these components are taken account of in designing provision which is capable of being recognised by both inspection authorities, but more importantly by those who use services, as *high quality provision*. Table 4 below provides the overall range of indicators and how they were met, but first each indicator is discussed and justified.

In order to meet the specific aims of this study, and to address strategic and operational issues around co-ordination; networking; and, in particular, the challenge of reach, the following indicators were selected:

- Children's Centres can and do act as a gateways to and from other services
- Children's Centres act as a co-ordinator and/or broker of service packages
- Children's Centre staff build links and partnerships with other agencies
- Centre staff seek to maximise access to services through imaginative, flexible and sustained outreach strategies
- Children's Centre staff support health agency colleagues to maximize access to/usage of health provision
- All Centre systems and the job specification for staff are aimed at building social and economic capacity in the local community

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[64] https://www.education.gov.uk/publications/eOrderingDownload/SSCC%20statutory%20guidance-2010.pdf

6.5.1 Indicator 1 - Centres can and do act as a gateway to and from other services

One fundamental building block in establishing optimum linkages with other services and practitioners is the overall design, dissemination and use of referral mechanisms which are straightforward, not time consuming, take account of the time pressures on other agencies, and yet simultaneously capture the essential information needed by the Centre to be of maximum relevance to *that* child and *that* family.

Using both the data on centre 'structure and services' as well as the 53 detailed individual cases from five of the six sites studies we can see that all five Centres acted as a gateway to users, see Table 2. This was mainly achieved as the Centre acted as a bridge to other services, which was true in almost all the cases (96 per cent). This was followed by high level of reach activity, evident in three quarters of cases (75 per cent) of the cases. This reflected, for example, staff engagement in facilitating access and maintaining service provision too hard to reach groups such as lone parents, those experiencing mental health problems or those who were socially isolated.

Table 2 Elements of the Centres acting as gateway

Indicator 1: Centres act as a gateway	Response Percent	Response Count
High level of reach	75.5%	40
User friendly referral forms	37.7%	20
Centre staff to act as a bridge to other services (e.g. health or school)	96.2%	51
Other	1.9%	1
Number of cases with Indicator 1		53

User-friendly referral forms

There is a consistent pattern across Action for Children Children's Centres of managers having the confidence to design and implement forms that "will work for everyone". Centre managers reported having identified lengthy referral forms as a barrier to referrals from external agencies such as local authority children's social care and took the initiative to actively draw the attention of potential referrers to the advantages of using e-Aspire referral forms - these are much shorter than many local authority forms.

"We have a short referral form asking for basic info about what the referrer is hoping to achieve …it has led to more referrals and then the Centre can do the needs assessment using ASPIRE. (Centre manager)

Sometimes it will be the employment and specific deployment of staff which "opens a gate".

Another gateway

A Children's Centre teacher is employed through the school and acts as a bridge between Centre and school. This sends traffic both ways and "*we realise the school staff have become much more sensitive to identifying needs in their children that they may not have recognised before*".

The range of '**_other_** *conduits to services'* includes a number of strategies, some fairly 'predictable', whilst others, such as *exploiting a simple device like a notice board*, are cheap, subtle and have a useful role in disseminating information within the community.

Many centres are working in diverse communities. Sometimes this includes areas where there are small but significant populations, for example Eastern European families, who do not have English as a first language.

Stopping language being a barrier

Leaflets describing the services provided in the Centre include a photograph of the key staff member responsible and in addition versions of the leaflets are available in a range of languages.

The role of the notice board

A common feature of *Action for Children* Centres is the welcoming and comfortable reception area within which a plethora of information is displayed for parents and indeed for other practitioners who are visiting the Centre**.** At a stroke the notice-board acts as a potential gateway to both services, and indeed in some Centres, as a means to employment opportunities, given that Job Centre Plus advertise vacancies on the board.

6.5.2 Indicator 2 – Children's Centres act as a co-ordinator and/or broker of service packages

The defining characteristic of all child and family circumstances is that need rarely takes a singular form. In most cases, at the very least, the families using or potentially using Action for Children Centres, will be dealing with a mix of emotional, social and practical challenges. This means that the responses most likely to deliver better outcomes for their children will need to be similarly diverse and it is likely that a single service will be insufficient as a response. Children's Centres are in a prime position to act as co-ordinators of packages of services.

Action for Children Children's Centres fulfilled indicator 1 and 2 in almost every case examined. The Centres assessed put together and delivered service packages, acting as service providers in 90 per cent of the cases. The Centres also provided further guidance and information in 67 per cent of the cases.

Table 3 Number and percentage of cases where Action for Children acted as a co-ordinator or broker of service packages in different ways.

Indicator 2: Children's Centres act as a co-ordinator and/or broker of service packages	Response Percent	Response Count
Assessment	84.6%	44
Putting together a package	61.5%	32
Deliver services packages	90.4%	47
Provide guidance and information for choice	67.3%	35
Number of cases with indicator 2		52
skipped question		1

An example of a package of services

A single mother reported to have a borderline learning disability was referred to a Centre for a family support service by a children's social care worker. The worker enabled her to have access to speech and language therapy for her child, benefits advice, emotional support through the key-working relationship and advocacy with the housing association. The mother and child also started to regularly attend the drop in "stay and play" sessions.

Some service packages will carry particular risk of appearing to confer stigma on the recipients of the advice and support available. This is likely to be a particularly increasing danger in the periods following the Comprehensive Spending Review (CSR) when welfare benefits will be under particular scrutiny. Action for Children Children's Centres possess considerable experience in undertaking strategic planning with other agencies to address these issues.

How to deliver services packages that address poverty and social exclusion

Links with a housing association have been established; and in addition to holding a weekly surgery at the Centre, their staff are able to provide "floating support" for tenants who are facing particular challenges. In the same Centre there is on-going episodic input from Job Centre Plus; and because the work is undertaken in the Centre, such employment advice takes on a non-stigmatising nature. Given the likely implications of the CSR for benefit levels and housing tenancies, this work is very timely.

6.5.3 Indicator 3 – Children's Centre staff build links and partnerships with other agencies

The research literature around family support highlights the value to children and their parents of agencies establishing cross-agency partnerships in order to maximize the range and relevance of any 'Centre service menu on offer'. It would be realistic to acknowledge that in a period of national financial retrenchment, this will be a simultaneously even more challenging task, but one which paradoxically can have even more impact on protecting service range. It is important to acknowledge the *diversity* within the voluntary sector, and especially the different sizes of organisations, with inevitable different degrees of agency vulnerability. By working in partnership with smaller organisations, as Action for Children does, as a *large agency*, it may both increase its own capacity, as well as complement the services delivered by smaller and/or one-site agencies.

Indicator 3 was met in 92 per cent of the 53 cases. Centre staff built links and partnerships with other agencies through inter-agency working (78%); commissioning

work such as specific parenting courses or services aimed at improving parents' mental health and reduce isolation in 70 per cent of cases. The centres also maximized informal partnerships with social care in 53 per cent of cases and there were evidence of secondments and interagency working both in health and education.

Table 4 Number and percentage of cases where Action for Children staff built links and partnerships with other agencies in different ways.

Indicator 3: Children's Centre staff build links and partnerships with other agencies	Response Percent	Response Count
Commissioning work	69.4%	34
Secondments/interagency- health	28.6%	14
Secondments- education	2.0%	1
Deployment	8.2%	4
Inter-agency working	77.6%	38
Maximise informal partnerships with Social Care	53.1%	26
Number of cases with indicator 3		49
skipped question		4

Given the role of health service staff in meeting child and family need, it is important to note that there are clearly good links between the Centres and health agencies.

Commissioning HomeStart

Commissioning work with the voluntary group Homestart has helped to develop and support volunteers when providing their services. One Action for Children Homestart contract is with five Centres in a cluster that are therefore able to minimise the cost-per-Centre but establish area-wide set of relationships.

Several Centres regretted either the absence or removal of link social workers from local authority children social care. A consequence of this was that referrals often came in too late when problems were entrenched. Addressing this difficulty is not easy and required imaginative and resourceful responses on the part of Centre managers who persevered with 'courting' the engagement of local social workers. These statutory workers, through no fault of their own, were being corralled into working exclusively at tier 4 (with children at greatest risk or need). Whilst in the case of children who were

subject of a child protection plan it might be expected that children's social care workers would engage with the Centre, Action for Children managers seemed adept at working to engage social care practitioners on a more routine basis. The challenge of building these relationships was, of course, aggregated by high staff turnover in many children services.

