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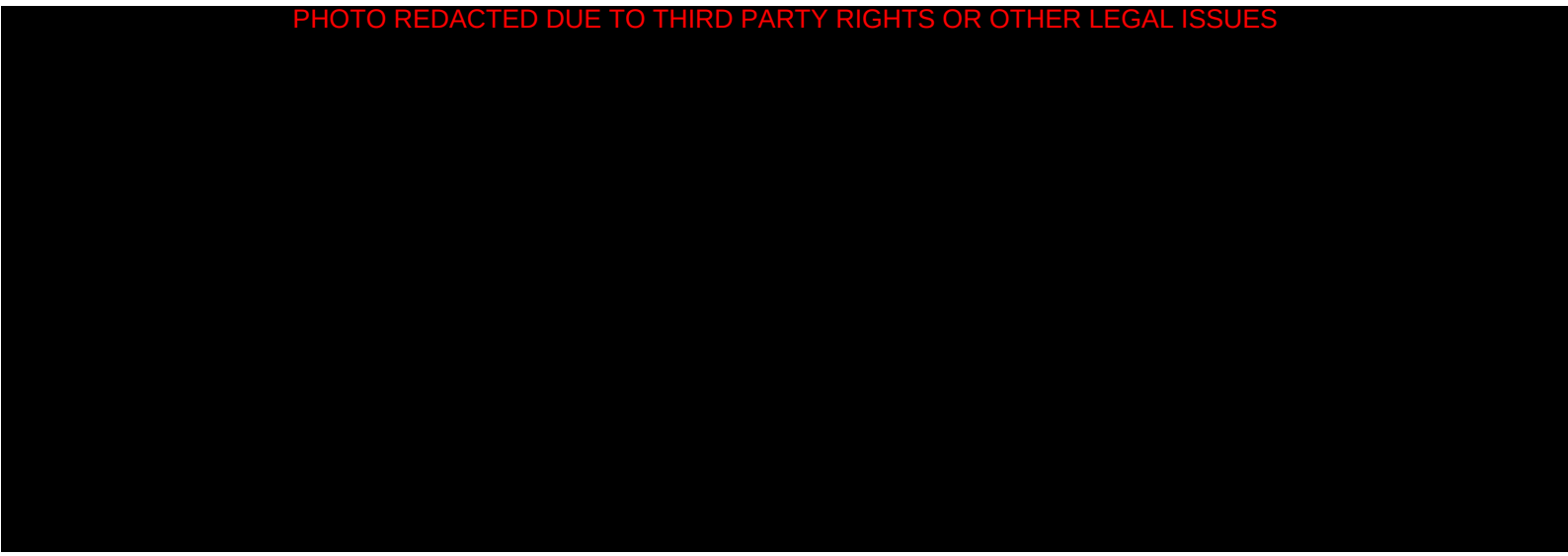

Understanding Variations in Effectiveness amongst Sure Start Local Programmes

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Evidence & research

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Understanding Variations in Effectiveness amongst Sure Start Local Programmes

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The following members of the NESS Implementation Team contributed to this report:

Author(s)	Departmental and institutional affiliation
Professor Angela Anning, Investigator	Institute for the Study of Children, Families and Social Issues, Birkbeck
Dr Jane Stuart, Senior Research Officer	Institute for the Study of Children, Families and Social Issues, Birkbeck
Michelle Nicholls, Research Officer	Institute for the Study of Children, Families and Social Issues, Birkbeck
Joanna Goldthorpe, Research Officer	Institute for the Study of Children, Families and Social Issues, Birkbeck
Anita Morley, Research Officer	Institute for the Study of Children, Families and Social Issues, Birkbeck

The National Evaluation of Sure Start Team is based at the
Institute for the Study of Children, Families & Social Issues, Birkbeck
University of London, 7 Bedford Square, London, WC1B 3RA.

Core Team

Professor Edward Melhuish, Institute for the Study of Children, Families & Social Issues, Birkbeck

(Executive Director)

Professor Jay Belsky, Institute for the Study of Children, Families & Social Issues, Birkbeck

(Research Director)

Dr Alastair Leyland, MRC Social & Public Health Sciences Unit, University of Glasgow (Statistician)

Impact Module

Professor Edward Melhuish, (Director)

Professor Angela Anning, University of Leeds (Investigator)

Professor Sir David Hall, University of Sheffield (Investigator)

Implementation Module

Professor Jane Tunstill, Royal Holloway, University of London (Director)

Mog Ball (Investigator)

Pamela Meadows, National Institute of Economic & Social Research (Investigator)

Cost Effectiveness Module

Pamela Meadows, National Institute of Economic & Social Research (Director)

Local Context Analysis Module

Professor Jacqueline Barnes, Institute for the Study of Children, Families & Social Issues, Birkbeck (Director)

Dr Martin Frost, Birkbeck (Investigator)

Support to Local Programmes for Local Evaluations Module

Professor Jacqueline Barnes, Institute for the Study of Children, Families & Social Issues, Birkbeck (Director)

Data Analysis Team

Dr Helena Romaniuk, Institute for the Study of Children, Families & Social Issues, Birkbeck
Guido Maggio, Institute for the Study of Children, Families & Social Issues, Birkbeck
Antero Malin, Institute for the Study of Children, Families & Social Issues, Birkbeck
Mark Hibbett, Institute for the Study of Children, Families & Social Issues, Birkbeck

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FINAL REPORT OF THE NESS PROGRAMME VARIABILITY STUDY

EXECUTIVE SUMMARY

Rationale for the Study

In 2005 the National Evaluation of Sure Start (NESS) Impact Study reported that overall effects in the cross sectional study of children and their parents living in the 150 Impact Study SSLP areas were small. It was still early stages for the intervention and research evidence shows that there is likely to be a delay between early interventions and the detection of their effects.

Effects that were detected related mainly to family functioning, with homes of mothers of 9-month-olds showing less evidence of household chaos and mothers of 3-year-olds showing more acceptances of their children's behaviours.

A key message was that there was large variation amongst programmes and some of the SSLPs were doing better than others in impacting on child, parent and family functioning measures. The Programme Variability (PV) Study was set up in 2004 to pursue evidence of what made SSLPs more or less effective. Two key terms used throughout the report refer to the proficiency of the processes by which the SSLPs were implemented and the effectiveness of SSLPs as measured by their Impact Study child, parent and family outcomes.

The Study had three aims:

1. To investigate why some SSLPs were more effective in achieving outcomes than others.

2. To characterise and explain variations between high, medium and low levels of SSLP proficiency in delivery of services.

3. To characterise and explain proficiency and potential effectiveness of services for families with young children in SSLPs as they were transformed into Children's Centres.

The study was designed in three stages.

Methods: Stage 1

The first stage addressed the question: *Why are some SSLPs more effective in achieving outcomes than others?*

Because every SSLP was implemented in a different way, within different local contexts, this was a methodological challenge. However, the SSLPs all had to implement their programmes in line with DfES guidelines. An evidence base of what works in early interventions underpinned these guidelines. A Programme Variability Rating Scale (PVRS) was designed with 18 dimensions of proficiency based on the DfES guidelines framework. The dimensions grouped into three broad domains:

- *Holistic* aspects of proficiency (vision, empowerment, communications, ethos);

- *How* processes underpinning programme proficiency (board representation and function, leadership/management, multi-agency working, pathways to specialist services, staff turnover, evaluation);

- *What* of proficiency in service design and delivery (core service provision, targeted service provision, identifying users, reach and strategies to improve reach, services innovation and flexibility).

Equivalent evidence from each of the 150 SSLPs was collated and used to rate the 150 SSLPs on the 18 dimensions. The assessors were blind to the Impact study outcomes for the programmes.

Statistical analysis was used to examine the overall predictive power of the 18 ratings in differentiating between more or less effective SSLPs. The results showed that the ratings were linked with better or worse than expected Impact study outcomes. Overall SSLPs tended to score high, medium or low across all dimensions. The measures of proficiency were strongly inter-related. The implication is that SSLPs that were able to develop proficient structures, systems (including high quality leadership and management) and good services across the board achieved better results on measures of effectiveness. We investigated whether specific ratings were related to specific outcomes.

Findings: Stage 1

The results showed significant effects as:

- For families of 9-month-olds, more *empowerment* was related to *higher maternal acceptance.*

- For families with 3-year-olds, *better identification of users* was related to *higher non-verbal ability for children*; *stronger ethos* and *better overall scores* on the 18 ratings were related to *higher maternal acceptance*; more *empowerment* was related to *more stimulating home environment*.

We also explored the relationships between number and type of services and number of staff involved in core services and child and parent outcomes.

The results showed that:

- having more *parent-focused services* was related to *less negative parenting;*

- having *more improved child-focused services* was related to *higher maternal acceptance*;

- and having a *greater proportion of staff that was health related* was associated with *higher maternal acceptance*.

This was an encouraging start to the Programme Variability Study. Although the relationships detected were not strong, it was encouraging that significant relationships detected between the processes of implementation of the SSLPs to common guidelines and the measures of child and parent Impact outcomes were all positive.