Taking every opportunity to maximise informal partnerships with children's social care

Examples included:

--Inviting social workers to informal lunches in the Centre

--Offering mentoring/ shadowing opportunities to social workers (often as part of their induction)

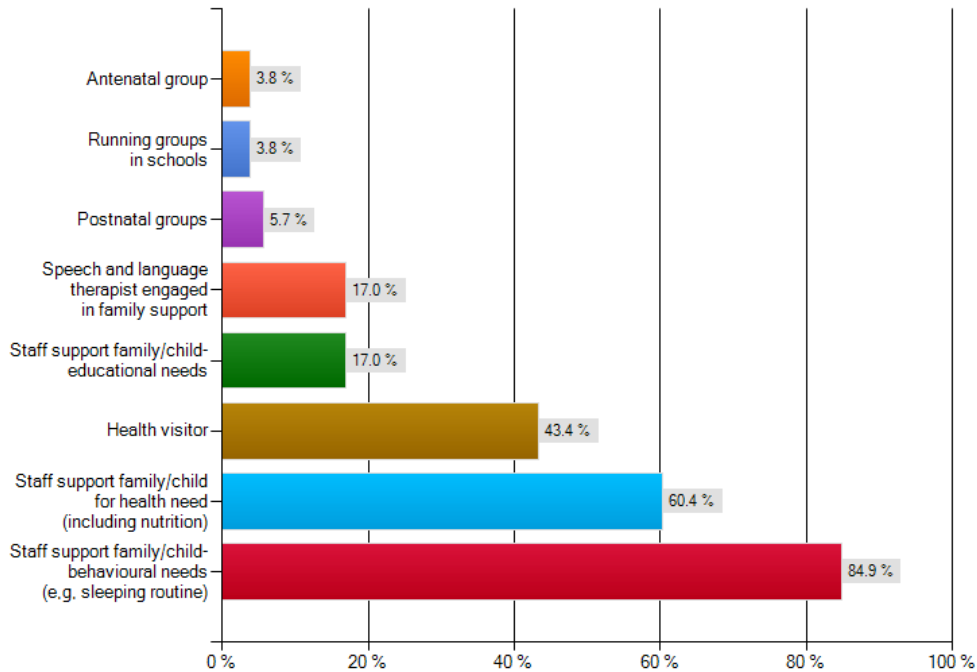--Providing practice placements for social work students

6.5.4 Indicator 4 - Centre staff seek to maximise access to services through imaginative, flexible and sustained outreach strategies

There are no 'silver bullets' with outreach or indeed as one manager put it "*you have to find everyone's carrot*". Different Centres have developed different approaches towards engaging parents.

Indicator 4 was met in 100 per cent of cases; Figure 10 shows that centre staff sought to maximize access to services through staff support of family and child behavioural needs (85%); their health needs in 60 per cent of cases. The Centres also provided a range of flexible services such as in house health visitors and speech and language therapists as well as running antenatal and postnatal groups.

Figure 10: Indicator 4

Indicator 4: Centre staff seek to maximise access to services through imaginative, flexible and sustained outreach strategies

Service	Percentage
Antenatal group	3.8 %
Running groups in schools	3.8 %
Postnatal groups	5.7 %
Speech and language therapist engaged in family support	17.0 %
Staff support family/child-educational needs	17.0 %
Health visitor	43.4 %
Staff support family/child for health need (including nutrition)	60.4 %
Staff support family/child-behavioural needs (e.g, sleeping routine)	84.9 %

Speech and language therapist engaged in family support

A speech therapist seconded from the NHS (not initially welcomed by NHS) was nevertheless able, through her family support role, including outreach, to engage families who had been formerly hard to help in this respect

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Antenatal groups

Midwives are members of antenatal groups for young mothers and consciously use the session to draw them in to using other services. In some cases they may use the local GP surgery to hold clinics helped to draw families into other services at the Centre.

Running groups in schools

Children's Centres are invited by local schools to use the Centre venue to run parenting and other groups, including those focused on skills and employability.

6.5.5 Indicator 5 – Children's Centre staff support health agency colleagues to maximize access to/usage of health provision.

For the 53 detailed individual cases indicator 5 was satisfied in 94 per cent of cases. Table 5 shows that this was achieved through a range of activities. The most significant form was through formal links with health and directly recruiting family support workers (58 per cent each). In a considerable number of cases the Centres forged formal links had been established with social care, enabling monitoring of child's health indicators and maintenance of shared targets with other agencies.

Table 5

Indicator 5: Children's Centre staff support health agency colleagues to maximize access to/usage of health provision.	Response Percent	Response Count
Informal links with Social Care	18.0%	9
Formal links with Social Care	32.0%	16
Formal links with health	58.0%	29
Informal links with health	36.0%	18
Shared targets	36.0%	18
Integrated health meetings	14.0%	7
Recruiting support workers	58.0%	29
Links with dietician	2.0%	1
Support with breastfeeding	2.0%	1
Monitoring child's health indicators (vaccinations etc)	22.0%	11
Midwife/health visitor based in Centre	6.0%	3
Number of cases with indicator 5		50
skipped question		3

Health visitors are the highest source of referrals to the Centres reviewed for this study, accounting for 41.5% (22) of all responses. It is hoped that an increase in health visitors will mean more time for them to engage fruitfully with Children's Centres and local Sure Start teams. Although only three of the five Action for Children Centres sampled had a health visitor based there, all of the Centres arranged secondments to build interagency links and partnerships with the health sector (indicator 3).

Linking with health services

Monthly targets are set at an integrated health meeting, involving members of Children's Centre staff and health professionals. Integrated health meetings are working on strategies with health partners to ensure joint working is on the health team's agenda to

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increase registrations with NHS services within a locality.

Four full time equivalent (FTE) family support workers have been recruited in one Centre, two of whom are allocated cases with pregnant women and parents with children under one year of age, in order to help reduce the infant mortality rate in the local area.

It is important to note that this project is being undertaken in a particularly challenging period in respect of the configuration of community-based health provision. The plans for Primary Care Trusts (PCTs) within the White Paper - *Equity and excellence: Liberating the NHS -* may have far reaching consequences for inter-professional collaboration. At the present it was possible to identify a number of widely adopted strategies, which by capitalising on the presence of NHS staff in the Centres, ensured that health outcomes were central to the design of many of the individual services and activities in those Centres. This might be at a very explicit level such as the provision of support for mothers in breastfeeding routines or implicitly as a facet of more general parenting support.

One day's group activities in a Centre

- **Tiny Tots** – a group for babies, toddlers and their carers.
- **The Joy of Food** – a cook and eat session including cooking recipes, trying new foods and learning how to plan and shop for healthier, more sustainable choices.
- **Specialist antenatal clinic** - for expectant parents in the local community.
- **Under 2/3 Baby Group** - a group for new parents and their babies aged 2/3 and under, including baby massage, breast and bottle feeding, weaning, sleep routines and budgeting.
- **Up 2 Ones** - a group for first time parents with children aged under one to have coffee and chat with other parents.
- **Bumps 2 Babies** - a teenage parentcraft group with a midwife and young parent advisor explaining what parents need to know before birth and after.

Integrated health visiting teams

A dominant model that has been adopted widely across Action for Children Children's Centres has been the introduction of integrated health visiting teams in the Centres.

Midwifery services as a gateway to other services

- A Midwife is based in the Centre but runs other clinics in the wider area, and is able to disseminate information about the Centre more widely.

- Midwives running antenatal groups for pregnant young people were able to signpost them to a range of other services, some focused on parenting, but others, for example, helping to ensure that teenage parents do not drop out of education and/or develop their ability to earn a wage.

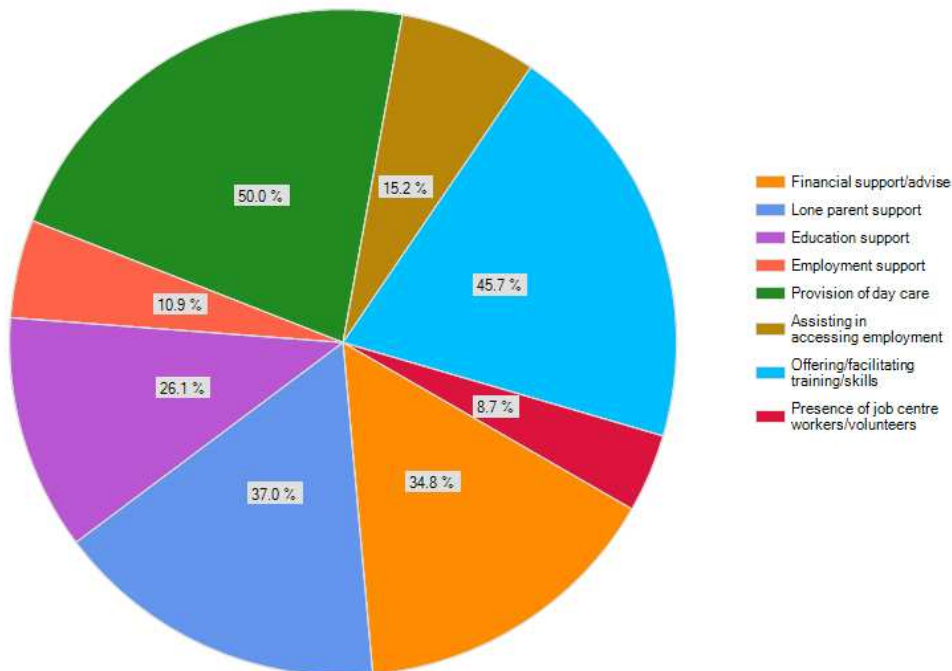- One Centre is part of the Teenage Parents Network, developed by the Teenage Parenting Midwife.

6.5.6 Indicator 6 - All Centre systems and the job specification for staff are aimed at building social and economic capacity in the local community

A key dimension of the work of Action for Children Children's Centres is their capacity to meet parents' needs which are not directly related to child care and yet have a clear impact on an individual's capacity to parent. That is, access to employment and training opportunities not only enhances the economic capital of the family but also releases social and psychological capital. This operates at both the individual family, but also at community, level, and there were a number of direct examples of the Centres linking parents who might otherwise have felt intimidated or stigmatised by approaching agencies such as Job Centre Plus. There were also indirect examples whereby parents took on voluntary roles in the centre, such as members of parents' forums and/or through volunteering in activities such as 'stay and play'. We interviewed parents who had moved from volunteer roles and, in some cases via training programmes, into paid roles in the centre and local community.

Figure 11: Indicator 6

Indicator 6: All Centre systems and the job specification for staff are aimed at building social and economic capacity in the local community

- Financial support/advise
- Lone parent support
- Education support
- Employment support
- Provision of day care
- Assisting in accessing employment
- Offering/facilitating training/skills
- Presence of job centre workers/volunteers

For the 53 individual cases the Centres satisfied indicator 6 in 89 per cent of them. As Figure 11 shows this was achieved through a range of activities and support mechanisms including offering and facilitating training and skills acquisition, financial support and advice, including offering free child care places, supporting lone parents for example.

Lone parent advisor from Job Centre Plus

A lone parent advisor from Job Centre Plus attends the drop-in clinic on a monthly basis. She also attends the Children's Centre Advisory Board to participate in the review of local need and planning.

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Accessing employment

Individuals are sign-posted to the electronic Job Points and telephone access line which are available at the local school. The Centre provides the direct telephone number of the Job Centre Plus Personal Adviser to families when appropriate.

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A volunteer strategy

A volunteer strategy facilitates participation in accredited training that is offered by Action for Children - 5 volunteers have been trained;15 are currently in training; and 3 have gone on to paid employment. One manager commented: "We *notice parents' confidence to take on volunteering increases after group services, including anger management*"

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6.6 Summary of the centre 'inputs'

Overall, in all of the 53 individual cases Action for Children Children's Centres reflected most of the six service indicators we explored. The study sample is too small to permit us to be anything other than cautious in drawing conclusions as to the association between centre-style and child level outcome. However, we can be confident in having presented a true picture of the range of services being delivered, and as importantly, of the work done to maximize access to them, and usage of them, by all groups in the community, regardless of 'complexity of need'.

Table 6 breaks down how each of the five Centres satisfied different indicators and shows that the level of achievement was similar across different sites.

Table 6

Centre Indicators	Centre Name				
	North east centre	**Midlands centre**	**North centre**	**Sea-side centre**	**East centre**
Indicator 1					
Yes	10 (100%)	10 (100%)	14 (100%)	10 (100%)	9 (100%)
No	0	0	0	0	0
Indicator 2					
Yes	9 (90%)	10 (100%)	14 (100%)	10 (100%)	9 (100%)
No	1 (10%)	0	0	0	0
Indicator 3					
Yes	9 (90%)	9 (90%)	14 (100%)	8 (80%)	9 (100%)
No	1 (10%)	1 (10%)	0	2 (20%)	0
Indicator 4					
Yes	10 (100%)	10 (100%)	14 (100%)	10 (100%)	9 (100%)
No	0	0	0	0	0
Indicator 5					
Yes	9 (90%)	9 (90%)	14 (100%)	9 (90%)	9 (100%)
No	1 (10%)	1 (10%)	0	1 (10%)	0
Indicator 6					
Yes	8 (80%)	7 (70%)	13 (93%)	10 (100%)	9 (100%)
No	2 (20%)	3 (30%)	1 (7%)	0	0

6.7   Understanding Centre outputs

It is important to recognise that the Centres offer services and support to a considerable number of children, young people and their families. In this study we selected six, (subsequently five sites participated) to examine the profile of children and young people using the Centre. This includes their personal characteristics, types of need, types of services offered as well as reported outcomes for some of them. The Centres are recording some of these cases on Action for Children's computerised database (e-Aspire), however, the records only reflect a small sample of the total cases serviced by the Centres. During 2009-10, it is estimated that the five selected sites had offered services or support to over 8000 individual children. However, detailed information was electronically recorded on 1577 children in the e-Aspire system.

The figures referred to above relate to the following, the largest figure for each centres is the actually reach, registration and attendance of children in each centre. For

example, the overall figure relating to the whole service provided out of the centre delivered by many agencies. The smaller figure refers to the actually direct work delivered by Action for Children staff which is recorded on an internal case management system called E-aspire. This system identifies specific service user need, outcomes required and records whether things have stayed the same or improved. This detailed data for the larger number figure is not available at this time.

In this section we provide some investigation of the characteristics of these cases as a sub-sample of the total group of children receiving services from five selected Centres. We also consider an analysis of self-reported outcomes of a sample of 'closed' cases during the last quarter (July-September 2010).

Figure 12 shows that during the period from March 2009 to April 2010; the six selected sites maintained detailed information on 1577 individual children or young people. Out of these, 1041 are still current users, or 'open cases'; while 536 are 'closed cases' where an outcome was reached or the individual stopped receiving the services for other reasons such as opting out or moving. Focusing on 'open cases' we provide some exploration of the profile of this sample of children and young people who are still users of the Centres.

In terms of age and types of needs, Figure 13 shows that the majority of open cases may be identified as children who are 'vulnerable with additional needs' and as within a young age group (less than five years). The concentration on younger ages may be due to the way records are kept in the Centres as well as the initial focus on services for children aged under five. Just over a quarter of children/young people are identified as vulnerable while an additional half (50 per cent) are described as vulnerable children with additional needs. The latter group includes cases where there is a specific health concern. One tenth of open cases relate to children in need and only five per cent concern child protection issues.

Figure 12: Total recorded cases in the Centres reported by whether they are still 'open' or 'closed' (n=1577)
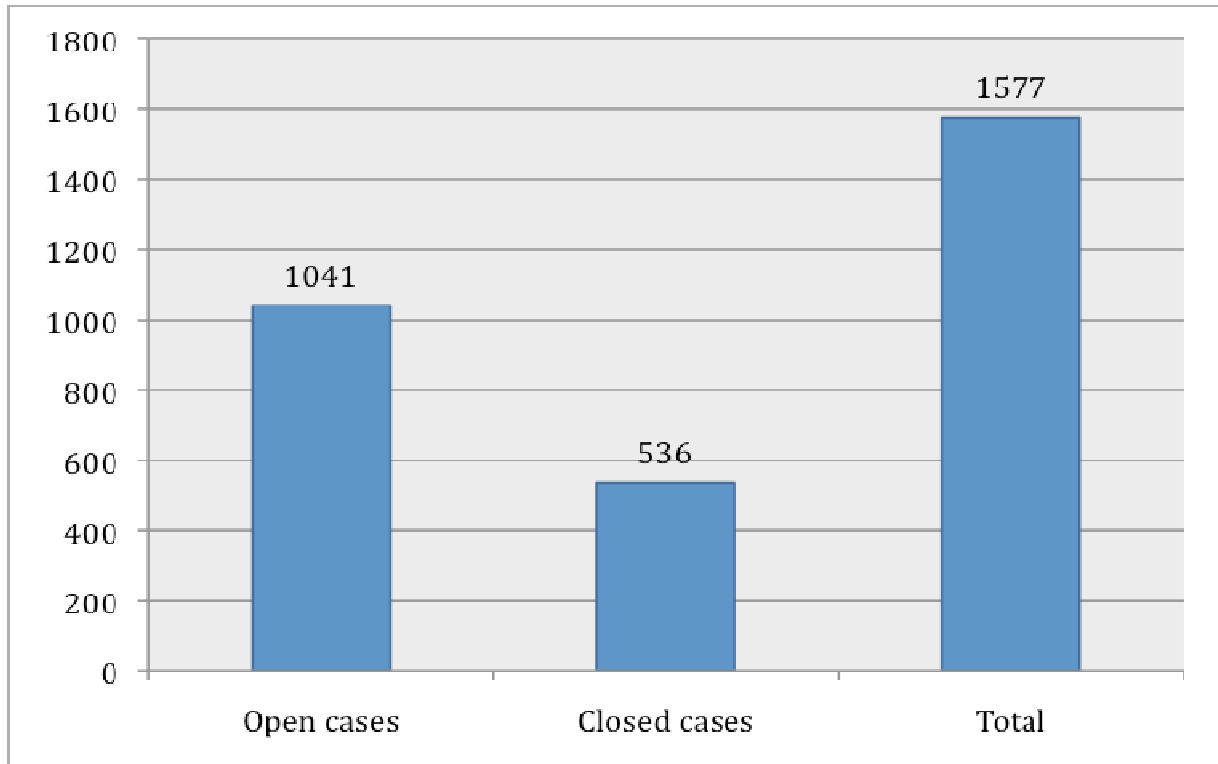
Action for Children Children's Centres are used by children and young people from different ethnic backgrounds. Just under three quarters, 72 per cent, of cases are identified as white British children/young people, 13 per cent are identified as having Asian backgrounds and 5 per cent are from mixed ethnicities.