Implications for Children's Centres from Stage One Findings

- Children's Centres need to implement the whole model that is integral to the original Sure Start vision. The most proficient and effective Children's Centres will perform well across all 18 dimensions of the model. The dimensions of proficiency include:
    - holistic aspects such as establishing a welcoming, friendly and professional ethos and empowering parents and providers of services.
    - ensuring that strategic, systemic processes are firmly in place such as governance that is representative of key stakeholders and functions well.
    - having clear operational systems for identifying users, monitoring service use and identifying service impact at both group and individual levels.
- For families with very young children services which address the needs of both parents and children concurrently are likely to be successful.
- Children's Centre managers need to pay attention to training multi-agency teams to work together in new ways.
- Children's Centre managers must build on the strengths of inherited services that have a proven track record of good quality and measurable impact.

Methods: Stage 2

The second stage of the Study addressed the question: *How can we characterise and explain variations between high, medium and low levels of SSLP proficiency.*

In order to focus on the nuances of what worked and did not work in the processes of SSLP implementation, we used a case study approach. It was important to consider the socio-cultural and demographic contexts in which each case study was situated. It was unlikely that we would find a one size fits all model of proficiency.

Sixteen SSLPs were selected representing a range of community types and located in a range of *government regions*. They represented *a range of Programme Variability Scale scores (across 4 quartiles of proficiency)* and *better or worse than expected Impact outcomes.*

The researchers were blind to the ratings and outcome scores. The fieldwork was carried out to common protocols and using common schedules, but also using research diaries to enter additional evidence of proficiency. The SSLPs were then rated, without reference to earlier ratings, on the Programme Variability Rating Scale.

Findings: Stage 2

The ratings on the first and second stages were consistent. Consistent patterns of the characteristics of more or less proficient SSLPs emerged clearly. As at the first stage, findings were that SSLPs scored high, medium or low across the board.

Underpinning features of proficient programme implementation were:

- *Governance and management/leadership* (reflecting a range of stake-holders, showing sensitivity to local communities, demonstrating flexibility in responding to changes in national and local policies, managers/leaders with skills in (or buy-in) project management, budgets, human resources and IT).
- *Ethos* (demonstrating a welcoming and inclusive atmosphere, with friendly and knowledgeable staff, having buildings which are attractive and user friendly within walking distance).
- *Capacity to empower providers and users of services* (engendering mutual respect for the contribution of providers and users of services, providing high quality training for volunteers and paid staff, achieving a balance between levels and types of service providers) .

Factors that characterised proficient programmes leading to good measures of effectiveness (that is better than expected child and parent outcomes) were:

- Effective auditing of local needs in order to tune local services to community priorities.
- Identification and targeting those with specialist needs with appropriate treatments, as early as possible.
- Allocation and training of appropriate providers including the strategic deployment of generic and specialist staff to deliver effective services at point of need.
- Training and management of providers for proficient multi-agency teamwork.
- Training of managers/leaders in budget and project management skills.
- Sustaining service use and increasing reach figures (including accessing the 'hard to reach').

Implications for Children's Centres form Stage Two

- Children's Centres need to plan their programmes with reference to a wide range of performance indicators.
- They need regular and systematic self-evaluation strategies to monitor the proficiency and effectiveness of their programmes and services. Evidence of more or less proficiency in the SSLPs' histories of implementing complex menus of services for families with young children, will be useful material in planning for their own practice, identifying challenges that have been overcome and avoiding unproductive practices.
- In particular they need to ensure that there are robust structures for governance and leadership. They need to establish an ethos that is welcoming and inclusive, with friendly and knowledgeable staff. They need to focus staff on their capacity to empower providers and users of services, even when this requires staff to step outside their comfort zones.

- Features of proficiency that were linked to effectiveness include:
    - Auditing local needs in order to continually tune local services to (sometimes changing) community priorities.
    - Identifying users and targeting those with specialist needs for appropriate treatments as early as possible.
    - Recruiting, allocating, training and deploying appropriate providers to deliver services, including a firm understanding of the impact and costs of deploying generic and specialist workers
    - Managing multi-agency teamwork at service delivery levels.
    - Sustaining service use and striving to continually increase reach figures (with particular attention to accessing the 'hard to reach').

Methods: Stage 3

The third stage of the Study turned up the microscope on the characteristics of services delivered by proficient SSLPs that were being transformed into Children's Centres. The aim was *to identify good practice in services.*

Twelve Children's Centres, representing a range of community characteristics, were identified where there was a history of high proficiency ratings and evidence of better than expected child and parent outcomes from the Impact study data.

We *mapped the services* delivered during the last 12 months from the Children's Centres.

We interrogated experienced *professionals* delivering core services in the areas on *what works.*

We triangulated their perspectives with the views of a range of types of *users* of these services on *what worked for them.*

We tracked down and listened to the voices of a range of types of *non-users* of services and the so-called *'hard to reach'*.

Findings: Stage 3

The views of providers

(1) The rationale for core services

Providers of proficient services reported that they based decisions about core service provision on the audited needs of local communities and on demands from local people. Health workers put slightly more emphasis on the importance of an evidence base, while family support workers referenced intuition and statutory requirements as drivers of their decisions.

Decisions about the location of services, centre based, outreach or both, were also driven by needs and demands, but also the realities of resources (essentially spaces and staffing).

The format of services (for example whether it was a workshop, drop in or one to one session) was also driven by resources, though needs and demand were also cited. Research evidence was less important for decisions about format.

Decisions about who would deliver services were based on qualifications, especially for health providers, with family support workers indicating that matching staff to users was important.

Service Use

Providers from proficient services reported that their main users were all families, but with a range of specialist targets such as vulnerable families, teenage parents, grandparent and childminder carers, travellers, refugees and asylum seekers.

When asked why people did not use their services providers were more likely to attribute non-use of their services to weaknesses within user groups, rather than to features of their services. They gave as reasons 'user lack of confidence/motivation' as a prime factor, with unsuitable service times, cultural/religious barriers, and access as subsidiary factors.

Initial contacts with users were mainly through word of mouth, with publicity through local networks and targeted invitations (by telephone, letter or door knocking). Identifying users for treatments was through referrals from Centre staff and outside agencies, word of mouth and self-referrals.

Sustaining attendance was achieved by follow up telephone calls, letters or house-calls and by providing incentives. Key contributory factors in maintaining service use were quality of staff, regularity of service, availability of childcare, format of service, venue and timing.

Outreach

Providers of proficient services reported that outreach was pivotal to proficiency in service delivery, but needed to be balanced with group activities in centres. It was important to understand and justify the fitness for purpose and real cost benefits of home-based versus centre-based service delivery. It was important that staff delivering through outreach work and centre-based staff were working towards the same goals and giving consistent messages.

Users were mostly identified for outreach through referrals from outside agencies and centre staff, self-referrals and word of mouth. Outreach was mostly delivered by centre staff with some support from para-professionals (such as generic family workers), community workers and volunteers. The supervision of case workers was usually monthly or six weekly, but cases were reviewed frequently or when necessary on a needs basis.

The views of users

105 core service users reported in focus or paired group discussions on what makes services work for them.

For parents of young children, often facing difficult domestic and economic circumstances, Children's Centre services helped them get through the day by getting

them out of the house and enabling them to meet with like-minded parents in a safe and comfortable place within walking distance of home. They also benefited from the quality of staff and having access to education and training. They appreciated having emotional support and help with practical problems.

They saw as benefits of the services for their children giving them opportunities to play and helping them to socialise, as well as enhancing their development. They appreciated crèche respite or care for the child's benefit, claiming it improved their parent/child relationships. Parents of children with additional/specialist needs were grateful for the support given by Children's Centre services and staff.

The views of non-users

Non users of services, including particularly vulnerable groups, (such as travellers, asylum seekers, those involved in domestic violence, those involved in substance abuse) were asked in semi-structured one to one interviews why they did not use services. They reported as barriers:

- Fathers' perceptions that centres were a women's place.
- Few services offered outside school hours (i.e. mainly between 10 and 3) for working parents.
- Language and cultural barriers for Black and Minority Ethnic groups.
- Feeling that cliques dominated the group services.
- Associations with the stigma of a service for families in need.
- Lack of confidence in meeting strangers, entering new spaces.
- Unwillingness to be patronised.
- Concern about discussing intimate problems in public spaces.
- Already having a network of family/friendship support.

Implications for Children's Centres from Stage 3

- Children's Centre managers and practitioners can learn from models of proficient services inherited from Sure Start Local Programmes.
- The uptake of services is dependent on tuning into local needs and preferences.
- Information about universal services needs to be embedded routinely in health visitor and midwife protocols for home visiting all newborns and advertised for parents of children under school age in local GP surgeries, post offices, community centres and shops.
- Specialist services need to be targeted at point of need and monitored for impact by paper or electronic based systems for multi-agency team members to exchange information on a regular basis.

- There needs to be cohesion between principles and practice in centre-based and outreach services.
- Reach figures, particularly for the so-called hard to reach, were disappointing in many SSLPs.
- Barriers were specific to groups - for example fathers or working parents - or based on practicalities such as the attitudes of staff to changing their own traditional ways of working, location, timing and format of centre and satellite building based services. Children's Centres need to address these barriers to non-use.