Children identified as vulnerable with additional needs continued to form the majority of cases among different groups. However, 'child protection' and 'child in need' were identified more among white British children/young people than those from black and minority ethnic groups (BME). For example, 6 per cent of white British children were considered to have child protection concerns compared to 3 per cent among BME children; and 11 per cent of white British children were considered to be 'in need' compared to only 2 per cent among the BME groups.

Figure 13: Distribution of open cases by type of needs and age (n=1577)
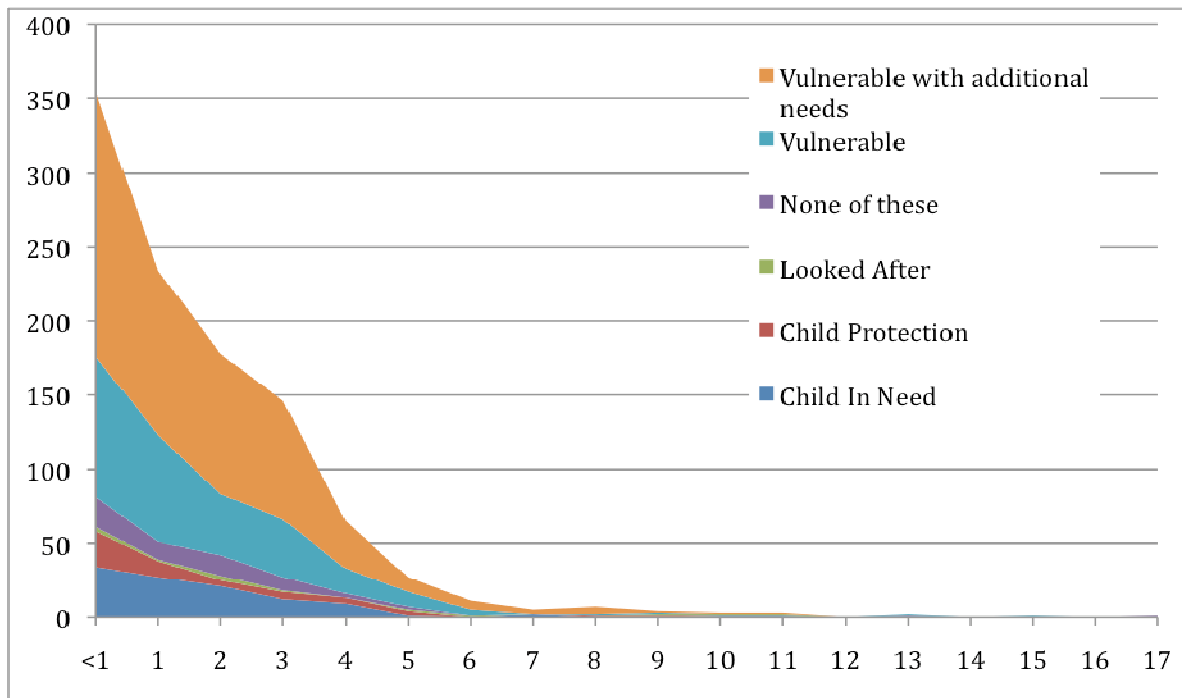
In the interests of 'clarity about service range', we have reproduced the pie chart shown above as Figure 9. Here (as Figure 14), it shows the services provided to the subgroup of open cases that had been 'authorised' for referrals. A considerable proportion (78 per cent) relate to family support services, some of which are targeted to disadvantaged young children such as the 2gether pilots (the Department for Children, Schools and Families' commissioned pilot programme of parent education classes for separating parents which were discussed by participants). Others are more generic in nature and reach a wider group of parents. Three per cent of the cases received parenting support (including teenage parents). Five per cent of cases (n=29) were recorded as receiving individualised services to meet their specific needs.

Figure 14: Types of services to referred cases in the selected sites
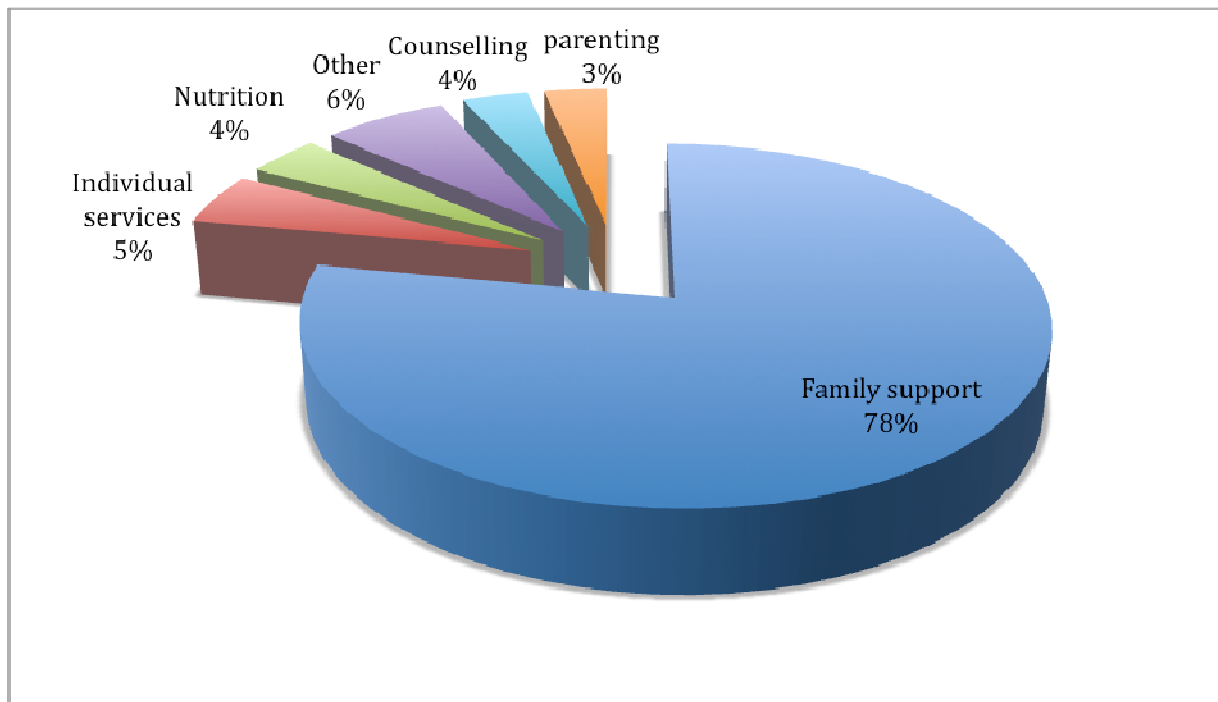
During the last quarter from July to September 2010, Action for Children started recoding the self-reported outcomes of all closed cases during the quarter. Among the six selected sites a total of 202 cases were closed. Children (where appropriate) and their carers were asked to identify 43 identified areas of *improvement*; *no change*; and *deterioration* at the time of closing the case. These indications related broadly to being healthy, staying safe, enjoy and achieve, making positive contributions and achieving economic well-being. Each individual may select more than one area of improvement; staying the same or deterioration. 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 were 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.

6.8 What does the study of individual cases show at of the level of child outcomes?

We now turn to the data captured in the study on what is in many ways the **key focus** of the study, in other words the *extent to which the centres succeeded in delivering positive outcomes for the children.*

This section provides an insight in to the interim outcomes which have been achieved for the children themselves and families. In this report we have drawn on the quantitative data set to provide an overview of the relationship between the need level that brought children and their families to a Centre and the extent which those needs have been met. In Figure 16, T1 presents the "starting date" in the Centre. In most cases this will be the point at which parent first attended on the basis of a self-referral or referral from another agency. T2 represents the last date of service input on record and/or the closure of the case. We have already explained our approach to measuring outcomes in the section on methodology but it is briefly re-visited here.

It is absolutely essential to acknowledge the complexity of measuring *outcomes* within a relatively short period. For example, in respect of a high proportion of the families whose service experience is reflected in Figure 16, the very maintenance of 'status quo' is itself a positive outcome. In terms of health outcomes, it is only realistic to expect very obvious measurable outcomes over a much longer period. This research reality underlines the validity of the concept of 'as long as it takes'.

EXPLAINING THE RATINGS SCALE WE USED IN THIS STUDY TO MEASURE OUTCOMES FOR THE CHILDREN, INCLUDING HEALTH OUTCOMES

A rating of 4 will reflect 'progression' in scenarios such as these typified below:

- **Safeguarding concerns raised with regard to a young parent shortly after the birth- with intensive, support these concerns subsequently diminished.**

- **A family with very long-term concerns around the developmental delay associated with long-standing neglect remained fully engaged with the project over a long period, and in regular contact with the centre health visitor.**

- **The youngest child with a serious physical disability condition (cerebral palsy) the family came into local authority care. However this was done in a planned way, with the maintenance of close links with both birth family and the centre.**

A rating of 3 will reflect progression in scenarios such as these typified below:

- **Progress had been very fragile for a family where a parent had a mental health difficulty and was still in an unstable situation. There may have been progress with the children; there were some setbacks, including a disruptive hospital admission, but this established an on-going link with the practice nurse in the GP practice, who linked with a family support worker in the centre.**

- **A parent struggled in their relationship with a teenage child, but the family still access services and remain engaged, albeit with frequent crises.**

A rating of 2 will reflect progression in scenarios such as those typified below:

- **A young, new, mother was overcoming serious drug misuse problems, and working with the centre midwife to establish a healthy nutrition plan for herself, and persist with breast feeding. Significant problems remained.**

- **Parents of a young child had struggled with a volatile adolescent who continued to experience frequent crises but the centre were still able to periodically engage and make some progress. A link was made to the local CAMHS service, and the parents attended behavior management sessions. However the young person refused to engage and is currently excluded from school.**

A rating of 1 will reflect progression in scenarios such as those typified below. :

- **A family with concerns around neglect where problems had increased with no significant progress and parents had disengaged entirely.**

- **A family had begun to attend the centre but after a brief involvement in a parent education class, had stopped. There were concerns regarding domestic violence, and at present the father made threats to staff and the father in a family he knew who were using the centre.**

Figure 15 below presents the data we collected in relation to the sample of 53 cases looked at by the research team. We considered the outcome achieved guided by the above 4 levels. The sample comprised both closed (n=35) and open cases (n=18). Of course, there is still room for improving outcomes for the 18 open cases, and so examination of outcomes at closure *and* progress within intervention, are equally important.

Figure 15: Overall level of outcomes

Overall level of outcome (subjective measure)
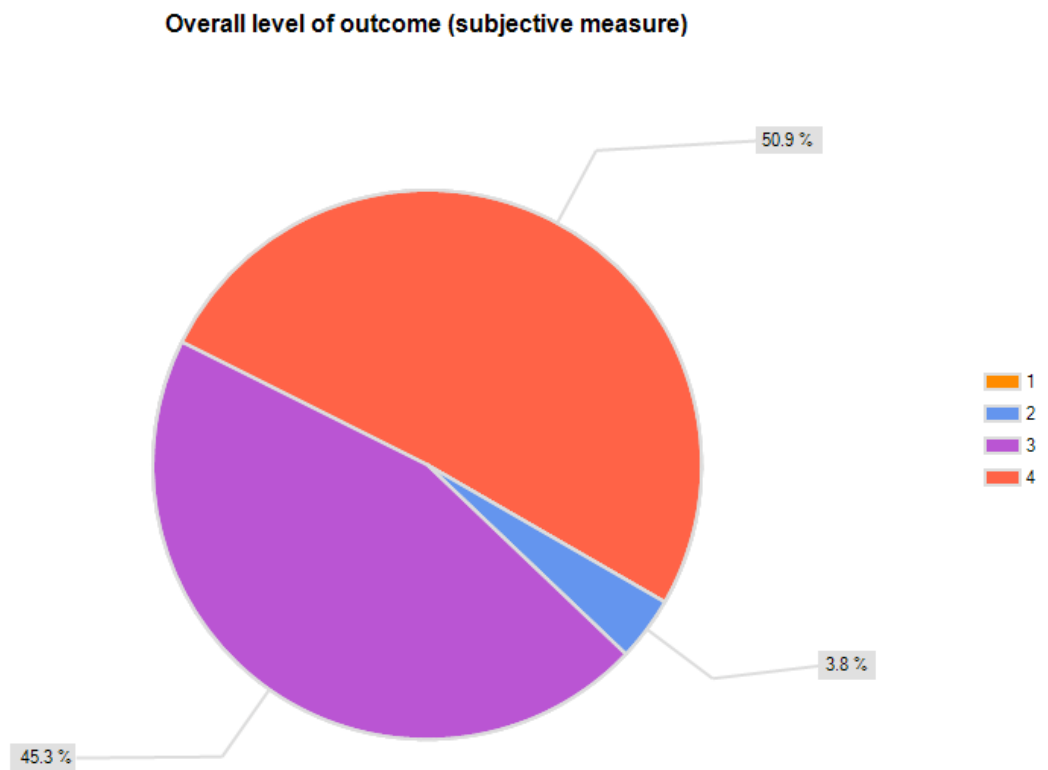
This pie chart indicates that for the vast majority of cases (96%), the *outcome for the child* was at a 'high' level, i.e. considered to be of level 4 or 3, thereby denoting improvement in terms of any/all of the health, social, developmental and behavioural issues which may have brought the children and parents into contact with the centre. In

only a tiny percent of cases was the outcome rated at level 2, and none of the child level outcomes was judged to be of level 1.

Figure 16: The extent to which the Centres were described as meeting identified needs: T1 being the start of the Centre involvement and T2 the last service record/closure of the case by percentage (n=53)
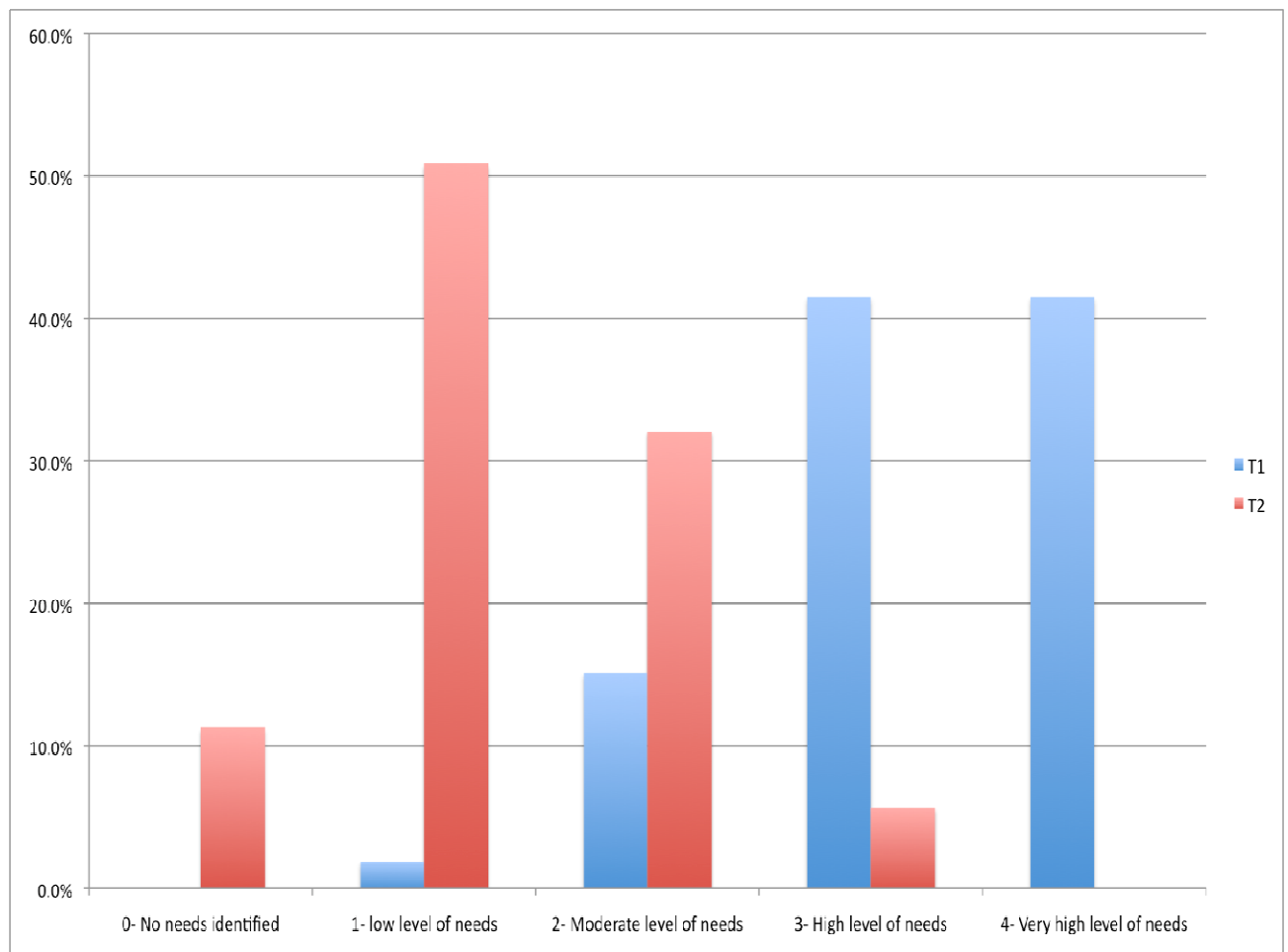