Conclusions

Children's Centres must take a holistic approach to planning and delivering their services. The original vision of Sure Start is vindicated by the finding that high scores in the measures of proficiency that were based on the principles set out in the Guidance for SSLPs, were associated with small, but significant, better than expected parent and child outcomes. It is important to recognise that though we did identify some links between specific dimensions and impact outcomes, much more important is that they were all inter-related.

There are practical lessons to be learned from the way more proficient SSLPs confronted the challenges of implementing a complex model of early intervention:

- The levels of demand were high on managers in expanding staffing, project managing new buildings, negotiating funding arrangements with agencies and consulting local stakeholders.
- Staff were expected to adopt new ways of working, often moving from site to site, learning how to function in multi-agency teams, all at a rapid pace.

It is not surprising that some challenges were not met, and Children's Centres can learn from what did not work in SSLPs. In particular the issues of improving reach, accessing the hard to reach within communities and multi-agency teamwork will need to be confronted in Children's Centres. There is a challenging training agenda for children's services directorates associated with these problems.

There is much to be done in creative thinking about service delivery in disadvantaged areas. Some practitioners are inclined to stay within the comfort zones of traditional practices. Those who use their services tend to be enthusiastic about their benefits, and often return for several services each week, but many remain outside the loop of service provision. Those who did not use services were articulate about the barriers for them, and professionals will need support in finding solutions to overcome them.

There is also much to be learned about monitoring service treatments and measuring their impact. Much of the current evaluation of service impact is narrowly focused on user satisfaction surveys and anecdotal evidence. Children's Centres need support in designing user-friendly systems for tracking the use of groups and individuals of services and measuring progression and recording evidence of impact. This would need to be embedded in the self-evaluation systems Children's Centres are required to operate.

CHAPTER 1. INTRODUCTION

1.1 The rationale for the Programme Variability Study

1.1.1 In 2005 the National Evaluation of Sure Start (NESS) Impact Study Team reported on their initial findings from a cross-sectional study of the impact of Sure Start Local Programmes (SSLPs) on child and parent outcomes (NESS Research Team 2005a). The sample of SSLPs included the 150 SSLP areas featured in the Impact longitudinal study and 50 (Sure Start-To-Be) comparison areas. The comparison areas were similar areas of disadvantage and social exclusion, designated to have SSLPs at a later date, but where SSLP services and facilities for the families had not yet been established.

1.1.2 Extensive data on child, family and area characteristics were collected to ensure comparability between the groups in SSLP and comparison areas. Evidence based on extensive home-based interviews with parents and observations of 9-month-olds and 3-year-olds was used. Measures included parental report, observations in the home and developmental assessments of the children.

1.1.3 The Impact Study analyses revealed that overall effects in the cross-sectional study of children and parents living in SSLP areas, where treatments had been delivered for three years, appeared to be small. However, SSLPs had taken longer to become established than expected and previous research evidence from the USA indicated that there is likely to be a delay between early interventions and the detection of their effects (Love et al 2002).

1.1.4 Effects that were detected related mainly to family functioning. The homes of mothers of 9-month-olds were scored as showing less evidence of household chaos. Mothers of 3-year-olds showed more acceptance of their children's behaviour. For example, less scolding, slapping or physical restraint was observed in their interactions with the 3-year-olds. Non-teen mothers of 3-year-olds (86% of sample) showed fewer signs of negative parenting.

1.1.5 One message was that relatively less disadvantaged families, (homes where at least one adult was in work, not lone single parents, or teenage parents) appeared to be gaining more from the SSLP intervention. For example, 3-year-old SSLP area children of teenage parents scored lower on verbal ability and social competence and showed more behaviour problems than those in the comparison (Sure Start-to-be) areas.

1.1.6 However, another key message was that some of the SSLPs were doing better than others in impacting on child, parent and family functioning. The Programme Variability Study was set up in 2004 to pursue evidence of what made SSLPs more or less effective. This is the final report on two years research by the Programme Variability team.

1.1.7 In this report we make a distinction between the *effectiveness* of SSLPs (as measured by their scores on the Impact Study child and parenting measures) and the *proficiency* of SSLPs (as measured by their scores on the Programme Variability Rating Scale).

1.2 Sure Start Local Programmes

1.2.1 The first Sure Start Local Programmes (SSLPs) were set up in 1999 as localised, comprehensive, community based projects targeting the most disadvantaged communities in England. By 2004 there were 524 SSLPs. Whole communities were targeted, rather than vulnerable children and families, to avoid the stigma associated with identifying and treating families deemed 'to be at risk'. The intervention was designed to improve the well being, attainments and life trajectories of all children aged 0-4 years old in the SSLP areas and to support their families (Glass 1999). It was designed as an universal intervention. However there was an expectation that within universal services, screening would enable the early detection of health, developmental, well-being and domestic problems and targeting of specialist treatments for those who would benefit.

1.2.2 The SSLPs had four key objectives:

- Improving social and emotional development.
- Improving health.
- Improving children's ability to learn.
- Strengthening families and communities.

1.2.3 SSLPs were charged with providing a raft of services within pram pushing distance of local parents to achieve these four objectives.

1.2.4 The objectives were underpinned by key principles which were to:

- Co-ordinate, streamline and add value to existing services in the SSLP areas, including sign posting to existing services.
- Involve parents.
- Avoid stigma.
- Ensure lasting support by linking effectively with services for older children.
- Be culturally appropriate and sensitive to particular needs.
- Be designed to achieve specific objectives related to the overall SSLP intervention.
- Promote the participation of all local families in the design and working of the programme.

1.2.5 SSLPs were required to offer five core services:

- Outreach and home visiting.
- Support for families and parents.
- Good quality play, early learning and childcare.
- Primary and community health care and advice about child and family health.
- Support for children and their families with special needs or disabilities.

1.2.6 Local partnerships, including representation from health, education, social services, the voluntary and private sectors, and parents were to be set up to manage the SSLPs. But there was no specification as to how the services would be implemented. Consequently, there was great diversity in how each of the 524 SSLPs implemented the Sure Start vision in the design of their programmes and delivery of their services.

1.2.7 However, the Department for Education and Skills (DfES) Guidance for the implementation of the programmes was based on evidence of what had worked in

previous early intervention programmes. The Sure Start Unit published guidelines each year from 1998 to 2002 updating these key principles.

1.3 Research Evidence of Early Intervention Programme and Service Effectiveness

1.3.1 Sure Start was presented as an evidence-based initiative (Glass 1999). In this section of the report we summarise research evidence that underpinned the design and guidelines for the ambitious Sure Start Local Programme intervention. It is against these generic findings on effectiveness of early interventions and related services that we must consider the variations in the ways SSLPs interpreted and implemented their programmes, with more or less proficiency, in their local contexts. We summarise reviews of literature from selected NESS Themed Studies done over the period of the NESS evaluation, because these are of particular relevance to our research questions. We also refer to earlier evidence of variations in SSLPs from the NESS Implementation Reports (Tunstill et al 2005).

1.3.2 The Effectiveness of Early Intervention Programmes

Ramey and Ramey (1998) reported on key principles from research into what works in promoting child development through early intervention programmes. Principles of what works were:

- Early interventions are sustained over time.
- Intensive treatments with regular participation by users.
- Educational experiences for children are direct (rather than mediated through parent training only).

1.3.3 Findings were that effective programmes:

- Deliver multiple routes (for example a combination of home and centre based services, and generalist and specialist treatments) to enhance development rather than having a narrow focus.
- Children benefit differently from treatments in relation to their initial risk conditions.
- Initial positive effects of interventions diminish without adequate environmental (family and community) support.

1.3.4 Love et al. (2002) identified key messages from the positive impact of Early Head Start in the USA on infants, toddlers and their families. Findings were:

- Fully implementing the Head Start Programme Performance Standards resulted in stronger patterns of impact on children and parenting.
- Centre based programmes enhanced children's cognitive ability and by the age of 3 reduced negative aspects of social emotional behaviours.
- Home based programmes contributed to enhanced language development at 2 (but not at 3) and the quality of parent/child play interactions.
- A mixture of centre and home based programmes produced stronger impacts.
- Enrolling parents on programmes before their children were born was more likely to engage them in services.
- There was less impact on the highest risk families with young children.

1.3.5 Service Effectiveness

Evidence for 'what works' in the core services of family support, early learning, play and childcare, support for families with children with Special Educational Needs and disabilities and maternity services were reported in NESS Themed Studies. Key findings are summarised below.

1.3.6 Family Support and Parenting Programmes

Barlow (2006) reported on key issues and evidence of what works in Family Support and Parenting. Parenting is a mediator of the effect of socio-economic deprivation in childhood on outcomes in later life (Conger et al. 1992; Zaslow et al. 1989). Her synthesis of research evidence of links between parenting and family functioning showed relationships with:

- Educational achievement/school dropout (Desforges 2003).
- Behaviour problems, delinquency, criminality and violence (Patterson et al. 1989; Farrington 2003).
- Teenage pregnancy (Scaramella 1998).
- Drug and alcohol misuse (Egeland et al. 1993).
- Mental and physical health (Stewart -Brown Shaw 2004).

1.3.7 Barlow cites Moran et al (2004: 11) in summarising key messages from research about what works in family support and parenting programmes as:

- A robust theory base.
- A clearly articulated model of the predicted mechanism of change.
- The use of manualised programmes that are structured to ensure that their delivery remains consistent.
- Clear, measurable and achievable objectives.
- Delivery by appropriately trained professionals.
- Good management and support.

A NESS themed study on parenting programmes is in press. The authors found that few SSLPs used manualised programmes for parenting/family support services. In fact the model, as characterised by bullet points 3 and 4, runs counter to the ethos of flexibility and responsiveness to clients which was integral to the Sure Start vision.

1.3.8 Maternity Services

Kurtz et al. (2005) reported on evidence of what works in maternity services. She identified that the mother's circumstances, health and choices determine the main risk factors to the life chances of a child during and after pregnancy. Babies of women living in poverty, without partners or as teenagers are more likely to be born with a birth weight lower than 2500 grams, before term, with congenital abnormalities, stillborn or die in their first year. Apart from poverty, ethnicity and age, the main risk factors are life style behaviours and circumstances of the mother including smoking, poor diet, substance abuse, mental health problems, domestic violence and lack of social support. Breast-feeding is associated with better outcomes.

1.3.9 D'Souza (2003) reported on what works in services for disadvantaged women in the prenatal period. Olds et al (1997) reported on the impact of home visiting on maternal life course and child abuse and neglect. Curtis et al (2003) reported that the delivery of proficient services in the UK is threatened by ongoing shortages of midwives and health visitors.

1.3.10 The common elements of interventions that maximised women's engagement with services, empowered them to seek appropriate help and enabled them to take greater responsibility for their own health and that of their families are listed below:

- Antenatal identification of women and mothers and babies at risk of poor outcomes.
- Strategic signposting of women at risk to appropriate specialist services.
- Building a trusting relationship between service providers and users.
- Offering continuity of professional carer, providing sustained and where necessary intensive support.
- Empowering women to be self-motivated and pro-active in changing their behaviours and maintaining healthy life styles.
- Timely services delivered by multi-agency teams with the capacity to address multi-faceted family needs.

1.3.11 Early Learning and Childcare

Anning et. al. (2005) reported on evidence of effectiveness in pre-school and childcare services.

1.3.12 Early Learning

The Effective Provision of Pre-School Education (EPPE) Project has been influential in providing evidence of effectiveness. It reports that all children in the study who attended some kind of pre-school (even if it was part time), but particularly those from a disadvantaged context, demonstrated better cognitive and social competence outcomes when they started school (Sylva et al 2003).

1.3.13 High quality pre-school provision was characterised by an approach to pedagogy that promotes:

- Episodes of adult/child 'shared sustained thinking', open ended questioning and formative feedback to children involved in learning episodes.
- Employment of practitioners who have a clear grasp of child development and knowledge of the curriculum.
- Practitioners who share the aims for children's learning with their parents.
- Transparent behaviour policies and practices.
- Play activities where adults are engaged as play partners and where practitioners tune into and accommodate the knowledge and culture of the parents (Siraj-Blatchford 2004).

1.3.14 In the EPPE study the group settings most likely to provide high quality pre-school provision, and to promote better outcomes for children, were Integrated Care and Education settings and Nursery Schools. But the small sample on integrated

settings included some very well resourced Centres of Excellence set up by the government to model good practice.

However, equally important for promoting good outcomes for the children was the learning environment of the home. Where parents engaged in learning activities with their children, regardless of parents' social class or level of education, children's social and cognitive attainments were enhanced.

1.3.15 Special Educational Needs and Disabilities

The particular challenges of working with children and families with special educational needs or disabilities were explored in the Themed Study, *A Better Start* (Pinney 2006).

1.3.16 Key findings were:

- Family support plays a critical role in overcoming barriers to access to specialist services and supporting families at times of crisis.
- It is important to target and offer specialist services (such as Speech and Language Therapy and Occupational Therapy) on a preventative basis.
- Routine procedures and protocols should be in place for including children with diverse needs in early learning, play and childcare services within their communities.

1.3.17 In a parallel project to the EPPE study Sammons et al (2003) investigated good practice in provision for children with diverse needs. They argued that there need to be stringent systems in place to identify, respond to and provide appropriate support/treatment for children with Special Educational Needs or Disabilities, in particular at points of transition from one setting to another and at transfer to school.

1.3.18 Childcare

Melhuish (2004) cited research evidence that where children attend high quality childcare, they demonstrate enhanced social and cognitive effects. Belsky (1999) argued that where children experience poor quality day-care, characterised by emotionally detached caring, of more than 12 hours a week (particularly where they are living in poverty or in disadvantaged home settings) they are likely to display aggressive behaviours and less social competence when they start school. One of the greatest challenges is settling children into group settings (Holmes 1993). Elfer et al. (2003) argue that young children have the right to bond with a key worker within the resources and structures of a well-managed system of daycare.

1.3.19 Melhuish (2004) summarises the characteristics of good quality childcare as:

- Well trained staff committed to their work with children.
- Facilities that are safe and sanitary and accessible to parents.
- Ratios and group sizes that allow staff to interact appropriately with children.
- Supervision that maintains consistency.
- Staff development that ensures continuity, stability and improving quality.
- Provision of appropriate learning opportunities for children.

1.4 The National Evaluation of Sure Start: Programme Variability Study

1.4.1 The diversity of models of SSLPs posed challenges for the National Evaluation of Sure Start (NESS) evaluation of the processes of SSLP implementation (that is their proficiency) and their relationship to outcomes (that is their effectiveness). Full details of the NESS methodology can be found at www.ness.bbk.ac.uk.

1.4.2 The implementation module team reported in Tunstill et al (2005) on the first four years of the processes operated by 260 SSLPs (Rounds 1-4). They used a national survey applied annually over a three year period. The survey was followed up with a set of case studies of 10% of the SSLPs. A cost effectiveness study is also in process (Meadows 2005).Themed studies were commissioned on particular issues (for example Special Educational Needs, Maternity Services and Employability of Parents). These reports are located at www.ness.bbk.ac.uk.

1.4.3 At the same time a Local Context Analysis (LCA) study charted changes over time at a community level in each SSLP area, as well as across all Rounds 1-4 SSLPs, on a number of indicators. The indicators include measures of poverty and worklessness, child health, child welfare, school achievement, childcare and health services, and community disorder (Barnes et al 2006). Five types of SSLP communities were identified: Less deprived (21%), Typical (34%), More deprived (11%), Ethnically diverse (23%) and Indian subcontinent (11%).

1.4.4 One hundred and fifty SSLPs were selected as representative of the 260 surveyed by the impact team for a NESS *longitudinal study* of the effectiveness of the Sure Start intervention. The Impact study reported on the results of the analysis of aggregated data from *the cross sectional phase* of their research on child and family functioning in 2005. Overall few effects of living in SSLP areas were detected. However, we would expect effects to be slow to be detected in an early intervention programme of this kind. Moreover the Implementation Study reported evidence that the SSLPs took longer than anticipated to get their services/treatments up and running. The longitudinal study is still in process and will report again in 2008.

1.4.5 However, there was substantial *variation* in the degree to which SSLPs appeared to be more or less effective. There were indications too that programmes where the lead agency was a health authority were gaining better outcomes for children and parents. These indications of differential effectiveness in SSLPs led to setting up the within group analysis of the Programme Variability (PV) study. The study focused on the 150 SSLP areas in the NESS longitudinal study.

14.6 The PV study was designed in three stages. The key research questions were:

Stage 1: Why are some SSLPs more effective in achieving outcomes than others?

Stage 2: How can we characterise and explain variations between high, medium and low levels of proficiency in SSLPs?

Stage 3: How can we characterise and exemplify proficiency, and potential effectiveness, in services for families and young children as exemplified in SSLPs as they were transformed into Sure Start Children's Centres (SSCCs)?