Figure 16 provides a graphic summary of the relationship between the level of need presented by each of the children in the sample at the start of their engagement with Action for Children (T1) and at the point when it was closed, (if it was one of the 35 closed cases examined) or at the time of the analysis, (if one of the 18 open cases), i.e. T2. As is clearly shown in Figure 16, at Time 1 (the blue-coloured bar) the majority of

cases were identified to high or very high levels of need (83%). By the end – or (in the cases not closed) part through the engagement with the centre, at Time 2, the majority of cases were considered to have *no needs* (11%), have a *low level of need* (51%) or have a moderate level of need (32%).

To summarise, the data analysis generated an overall picture of '*children doing better'* in open cases *after the beginning*, and in closed cases *by the end*, of their contact with the centre staff and the services on offer.

6.9 A close-up on child-level outcomes

To complement, the quantitative data on improved outcomes, presented above in Figure 16, we have selected and presented six illustrative '***service chronologies'*** (covering seven children). We selected them with a view to providing a 'clearer picture' of the many forms that 'progress' can make in the context of families with diverse and high levels of need. In particular we wanted to capture the importance of health-related issues and health-related outcomes, so the cases are chosen to illustrate the specific way in which Centre services contribute to *health outcomes* for children (all names have been anonymised).

Each example illustrates the complex nature of child developmental and health needs, showing the way that disadvantage can accumulate across many dimensions of family, economic situation and community capacity. The approaches adopted in the Children's Centres, in turn, adopt a broad and integrating approach to combating these multiple issues, reflecting the latest recommendations in the literature about promoting the foundations of health development.[65]

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[65] Center on the Developing Child at Harvard University (2010) *The Foundations of Lifelong Health Are Built in Early Childhood.* http://www.developingchild.harvard.edu

6.9.1 Physical health and development

Example 1 shows how physical health and development are supported, through promoting childhood immunizations and allowing the toddlers the space to run around and test their ability to jump and climb. Successful development depends upon access to a physical environment that allows and enables such simple childhood opportunities, which could be inhibited by overcrowded living conditions. At the same time, these children are able to begin to develop early speech in an environment that encourages and enables language use, before the sensitive period for speech development has passed. Whilst the twins are enjoying these simple essentials for their growth, their parents are gaining from some relief of the stress of childcare demands, enabling them time to concentrate on themselves and the twins' older siblings for a small part of the week. Parental (caregiver) physical and mental health are part of the essential ingredients of early child development.

1. John and Tom
Vulnerable with additional needs Age at referral: 2 years
Summary: twins, over-crowded, lack of space to play/develop; reconstituted/complex family; minor developmental delay. Had not had the triple injection, but other immunisations are up to date.
Services used: places provided in Early Years development play session once a week, funded childminder places.
Potential difficulties: lack of opportunities to play and family stress from overcrowding could cause further delay and family breakdown.
Outcome after 9 months: had made progress in Early Days, overall development has moved from 18-22 months stage of the Early Years Foundation stage to 22 to 36 months. Still need support with his speech and language and social development. ***Potential difficulties averted, developing at normal pace, but not yet caught up.***

6.9.2 Physical health and development

The second example, Pavel, is equally complex, but in a very different way. The combination of the child's major congenital anomaly and a family for whom English is not a first language might have obscured the second diagnosis of autism, until after the child started school, yet good interagency co-ordination enabled this to be picked up in a timely way. The child was introduced to groups and activities with mainstream children to enable socialization and physical development, with early specialist speech therapy to support language development and nutrition/feeding. Simultaneously, the parents were supported to cope with the complex diagnoses and to manage a younger sibling, and identification of a suitable school and transition was managed with Centre support. The multi-agency, integrated approach enabled a potentially very disabled and disadvantaged child to achieve all the foundations for development.

2. Pavel
Vulnerable with additional needs Source and Age at referral: self-referral by parents when child aged 2½ years
Summary: physical health concern stemming from congenital disability, and surgery to repair birth defect. This left a narrowed oesophagus, so care is needed with feeding. Speech delay (English is not first language of parents), needs more interaction with other children. Diagnosis of autism made 9 months after referral, i.e. age 3 years.
Services used: Early Days Development Centre twice a week; day nursery three times a week; drops in to open sessions, e.g., playtime, musical mini's and walkers to talkers; specific speech therapy sessions and help with nutrition and feeding.
Potential difficulties: perceived as a 'hard to manage' child, with physical and mental health problems that could have escalated. School entry needed managing.
Outcome after 18 months: (child aged 4 years), for child: timely diagnosis of autism, vocabulary increased, better able to concentrate on play, beginning to interact more with other children, continent, integrated with pre-school team; for parents/rest of family: respite, support with understanding autism diagnosis, support with new baby (3 years

younger).

Potential difficulties averted: timely diagnosis supported through access to appropriate services, school entry managed appropriately and parents supported to manage child's difficulties. Siblings/family life supported.

6.9.3 Child maltreatment

Concerns about the potentially toxic impact of child maltreatment on a developing child were to present for the child offered as example 3, Narinder. Already at risk of developing mental health problems as a result of early bereavement (death of his father) and learning disabilities, this youngster was supported in two ways. First, as his developmental age permitted, he was supported to develop some personal resilience, which could provide him with some protection in the face of maternal inconsistencies and neglect. Second, in due course, when his mother was unable to provide a safe home for him, he was supported to move to a different environment with other family members. Safe, responsive relationships are essential to the growing child, and the Children's Centre provided a 'safe haven,' modeling of a caring environment, to mitigate some of the worst effects of his home situation.

3. Narinder
Vulnerable with additional needs/ Child Protection concerns Source and Age at referral: Children's social care, 8 years old
Summary: educational attainment is low, attends special school. Global developmental delay and speech delay. Father died following long illness. Mother reported to lead 'chaotic' lifestyle. Emotional and social needs of child need to be developed, enabling him to participate in and enjoy a social group.
Services used: Children's services, Children's Food Group
Potential difficulties: bereavement/mental health problems developing in already vulnerable child, family breakdown and potential abuse, risk of criminal justice issues emerging among parent and her network.

Outcome after 4 years: child attended and enjoyed the weekly after-school sports group on a regular basis, and began to join in the activities. Child moved to live with his brother and family when aged 11, due to ongoing risks of neglect and lack of safe parenting. Moved out of the area and is accessing local activities and groups.
Potential difficulties averted: long term positive reinforcement and support to avert mental health problems. Established positive role models for growing child.

6.9.4 A safe home environment

The lack of a safe home environment featured in our fourth example of Clarice, too. The apparently good interagency working is essential for this sort of high risk situation, in which a parent is unable to care adequately for a small child, because their own overwhelming needs, in this case due to use of illicit drugs. The recorded inconsistency in nurturing, or even basic food and care, is potentially dangerous and toxic to the developing child, and the heightened awareness of Children's Centre staff shown in their outreach activities. Regular monitoring and changing action plans in response to rising concerns is intended to ensure that the child does not slip under the radar, and is kept safe.