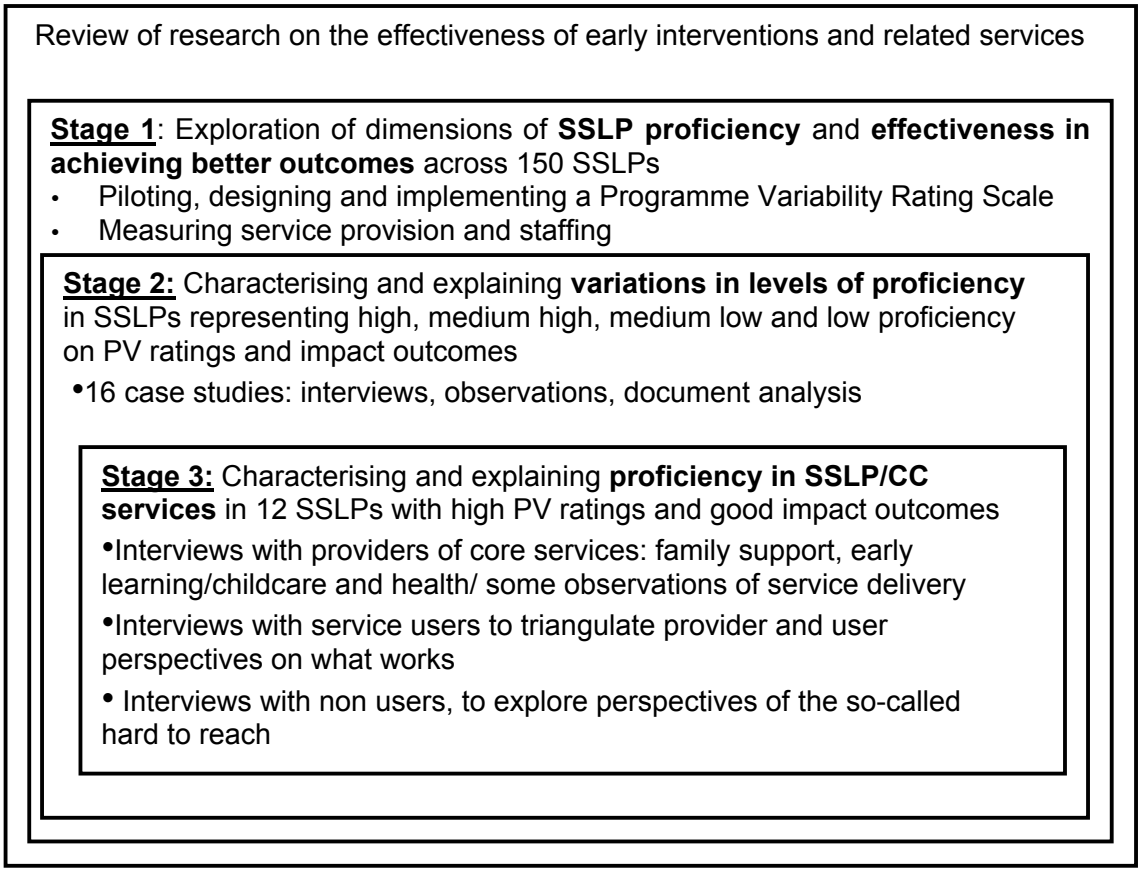
CHAPTER 2. METHODOLOGY

2.1 Research Design

There were three parts to the conceptual framework of the research design as outlined in Figure 2.1. Each stage addressed one of the three key research questions detailed at the end of Chapter 1.

1. *Why are some SSLPs more effective in achieving outcomes than others?*
2. *How can we characterise and explain variations between high, medium and low levels of proficiency in SSLPs?*
3. *How can we characterise and exemplify proficiency and potential effectiveness in services for families and young children as exemplified in SSLPs as they were transformed into Sure Start Children's Centres (SSCCs)?*

Figure 2.1 Progressive focusing framework: the three stages of the Programme Variability Study



The time line for the three stages was:
Stage 1 September 2004 - August 2005
Stage 2 September 2005 - June 2006
Stage 3 July 2006 - November 2006

2.2 STAGE 1: Exploring 150 SSLPs' variations in dimensions of proficiency

2.2.1 It is always a challenge in evaluations of large-scale intervention programmes to test hypotheses about how the degree of its implementation relates to measurable outcomes. The exploration of interventions that are clearly defined, manualised, prescribed and implemented to common procedures is less problematic. But the SSLPs had no common models for ways of working. They were assigned funding directly from Treasury and charged with achieving common aims by the best means possible. Ways of operating SSLPs were determined by local partnerships/boards representing key agencies and the local community interests. SSLP partnerships, managers and their staff were free to interpret the guidance notes from the government in different ways. Thus the NESS team were faced with producing measures (quantitative) of the processes (qualitative) of implementing a diverse range of SSLPs. The challenge had no precedent in evaluations of UK based interventions and required innovative methods.

2.2.2 We argued that the common ground to all SSLPs was that they were interpreting (albeit in a variety of ways) the research evidence base that underpinned the design of the Sure Start intervention (Glass 1999) and the SSLP Guidance documents (Sure Start Unit 1998, 1999, 2000, 2001, 2002). This common ground of key constructs formed the conceptual basis for designing methods to measure variations in the implementation of the Sure Start vision within the 150 SSLPs.

2.2.3 Collecting and collating common data sets across 150 SSLPs

The NESS and the Sure Start Unit data on the 150 programmes were comprehensive. Data included the Implementation Module annual national survey responses, SSLP delivery plans, local evaluation reports, documentation from programmes describing their vision, their organisation/management structures and their publicity materials and Sure Start Unit monitoring data on reach and spend. Some programmes had been sites for Implementation case studies or themed studies and for these SSLPs data were even more substantial. Much of this information was already stored in NESS programme files.

2.2.4 Where relevant, data were supplemented by phone call surveys to programme administrators/managers to fill any gaps (for example in national survey responses or publicity material). In addition phone calls were made to regional Sure Start Programme Development Officers, Chairs of SSLP partnership boards, Local Authority early years officers and NESS regional support staff who were familiar with the programmes through regular visits to offer support for local evaluations. Full details of the relevant instruments and protocols are published in *Variation in Sure Start Local Programme Effectiveness: Early Preliminary Findings* (NESS 2005b).

2.2.5 The challenge was to synthesise all the data into a common template and to design a method of rating all 150 programmes for their proficiency and potential effectiveness. A team of researchers was trained to collate and enter the data on a template reflecting the conceptual framework of the Programme Variability Rating Scale.

2.2.6 Applying the Programme Variability Rating Scale

Building on a pilot study, the team designed a Programme Variability Rating Scale (PVRS) with 18 dimensions of implementation each including 7 levels of proficiency. (see Appendix A). The ratings of programmes, based on the common data sets for 150 SSLPs, were done by two experts, who were blind to the Impact outcomes.

2.2.7 A higher rating(relative to other SSLPs), indicated more proficiency in that domain. A statement of proficiency illustrates each dimension (see below).

1. **Vision:**
   SSLP has a well-articulated vision that is relevant to the community.
2. **Partnership: composition:**
   SSLP Partnership Board includes a balanced representation of organisations, education, social services, local NHS, voluntary and community organisations and local parents.
3. **Partnership: functioning**:
   The Partnership is functional (operates across agencies, resolves conflicts, includes all stakeholders in decisions) to a high degree.
4. **Empowerment:**
   SSLP tries to create an environment empowering users and staff.
5. **Communications**:
   Communications reflect and respect the characteristics and languages of communities.
6. **Leadership**:
   SSLP has effective leadership/management.
7. **Multi-agency working:**
   Multi-agency teamwork is well established in the SSLP.
8. **Service access**:
   There are clear pathways for users in accessing specialist services.
9. **Staff turnover:**
   Staff turnover is low.
10. **Evaluation use:**
    SSLP takes account of, and acts upon, the evaluation findings.
11. **Identifying users:**
    SSLP has strategies for identifying users.
12. **Reach:**
    SSLP is showing a realistic and improving reach to children. (In real terms this was 26% or more of families with children under 4 in the SSLP area).
13. **Reach: improvement:**
    SSLP has strategies to improve and sustain use of services over time.
14. **Service: quantity**
    Service delivery reflects the guidance requirements for the provision of core services in support, health, play, early learning and childcare.
15. **Service: delivery**
    Services reflects a balance between children, family and community.
16. **Service: innovation:**
    SSLP shows innovative features in service delivery.
17. **Service: flexibility:**
    Services accommodate the needs/preferences of a wide range of users.
18. **Ethos**:
    Overall the SSLP has a welcoming and inclusive ethos.

2.2.8 For each dimension level statements from 1 (Inadequate) to 7 (Excellent) were designed. Figure 2.2 below indicates the full range of ratings.

Table 2.1: Ratings for the Programme Variability Rating Scale

1	2	3	4	5	6	7
Inadequate		**Minimal**	**Satisfactory**	**Good**		**Excellent**

In Appendix B there are full details of how the rating system operated. Full details of inter-rater reliability are given in NESS *Report 014, Variation in SSLPs Effectiveness: Early Preliminary Findings* (NESS 2005b). Reliability was good with levels of agreement within 1 point being from 77% to 98% with a mean of 87%. The intra-class correlation (i.e. the weighted Kappa statistic) ranged from 0.55 to 0.97 with a mean of 0.77.

2.3 Measuring 150 SSLPs' service provision and staffing

2.3.1 A second enquiry was to explore the **number and types of services** offered by the 150 SSLPs. Information on the number of services offered by each of the 150 SSLPs was extracted from responses to the national surveys of SSLPs carried out by the Implementation team. Where necessary, missing data were collected by telephone interviews.

2.3.2 The services were categorised as:

- Family focused services: targeted at the whole family.
- Individual parent focused services: targeted to support parents.
- Child focused: targeted at children alone.
- Community focused: services with a wider remit such as GP surgeries and leisure facilities.

2.3.3 The framework used to **classify the services** into these four categories is shown in Appendix C.

2.3.4 Each service was also categorised **as inherited, improved or newly set up** by SSLPs.

2.3.5 Data were collected on the **number/proportion of staff** who delivered:

- Outreach activities.
- Family support.
- Health services.
- Early learning, play and childcare.

2.4 Data Analysis at Stage 1

2.4.1 Data analysis at Stage 1 focused on why some SSLPs in the sample of 150 were more proficient in the processes of implementation and more effective than others in achieving outcomes. There were three stages to data analysis.

2.4.2 The data were first analysed to test the predictive power overall of the 18 dimensions of proficiency ratings to differentiate between effective (in relation to child and parent outcomes) and ineffective SSLPs.

2.4.3 Next the relationship between specific dimension ratings and specific measures of child and parent outcomes at 9 months and 3-years-old was explored.

2.4.4 Technical details of the analysis are on pages 17-21 of *Variation in Sure Start Local Programme Effectiveness: Early Preliminary Findings* (NESS 2005b).

2.4.5 Four (the number of child, parent, family and community focused services) x three (the number of inherited, improved and new services) = twelve service variables were analysed in relation to outcomes for children at 9 months and 3-years-old and their parents. An example of a child focused service is childcare or early learning activities. An example of a parent focused service is pre and post natal care, nutrition advice or parenting programmes. An example of a family focused service is outreach services to support family functioning or leisure activities within sports centres or libraries. Inherited services refer to those predating the SSLPs. Improved services are those reported in the Implementation Module Survey returns as improved by SSLPs. New refers to services introduced by the SSLPs. (NESS, 2005b, p.21-23)

2.4.6 The relationship between staffing variables (the number of full time equivalent staff employed in outreach, family support, health and early learning, play and childcare activities) and child and parent outcomes was explored. (NESS 2005b p.23)

2.4.7 Finally the ratings, services and staffing data were considered together. The service variables were all related to each other (NESS, 2005b, p.24-25).

2.5 STAGE 2: 16 case studies to characterise and explain levels of variation in effectiveness

2.5.1 Sampling the 16 case study sites

By the end of Stage 1 of the Programme Variability Study we had gained broad-brush insights into why, within the sample of 150 SSLPs of the NESS longitudinal study, some SSLPs were achieving better or worse outcomes than others.

2.5.2 We now needed to turn up the microscope to enquire into the nuances of proficiency. At Stage 2 our focus was on the implementation of the SSLPs and features of how their service provision were planned, delivered and evaluated in order to attain better or worse impact on the children, parents and families.

2.5.3 Sixteen case studies were selected. They represented a range of proficiency identified at Stage 1: four within each quartile rated as high, medium high, medium low, low on their overall ratings on the Programme Variability Study Rating Scale. The case studies reflected a range of demographic and geographical contexts, drawing on the Local Context Analysis typology of SSLPs.

2.5.4 Findings from Stage 1 of the PV Study were that SSLPs scored consistently high, medium or low across the 18 dimensions. Core assumptions to be tested by analysing the more detailed data to be collected for the 16 case studies were:

Where SSLPs were rated high across the 18 dimensions, they would also be delivering proficient services, which in turn might contribute to their effectiveness in attaining better than expected child and parent outcomes.

2.5.5 It was also important to investigate what it was that SSLPs rated as not proficient, and achieving worse than expected outcomes, were *not* doing in delivering services. Moreover only looking at high and low levels of proficiency and effectiveness gives a distorted view of evidence of variations in programmes and their services. It was important therefore to investigate the strengths and weaknesses of the implementation of services of the 50% that fell within the two medium quartiles.

Table 2.2 Sampling frame for 16 case studies

Programme Variability ratings of proficiency	Effectiveness for child/parent impact outcomes		
	High	Medium	Low
High	4 cases		
Medium		8 cases (5 medium high and high and 3 medium low)	
Low			4 cases

2.5.6 Data collection and management

Design of the schedules and processes for data collection at each of the sixteen case study sites focused on the *what, how and why* of service delivery at different levels of proficiency. At Stage 1 SSLPs had scored consistently high, medium or low across all 18 dimensions. Our findings indicated that the contextual features of their organisation and management underpinned the proficiency of their services. They were also influenced by the overall approach of the SSLP to interpreting the Sure Start vision. Therefore all 18 dimensions of proficiency were explored for the 16 case studies.

2.5.7 The design of the instruments was based on the conceptual framework underpinning the dimensions and ratings of proficiency in the Programme Variability Study Rating Scale. **An important principle of the research design at Stage 2 was that the principal researcher and fieldworkers remained 'blind' to both the PV ratings and the Impact outcomes for the SSLPs they were studying**. They therefore operated without any potential bias in the lens that they applied to data collection and analysis.

2.5.8 Fieldwork at each site took 5 days, with some service delivery observed at each SSLP. In Appendix D there is an exemplary schedule.

2.5.9 As well as using pre-determined schedules and instruments to collect and collate data, the experienced fieldworkers kept research journals. The journals were used to note additional evidence, and insights gained from analysis of that evidence, to ensure that the study maintained a flexible and open approach to refining our understanding of proficiency and potential effectiveness at programme and service levels. The team met regularly to discuss emergent themes.

2.5.10 Finally we explored documentary evidence of the range of services delivered by the SSLPs and, where available, indicators of their quality from Ofsted and local authority systems of quality assurance and from in-house or external evaluation reports.

2.5.11 Each of the 16 case studies was rated on the rich data collected on the 18 dimensions of proficiency using the 7 point scales of the Programme Variability Study Rating Scale. The principal researcher rated the Stage 2 Case Studies. She was one of the two expert assessors for all 150 SSLPs in the Impact Study at Stage 1 of the Programme Variability Study. However, the ratings for the 16 SSLPs were done independently of and blind to those done at Stage 1. Our findings were that it was unusual for Stage 1 and 2 dimension ratings to diverge by more than two levels.

2.5.12 The possibility or repeat assessor effect must be acknowledged here. However, the Stage 1 rating of 150 SSLPs was shared between two experts. There was thus a 50% chance of the Stage 2 assessor rating the same programme twice. Indeed when this replication occurred the possibility of her remembering the detail of 18 dimension ratings across 75 programmes was unlikely.

2.5.13 Data analysis at Stage 2

Data management and analysis were to a common framework across the fieldworkers with procedures for data analysis, synthesis and writing up to an agreed format.

2.5.14 Data analysis focused on the characteristics of SSLPs rated as high, medium or low levels of proficiency (on Programme Variability measures) and effectiveness (better or worse than expected child and parent Impact outcomes) and the potential effectiveness of their services.

2.6 STAGE 3: Effectiveness in services in SSLPs and emergent Sure Start Children's Centres

2.6.1 At the third and final stage of the Programme Variability Study the microscope was turned up even more closely on characteristics of more or less proficient *services*. The focus was on evidence of service intention, content, mode of delivery, frequency, usage and impact.

2.6.2 It was, therefore, a priority to access the *views of users and non-users* of the services. An intervention can only ever be as effective as the number of users it attracts and retains on its programmes and services and the NESS evaluation needed to access their voices.

2.6.3 The Sample

Many of the 150 SSLPs that scored high on dimensions of programme proficiency and demonstrated better than expected effectiveness on child and parent outcomes in the first stage of the Programme Variability study were selected by local authorities and regional directors of children's services as the basis for developing the first round of Children's Centres.

2.6.4 Twelve of these SSLPs/CCs were selected. The 12 sites were representative of community and programme types and geographical locations across the regions. We included in the sample 3 sites from the 16 Stage 2 PV Case Studies where we already had evidence of good models of service design, delivery and monitoring. We therefore built on empirical findings on programme and service proficiency from all previous work in the Programme Variability Study as well as the Implementation and Impact modules.

2.6.5 The perspectives of providers, users and non-users

2.6.5 The perspectives were investigated of providers, users and non-users on what services worked and what did not work[*] in Sure Start Local Programmes (SSLPs) where Children's Centres (CCs) were developing.

[*] The phrase 'what works' has been common parlance in government policy. In this report the phrase is used as shorthand for the proficiency and effectiveness of programmes and services. Implicit in the way we use it is the notion of relativism. That is programmes and services were successful in different ways, in different contexts, for different groups of people at different points in the history of their communities and service provision.

2.6.6 *Service providers'* views were sought on:

- Perceived needs of different types of users (preventative versus remedial).
- Appropriate ranges of services offered and taken up (universality versus targeting).
- Frequency of availability and appropriate dosage for different types of users.
- The rationale (including cost effectiveness) underpinning decisions to offer services in group settings or through outreach.
- Hard evidence (rather than anecdotes) of the impact of service treatments on users.

2.6.7 Administrators in the setting were asked to demonstrate protocols and systems used for:

- Recording, monitoring and analysing *trends in the take-up of services.*
- Tracking the *use individuals and families have made of services* over time.

2.6.8 The views of providers of 'what works' in services were triangulated with the views of *users of the same services*. Users were asked to describe the characteristics of services that they had experienced as positively enhancing their children's or their own development, health and well-being.

2.6.9 The reasons *why non-users had rejected services* as not appropriate, useful or enjoyable for them or their families were also explored. We identified non-users from *so-called 'hard to reach' groups* to gain views of why they have not attended services and what might have encouraged them to access services designed to help and support them. Hard to reach groups included young, lone parents; fathers; families with no adult in employment; those with drug and alcohol abuse problems; asylum and refugee families; and Black and Ethnic Minority (BME) groups.