4. Clarice

Child in need
Source and Age at referral: Health visitors, age 2 years

Summary: Third of four children. Mother used heroin during pregnancy, now on methadone programme. No apparent lasting effects, although daughter needed special care at birth. Immunisations were late but now up to date. Child does not always receive a healthy and nutritious diet at home. Speech, language and communication skills are poor, limited opportunity to interact with other children, or play. Need for play, stimulation, family support.

Services used: outreach service as mother felt unable to attend services in Centre, Early Days Development Centre offered twice a week but attendance erratic.

Potential difficulties: worsening delays in child's development, concerns over general care/diet etc, professionals concerns about adequacy of monitoring and fear that services could lose contact with child due to parental non-engagement.
Outcome after 18 months: slow progress with child's development due to erratic attendance and non-engagement by parent. Outreach work and home visiting stepped up. *Potential difficulties averted: despite continued difficulties, child(ren) still seen regularly and contact maintained through outreach work.*

6.9.5 Physical health and development

The fifth child, Ravi, is another example where a significant physical problem could threaten the child's development. The toddler has a need for careful food management, but his mother was experiencing significant post natal depression (PND), such that she was initially daunted by the extent of her son's health needs. Appropriate nutrition is one of the key building blocks of early child development. Yet, PND can create a major barrier to maternal sensitivity, and reducing parental ability to take on board all the additional care required by a child with special dietary and other needs. In this case, outreach work focused on building the mother's confidence in the first instance, providing tailored support for the medial needs. The ability of the child care facility to cater for his special needs is also noteworthy.

5. Ravi
Child In Need/ Vulnerable with additional needs Source and Age at referral: health visitors, age 1 year
Summary: Fructose Intolerance, serious eye problem mother has post-natal depression, English is not first language, speech and social development are delayed, otherwise up-to-date in health outcomes.
Potential difficulties: mother's depression could lead to inability to notice difficulties

arising from child's physical health problems, or to communicate his needs to other family members. Fructose intolerance is a rare genetic disorder that can lead to convulsions, liver disease and death if the correct diet is not given. Eye problem affects vision, which may in turn affect fine motor co-ordination and long-distance sight, and needs monitoring.
Services used: Outreach support. Support with hospital appointments, Early Days development centre and day nursery, with special care around diet.
Outcome after 30 months: settled and ready to move on to day nursery, development progressing well; mother feels supported. *Potential difficulties averted: mother supported to cope with child's physical condition and hospital appointments. Nursery was able to cater for his special needs, so child was able to develop well and safely.*

6.9.6 Ongoing support

Finally, the example of an older child, Danny, for whom the Children's Centre had been part of his life for many years, illustrates the flexibility and impact of ongoing support. Once more, the child was supported to develop some personal resilience and to cope, as his developmental age allowed, with issues such as anger and difficulties in concentrating. The extent of services within the local community is shown through the lens of one child and family, but the impact of a resource being widely available should not be underestimated.

6. Danny
Child in need Source and Age at referral: Primary School, age (approx 7 years – records incomplete)
Summary: ADHD diagnosis and medication prescribed, behavioural problems with difficulties managing anger.
Services used: Team around the child, after-school sessions, family fun sessions, support for parents and individual work with child on anger management strategies and

positive time through holiday play schemes, family fun session during the school holidays, etc.

Potential difficulties: social isolation, mental health problems developing in a vulnerable child, risk of school exclusion and criminal justice issues emerging.

Outcome after 3 years +: (records pre-date system; reference to 10 years in mother's statement) Preparing to attend mainstream school. Attends local youth clubs and social activities, behaviour and anger problems appear to be under control.

Potential difficulties averted: social isolation and difficulties associated with unresolved anger management problems under control, smooth transition to mainstream school.

6.10 Overview of the contribution made by Action for Children Children's Centres to outcomes for children

In a study of this nature, with its limited sample size, and relatively short time scale, it is important to be cautious about drawing too 'far-reaching 'conclusions about outcome data. In addition, the sample of children was determined by the age range of children who are (currently) eligible for access to children's centre services. However, we can be 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 immunization options
- engagement (where necessary) with mental health professionals
- reduction in parents using A&E departments for child health problems

7.   Implications of the study data for commissioners and service providers

A number of key findings have emerged from this study of Action for Children Children's Centres. Given we are able to draw on data collected across responses from families, Centre staff and their inter-agency colleagues, as well as from face-to-face and observational methods we employed in site visits, we believe it is most helpful to group the themes under three topic headings. Of course each of them will have implications for both commissioners and providers, but there is a reassuring overlap across the issues they raise.

7.1 A number of social challenges currently face families in all the Centre localities

We identified reports (by families themselves and by centre staff) of increases in levels of community and family level economic and social stress. Both Centre staff and families reported increased economic insecurity and in some cases they related these circumstances to the benefits they derived from attending the Centre. The following statements speak for themselves:

> "This is the only public place we can use now my husband is out of work. It's here or Asda"

> "I don't live very far from my sister in law. Our problems are the same but she gets much more. I don't just mean the Centre…it's the leisure centre closing as well"

> "The stress on my family is made much worse by my worries about food prices"

> "My son is embarrassed by his clothes"

"Coming here makes me feel like I can hold my head up and contribute something"

This level of socio-economic adversity may be worsened by public sector cuts; and indeed the parallel necessity for agencies to demonstrate a targeted approach to commissioners. The combined effect of these two phenomena can easily be a reduced level of service available to children and their families. For example, we identified a loss of key health staff in Centres (e.g. 2 midwives out of 4 in one Centre) and the end of NHS cancer awareness programmes in another. However, Centre staff sought to ameliorate the effects of these by taking on higher levels of work themselves. This, in turn, could result in high levels of staff sickness and early retirement. In other cases, across agency boundaries with heath and indeed with children's social care, the weakening of links with health visitors and social workers has potential negative consequences for all children, but the most serious consequences for the (more difficult to identify and engage) children in families with higher and more complex levels of need.

Remaining eligible for services which parents recognise they need to maximize the well-being of their children, is less than 'straightforward' when the Centres they visit are being required to demonstrate a targeted approach. This may carry the potential risk of sacrificing a *more inclusive approach* and have negative implications for *achieving maximum reach.* Even with the best of intentions it is easy for Centre staff to become driven by the necessity to *provide evidence* of targeting, and this can overlap with the detrimental impact of stigma. Access to services is easily deterred by a sense of stigma on the part of families and there is a danger of reinforcing stigma when targeting the most vulnerable (e.g. by setting up a Teenage Mothers Project unless this is carefully portrayed). Access difficulties may also arise from other problems:

"I used to be able to see my social worker pretty easily. However they have closed the local office and now I have a real struggle with the bus fare….it's in (the) town centre" (mother)

7.2   Some service delivery approaches in use in the centres appeared to "*work best"* in order to maximize the process of meeting child and family needs?

A set of common challenges impact on both statutory and voluntary agencies and inevitably requires a degree of collaboration:

- Engaging *hard to reach* families
- Getting the design of recording systems right
- A changing model of accountability e.g. advocacy work around free schools, engagement with the private sector, becoming involved in G.P commissioning
- Shared workforce challenges
- Evidence-based parenting programmes have a place if they are surrounded by wrap-around services for whole family.

7.3   What key messages for good practice emerge across specific service partnerships?

- Action for Children Children's Centres have evolved a sophisticated range of mechanisms to maximize "reach" in even the most challenging circumstances.

- The Action for Children agency *partnership style*, working with other local agencies, and crucially health, maximizes service responsiveness for families and can help protect local family support capacity by engaging with small/medium sized agencies.

- Where an agency ensures that its recording and reporting formats are "worker friendly" and are perceived by staff as relevant to the measurement of their work with a family, then both the quality and quantity of the inputted data will be maximized.

- User-friendly referral forms maximize the possibility of access through referrals. There is a consistent pattern across Action for Children Children's Centres of

managers having the confidence to design and implement forms that "will work for everyone". Managers reported that lengthy referral forms act as a barrier to referrals from external agencies such as health and children's social care and reported taking the initiative to explore alternative forms.

- In most cases, at the very least the families using, or potentially using, Action for Children Children's Centres, will be coping with a mix of emotional, social and practical challenges. This means that the responses most likely to deliver better outcomes for the children will need to be similarly diverse and it is likely that a single service will be insufficient as a response.

- Early referral appears to be associated with a clear and concise record of assessed need.

- Action for Children's ability to assemble a skill mix (including but not necessarily dependent on *formal* secondment), can help to ensure cohesive and responsive service design and delivery.

- Centre-based work with *adults who are parents* means that individuals can be supported in developing their capacity as *parents*; as well as *adults in the community*, including facilitating their engagement with and entry to the labour market.

- Helping develop the confidence of adults to undertake good quality parenting is a key building block in the building of community capacity.