2.6.10 Key questions at Stage 3 were:

2.6.11 *For providers of services*

1. What were the views of key providers on *what* services should be available?

2. What were their views on *how* services should be delivered to best effect?

2.6.12 *For users of services*

1. *What* types of services had parents/carers used over the last 12 months?

2. *How useful* were they to them/their children?

2.6.13 *For non users of services*

1. Which services had they chosen *not to use* in the last 12 months and why?

2. What alternative services/modes of delivery *would they have found useful and why*?

2.6.14 We also searched for models of effective systems and structures for recording and monitoring the *impact of service usage* on individual children and their families**.**

2.6.15 Mapping the what of service provision

A list of services was compiled drawing on responses to the Implementation Survey questions about services, and on returns from Stage 2 of the Programme Variability Study about what services were currently being delivered by the 16 case study SSLPs. The services were categorised under the headings: Support related, Health related and Early Learning, Play and Childcare related services. (Appendix F)

2.6.17 Managers or administrators in the 12 CCs were sent the list and asked to indicate which of the services listed they had delivered in the last twelve months. Some returns were made in telephone interviews, some by post and some by fieldworkers working with respondents.

2.6.17 Effective services: The perspectives of service providers on what works

An interview schedule was designed for key providers of health, pre-school and family support services. These members of staff were the most knowledgeable and experienced professionals in the field as Children's Centre services were being set up. Providers were offered the choice of face to face or telephone interviews. Fieldworkers on site used a version of the schedule and responses were tape recorded as an aide memoir for data management and analysis. A second version was designed for telephone interviews with schedules/prompts sent out to professionals in advance. Both schedules were designed to enable researchers to annotate and code responses in order to facilitate analysis using SPSS software. An example of the schedule is in Appendix G.

2.6.18 Effective services: Tracking the dosage of individual service users

Children's Centre administrators were asked if they were able to demonstrate the system by which the dosage/usage of a list of individual children/families over the previous 12 months could be tracked. The intention was to pilot ways of identifying and describing examples of effective systems for measuring dosage of treatments.

2.6.19 Effective services: investigating the views of users on what benefited them

It was important to triangulate the views of providers of services with those of their users. We wanted to access as wide a range of user types as possible, not just regular attendees.

2.6.20 The providers of three core services (in health: early learning/play/childcare; and family support) we interviewed were asked to identify users of these services on the continuum of *autonomous* (confident enough to access services), *facilitated* (needing some support and encouragement) and *conditional* (needing additional, perhaps specialist support) types (See Tunstill et al 2005 for a full explanation of these user types set out by the Implementation Team: 147-8).

2.6.21 In the same report the Implementation Team also listed a five point continuum of service activity for users: initial contact, introduction to the service, autonomous take-up of one service, autonomous take up of more than one service, and autonomous take-up of services other than those provided by the SSLP.

2.6.22 We bore these two models from the Implementation Study in mind in drawing up protocols for accessing the perspectives of service users. Focus group schedules were designed. Prompts included accessing the views of users on services at the stages of pregnancy, pre and post maternity, infancy, toddler, pre-school and training/employment (See Appendix H)

2.6.23 Effective services: investigating the views of non-users/'hard to reach'

We identified non-users in each of the Children's Centre areas using a range of strategies. These included liaison with impact module fieldworkers about non-users of services they had identified in the area, asking parent forum representatives or service providers to identify 'hard to reach' families and approaching parents randomly in local shops and post offices. We offered shopping vouchers to those participants who agreed to a short one to one interview.

2.6.24 Prompts for the informal interviews included what problems the participants had faced over the last twelve months and what kind of services/support would have addressed their needs/might they have been used (See Appendix I).

2.6.25 Data analysis at Stage 3

Analysis focused on triangulating the perspectives of service providers, users and non-users on what works. This helped us to characterise and exemplify features of more or less *proficient and potentially effective services* and to *exemplify good practice* to inform the development of Children's Centre services.

CHAPTER 3 - RESULTS 1: VARIATIONS IN PROGRAMMES

3.1 STAGE ONE FINDINGS: UNDERSTANDING HOW SSLP SERVICE AND STAFF FEATURES AND IMPACT ON SSLP EFFFECTIVENESS

Implications for Children's Centres from Stage One Findings

- Children's Centres need to implement the original Sure Start vision in its entirety. The most proficient and effective Children's Centres will perform well across all 18 measures of proficiency and effectiveness.

- The dimensions of proficiency include:
  - holistic aspects such as establishing a welcoming, friendly and professional ethos and empowering parents and providers of services.
  - ensuring that strategic, systemic processes are firmly in place such as governance that is representative of key stakeholders and functions well.
  - clear operational systems for identifying users, monitoring service use and identifying service impact at both group and individual levels.

- For families with very young children services which address the needs of both parents and children concurrently are likely to be successful.

- Children's Centre managers need to pay attention to training multi-agency teams to work together in new ways.

- Children's Centre Managers need to take care to build on the strengths of inherited services that have a proven track record of good quality and measurable impact.

3.1.1 Do programme variability ratings overall predict SSLP effectiveness?

We set out to design a way of exploring variations in the way the 150 SSLPs in the Impact study implemented the Sure Start vision. We aimed to identify dimensions of proficiency that could account for some of the SSLPs achieving better Impact outcomes than others do. The Programme Variability Rating Scale we designed to achieve this aim included 18 dimensions.

3.1.2 The first task was to examine the overall predictive power of the 18 ratings in differentiating between effective and ineffective SSLPs (effectiveness being defined by their impact on parents and children). Details of the discriminant analysis procedure used are outlined in NESS 2005b (pp.17-18).

3.1.3 The results showed that the 18 ratings of the proficiency (that is how well they were being implemented) of the 150 SSLPs could differentiate overall between more or less effective programmes (that is those showing better or worse than expected child and parent outcomes in relation to other SSLPs) across the 150 SSLPs.

3.1.4 Do specific ratings predict specific outcomes?

The second task was to explore relationships between two 9-month parenting outcomes, and three parenting and three child development outcomes for 3-year-olds, and the 18 programme variability dimensions of proficiency. Details of why these particular outcomes were selected, and the measures used, are given in Appendix 7 of NESS Report 014 (NESS 2005b: p. 64-68).

3.1.5 To address this question the statistical technique of multiple regression analysis was used. Technical details are described in NESS 2005b (pp. 18-21).

3.1.6 Significant effects were:

For families with 9-month-olds:

- More *empowerment* by SSLPs was related to *higher maternal acceptance.*

For families with 3-year-olds:

- Better *identification of users* by SSLPs was related to *higher non-verbal ability for children.*
- Stronger *ethos* and better overall scores on the 18 ratings were related to *higher maternal acceptance.*
- More *empowerment* was related to *more stimulating home learning environment.*

3.1.7 Do the number and type of services predict different outcomes?

We explored the relationships between the number of child-focused, parent-focused, family-focused and community-focused services, and within these four categories whether the fact that they were inherited, improved or new made any difference to outcomes.

3.1.8 Findings were that:

- Having more *inherited parent-focused* services was related to *less negative parenting* (e.g. harsh discipline*).*
- More *improved child-focused* services was related to *higher maternal acceptance.*

3.1.9 Does the number of staff involved in core services predict different outcomes?

We explored relationships between the number of full-time equivalent staff involved in activities related to outreach family support, health and early learning/play and childcare.

3.1.10 Findings were that:

- Having a greater proportion of staff that were *health related* was associated with *higher maternal acceptance.*

3.1.11 Discussion

This was an encouraging start to the Programme Variability Study. The findings indicated some linkage between variations in the processes by which SSLPs were implementing the Sure Start vision and variations in child and parenting outcomes.

3.1.12 Although the relationships detected were not strong, it was encouraging that the small, significant relationships between the processes of implementation of the intervention and outcomes identified in the Impact child and parent measures were all positive. Higher proficiency of implementation was consistently linked with better effectiveness outcomes. If the significant results had been occurring by chance, we would have expected some of the findings to have been negative.

3.1.13 However the caveat is that the effects on child and parenting outcomes overall determined by the Impact Study were very small. Also they were generally related to enhanced parenting rather than child outcomes (see NESS 2005a for details).

3.1.14 Programmes tended to score consistently high, medium or low on all 18 ratings. But we did detect some variation related to specific dimensions. For example, high scores on *empowerment* were strongly related to *partnership composition and functioning, communication, leadership, multi-agency working* and *ethos*. SSLPs scoring high on *identification of users* tended to have particularly high scores on *reach strategies, leadership* and *ethos*. However, although these findings indicated some relationships between specific dimensions of proficiency, it is important to recognise that all 18 ratings were related to each other.

3.1.15 The pattern reported in the Impact Study results of the cross sectional study (NESS 2005a) of *parenting effects* being more evident was replicated in the analysis of Programme Variability data. Only one positive relationship was indicated between a programme variability rating and a *child outcome*. *Better identification of users* was associated with *higher non-verbal ability.* In contrast there were three positive relationships identified between implementation dimension ratings and parenting outcomes.