- Centre staff frequently build links and partnerships with other agencies, and by working in partnership with smaller organisations, as Action for Children does as a *large agency*, it can both increase its own capacity, as well as complement the services delivered by smaller and/or one-site agencies.

- There are no "silver bullets" with outreach - as one manager put it "you have to find everyone's carrot". Different Children's Centres have developed different but effective approaches towards engaging parents.

- A key dimension of the work of Action for Children Children's Centres is their capacity to meet parents' needs which are not directly related to child care and yet have a clear impact on an individual's capacity to parent. That is, access to employment and training opportunities not only enhances the economic capital of the family but also releases social and psychological "capital".

In the data presented above, on the inputs, outputs, and the outcomes achieved by a range of Action for Children delivered Centre-based services, it is possible to identify an overlap/fit between services that meet the needs of children and their families, and services whose identity and mode of delivery can potentially be seen to reflect 'value for money'. Examples of the former include the ability to ensure that the 'most vulnerable families' are encouraged and facilitated to access services, thereby maximising the range of developmental benefits for their children. Examples of the latter would include the brokering/co-ordination role played by Children's Centres, which can ensure that services are delivered in the 'right combination', for the appropriate period of time, and in a way which does not necessitate the construction of expensive and additional bureaucratic mechanisms. Furthermore, the way in which Centre services are configured may promote capacity building within the local community, in that some parents progress to paid employment on the basis of the experience of using a Centre or being involved as volunteers.

7.4   Inter-agency work with health services

In specific respect of health services, the ability of Children's Centres to co-ordinate services is crucial, in the context of possible changes to Primary Care Trusts. Given their (in many cases) success in overcoming the challenges involved in engaging GPs, it is likely that Children's Centres can work to familiarise local GP practices with the nature and distribution of social and family specific need. The new service vision and

health visitor implementation plan[66] reinforces the requirement, first articulated in the last government's Child Health Plan[67], for there to be a lead health visitor available to link with every Children's Centre. Arrangements to ensure health visitors retain or renew strong communication links with general practice should also be in place. This way of working is supported and reinforced by the high level of engagement with midwifery, health visiting, and speech and language therapy services in the Children's Centres.

7.5   An integrated approach to safeguarding

In parallel with these developmental aspirations, there is consistent integration by the Children's Centres of a robust commitment to undertaking, along with colleagues, responsibility for safeguarding children. It may well be argued that the sophistication demonstrated by Centre staff in respect of maximizing reach; and minimizing barriers to Centre-based parenting support, is a major building block in ensuring children are protected. The 'service flexibility' which Centre-based provision can offer and, in particular its ability to engage parents in the "*public space*", is a protective device in its own right. By acknowledging the deterrent role of stigma, associated with the design of some services, Action for Children can anticipate this hazard, and in many cases succeed in overcoming parental reluctance, by means of multi-faceted parental engagement strategies. It is a very different approach from the exclusively targeted work of children's social care social work staff, which was heavily criticised in the Munro report. It might well also be argued that it would be likely to comprise a potentially far more effective one.

7.6   Balancing the focus of Centre provision as between the needs of children and the needs of their parents/carers

An important element in the Action for Children approach is to embrace the dual role of 'adults as parents' and 'parents as adults'. Indeed it may be that the title 'Children's Centre' although a popular and familiar one, tells rather less than the whole story. The actual work which takes place reflects a very profound concern with the needs of all

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[66] ibid Health Visitor Implementation Plan
[67] Department of Health/Department for Children, Schools and Families (2009) Healthy lives, brighter futures. The strategy for children and young people's health. Gateway Ref: 10489. London: DH/DCSF.

members of the family, with a view to maximizing outcomes for the children. Indeed, in many cases they could as accurately be called Family Centres, given that they succeed in balancing the focus of Centre provision between children and families, with a view to improving life chances across the life course.

7.7   Capacity building in the local community

Parents and their children who use a Centre now and in the future, are members of local communities, with their attendant social strengths as well as, in many instances, economic weaknesses. The geographical locations of Action for Children Children's Centres mean their staff work disproportionately with families who face daily challenges from poverty, housing problems and social deprivation. In the context of the forthcoming changes to welfare payments, the work of the Children's Centres in supporting parents, and especially young parents, into training and employment, is a crucial part of their work. It is also one that can potentially contribute towards the improvement of outcomes and life chances for the children of those families, and at the same time, ensure the locality will benefit from the transition of some community members into less disadvantaged and sometimes alienated families.

8.   CONCLUSION

This study has described the way in which outcomes for children have been and can continue to be enhanced by the appropriate design and delivery of services by Action for Children Children's Centres. The focus of the study on health outcomes in particular has highlighted the value for children and their families of the approaches we have identified and described.

As we explained in the first section, there is currently a fast-moving change process in train, which involves almost every agency involved in the service system for children and their families. In particular the changes announced so far have very far reaching implications for health systems. The government's approach to the health of children and young people, as laid out in the Public Health White Paper and the intended design of a new decentralised approach to provision raises a number of issues including:

- The role of children's centres in respect of support for health visitors
- The role of schools & the Dept. for Education's responsibilities in promoting children's health
- The role of the GP in promoting child health
- The "local partnership's" role in promoting child health
- How early intervention can improve children's health later in life
- Improving mental health services for young people

While this study has investigated Children's Centres in very different contexts and localities, there are striking similarities. Our key messages focus on the interface of Children's Centres with different and equally important stakeholder groups of which the following are the most obvious.

8.1 Partnerships with health services and NHS professionals

In trying to maximise health outcomes there is a ready link into current wider discussions around public health, the value of parenting and social return on investment. The study has identified the potential role for Children's Centres to offer commissioners of health and children's services an evidence-based service that adds value to their investment and which is ready to engage with contracts that have outcomes as an element of terms and conditions. Children's Centres offer building-based opportunities for local health professionals to engage with parents in a family focused setting; they seem to have had particular success in engaging community based midwives and health visitors with local children's networks.

8.2 Maximising investment at the same time as building community capacity

Children's centres offer a wide range of 'volunteer opportunities' for members of the local community. These are beneficial to users of their services but also are helpful in enabling parents and members of local communities to share in support for families. While some volunteers may use this as a stepping stone into employment, others may find it useful in developing social capital. Centres themselves may benefit from the support of their local communities and may be less open to challenge that they are remote from the needs of hard-pressed families.

8.3 Access and acceptability for parents

There is a strong sense that Children's Centres have been able to roll back a long history of perceived threat to families from well-meaning professionals and charities. Centres have been sensitive to the wariness of parents and have made efforts to reduce the risk of stigma. This will be a challenge if they are to become more targeted. A key part of Children's Centres' work has been that while they have stressed accessibility they have also engaged in outreach. It is this that may reverse disengagement and may strengthen the link to parents who are most isolated and vulnerable. While the name Children's Centres suggests a focus on children, the case illustrations and the data collected all point to the circumstances and histories of parents as highly influential on the outcomes for their children.

8.4 Meeting some needs for *most* children to ensure that the needs of *vulnerable* children are identified and met

Action for Children Children's Centres can deliver a range of preventative services which make a major contribution to the range of outcomes for children, including health outcomes; behavioural outcomes; and developmental outcomes, all of which contribute short-term and life-long benefits, including the enhancement of school readiness. This breadth of early intervention applies as importantly both to children whose various special needs have already been identified; and to families who struggle with the challenges posed by the task of parenting, and who may need short periods of support in order to weather crisis or change.

It is also evident from the many sources of evidence collected for this study that Action for Children Children's Centres deal professionally and effectively with child protection and safeguarding. Many of the children they work with are at risk in this area, although levels of risk vary. In a small but significant number of cases the Children's Centres are part of a web of support for very vulnerable children. They also work with many children with disabilities and long-term health conditions. It is possible that their work with ill and disabled children will intensify, and they are in a strong position to respond to the many challenges involved.

8.5 Final word

Action for Children Children's Centres have the potential to act as a gateway, and in some cases one-stop-shop, for the early intervention which we know from the international and national evidence base, can improve outcomes, and especially health outcomes for children, both during their childhood and through to later life. Our findings highlight the value of the policy and practice approaches we found in the centres and would suggest that the Action for Children *service style* constitutes a very timely and effective way of delivering services in a period of particular resource challenge. For families the Children's Centres constitute a non-stigmatising and popular route into services; for service agencies and professionals they provide a crucial resource to help

them co-ordinate their work to the benefit of children, at the same time as reducing inefficiency and lack of co-ordination.

8.6 Acknowledgments

We are very grateful to all those who assisted in this study, especially to the parents who are using the using Children's Centres, and to the staff members, all of whom have been generous of their time in providing co-operation and assistance.