3.1.16 If we turn to findings on specific dimensions and their links with effectiveness*, Empowerment* was related to six other dimensions of proficiency and to two of the five parenting measures (9 month-old maternal acceptance and 3-year-old home learning environment). A discussion of the apparent importance of *empowerment* will be pursued later in the chapter. However an important feature is that high ratings for *empowerment* (See Appendix A Item 4 for level statements) refer to actual procedures in place for increasing parent and staff participation and collaboration towards achieving the Sure Start vision. They require concrete actions by SSLPs rather than merely having appropriate attitudes.

3.1.17 The results also indicated that *identification of users* had a positive relationship with *non-verbal cognitive scores of 3-year-olds*. Again the criteria for good scores on this dimension (See Appendix A Item 11) indicate concrete actions aimed at identifying, diagnosing and treating potential users of services in a systematic and cross agency way. These actions will have the positive effects of

increasing reach, targeting those who need specialist services and accessing the more vulnerable, hard to reach families.

3.1.18 Findings related to the *numbers of services* indicated that having *inherited more parent-focused services* might have had the cumulative effect of improving parents' parenting. It also appeared that where SSLPs had *improved child-focused services* this was having a knock-on effect on improving mothers' attitudes towards their children, so that they were demonstrating higher levels of acceptance of their children. In the long run positive effects on young children's development are likely to be mediated through enhanced parenting. We hope to find evidence of this in the results of the children's scores in the Impact Study longitudinal study of the children up to the age of 5.

3.1.19 Findings related to staffing variables indicated that *more health services staff* was positively related to *higher levels of maternal acceptance of parents of 3-year-olds.* We speculate that this relationship may be explained by the key role that health visitors and midwives, who made up the bulk of SSLP health service staff, have always played in supporting parents in the early stages of bringing up their children. These health workers had detailed knowledge of and experience in outreach work in the kinds of communities in which SSLPs were established. They also had effective systems for recording and monitoring treatments. This may have given SSLPs with a higher proportion of health services staff a flying start in the early stages of their delivery of services and administration of treatments.

3.1.20 In order to understand further how different dimensions/processes of implementation were related to outcomes, the second stage of the Programme Variability Study moved on to case studies. We turn now to the findings from this stage of the research. But first we summarise key findings from Stage 1.

Key Messages from findings at the End of Stage 1

3.1.21 Although there were some links between specific dimensions of proficiency and better than expected child and parent outcomes, the proficiency with which the *whole model* of the Sure Start vision was implemented (that is across all 18 dimensions of the Programme Variability Scale) had a *direct bearing on its effectiveness*. This has implications for Guidance for Children's Centres. An holistic approach to delivering good quality services is important.

3.1.22 There is more evidence of links between the processes by which SSLPs were implemented on *improvements in parenting* (higher maternal acceptance, less negative parenting, a more stimulating home environment) than on child outcomes (cognitive and social/emotional measures). It is easier to affect and identify changes in parenting behaviours. However, we would expect that these small but significant improvements in parenting would be passed on over time to impact on improved outcomes for their children. Better parenting mediates better child development outcomes in the long run.

3.1.23 Where programmes had *inherited higher levels of parent-focused services* we detected lower levels of negative parenting. Where programmes had *improved more child-focused services* we detected higher levels of maternal acceptance. These positive relationships make sense. An established history of types of services

in an area is likely to enhance evidence of early impact on users. A commitment to improving child-focused services is likely to alert parents to the importance of aspects of their development. This consciousness raising provides a basis for promoting improved relationships between parents and their children. The results support the benefits of treating children and their parents together in the delivery of children's services.

3.1.24 The involvement of *health workers* seemed important to the early success of programmes. We argued that these key workers were bringing to SSLPs track records of working within the conventions and sensitivities of home and centre based service delivery for families with very young children in areas of poverty. It is important that the active role of health workers is promoted in rolling out effective models of children's services delivered from Children's Centres.

3.2 STAGE TWO FINDINGS: CASE STUDIES INVESTIGATING LINKS BETWEEN VARIATIONS BETWEEN SSLPS AND THEIR PROFICIENCY

Implications for Children's Centres from Stage Two

- Children's Centres need to plan their programmes with reference to a wide range of performance indicators.
- They need regular and systematic self-evaluation strategies to monitor the proficiency and effectiveness of their programmes and services. Evidence of more or less proficiency in the SSLPs histories of implementing complex menus of services for families with young children will be useful material upon which to draw in planning for their own practice, identifying challenges which have been overcome and avoiding less productive practices.
- In particular they need to:
  - actively ensure that there are robust structures for governance and leadership.
  - establish and demonstrate an ethos which is welcoming and inclusive, with friendly and knowledgeable staff.
  - focus staff on their capacity to empower providers and users of services, even when this requires staff to step outside their comfort zones.
- Features of proficiency that were linked to effectiveness include:
  - auditing local needs in order to continually tune local services to (sometimes changing) community priorities.
  - identifying users and targeting those with specialist needs for appropriate treatments as early as possible.
  - recruiting, allocating, training and deploying appropriate providers to deliver services, including a firm understanding of the impact and costs of deploying generic and specialist workers.
- Managing multi-agency teamwork at service delivery levels.
  - sustaining service use and striving to continually increase reach figures (with particular attention to accessing the 'hard to reach').

3.2.1 The 16 case studies represented a range of proficiency and programme types in different geographical contexts. The case study approach allowed us to take account of the socio-cultural historical contexts in which staff were implementing

versions of the Sure Start vision. An important principle was that it was not viable to investigate service effectiveness without reference to the contextual features of service design, planning, implementation and refinement. What works in one context, for one group of people, may not work elsewhere with another group. A case study approach also allowed us to look across the 16 SSLPs to explore evidence common to the 16 programmes of what worked and did not work whatever the context and socio-economic history of the communities in the three broad domains and eighteen dimensions of proficiency.

3.2.2 The hypothesis we were testing was: *where SSLPs were rating high across 18 dimensions, they would also be delivering services that 'worked', which in turn might contribute to better than expected child and parent outcomes.*

3.2.3 The researchers and assessor were blind to the previous Programme Variability ratings at Stage One and to the Impact child and parent scores for the 16 SSLPs. The ratings of the 16 SSLPs on the detailed evidence collected and collated for case studies were consistently comparable with the dimension ratings of these same SSLPs at Stage One of the study. It was unusual for any ratings on the 18 dimension of the same programme at Stages One and Two to diverge by more than two (of the seven) level statements. This increases confidence in Stage 1 of the Programme Variability Study ratings made on the basis of much less rich data.

3.2.4 The 16 case studies were allocated to four quartiles of Programme Variability proficiency. Figure 3.1 shows the 16 case study SSLPs by quartile (Quartile 4 indicating SSLPs with the highest ratings and Quartile 1 indicating SSLPs with the lowest ratings). The two middle quartiles were seen as comparable, so the distribution across these were 5 scoring in the 3rd and 3 in the 2nd quartiles. The SSLPs have been allocated codes that will be used to identify individual programmes in the text that follows.

Table 3.1: The 16 case study SSLP characteristics and codes

Programme	Government Region	Community type	Stage 1 PV quartile rating
A	South West	Typical	4
B	Yorkshire & the Humber	Indian subcontinent	4
C	North West	Typical	4
D	North East	Less Deprived	4
E	North East	Most Deprived	3
F	South West	Typical	3
G	North West	Indian subcontinent	3
H	North West	Indian subcontinent	3
I	London	Ethnic Diversity	3
J	London	Ethnic Diversity	2
K	London	Ethnic Diversity	2
L	Yorkshire & the Humber	Less Deprived	2

M	Yorkshire & the Humber	Typical	1
N	North West	Typical	1
O	London	Ethnic Diversity	1
P	South West	Less Deprived	1

Table 3.1: The 16 case study SSLP characteristics and codes

3.2.5 Table 3.2 shows the Impact data for the 16 Stage 2 programmes. The Impact measures include three child outcomes for 3-year-olds (British Verbal and Non-verbal Ability and Social Competence) and three parental measures (Maternal Acceptance for families with 9 month olds and Home Learning Environment and Maternal Acceptance for families with 3-year-olds) in the Impact cross sectional study (Ness 2005a). Details of these measures and why they were selected for the Programme Variability Study are in NESS Research Team report (2005b).

Table 3.2: The 16 case study's SSLP Impact data

Programme	Verbal ability At 3 yrs	Non verbal ability At 3 yrs	Social competence At 3 yrs	Home learning environment at 3 years	Maternal acceptance at 9 months	Maternal acceptance at 3 yrs
A	1.778	1.648	0.295	0.549	0.047	-0.051
B	2.369	1.962	0.305	0.938	0.017	-0.241
C	1.450	1.444	0.143	1.384	0.074	0.149
D	-0.089	0.710	-0.154	1.296	0.073	-0.019
E	-1.301	-0.114	-0.274	2.519	-0.211	0.134
F	-0.028	-0.355	-0.039	-0.545	0.083	0.063
G	-0.600	-0.544	0.246	0.192	0.042	0.0437
H	-0.514	-1.053	0.403	-0.808	0.090	0.058
I	1.217	1.224	0.029	0.812	0.022	0.093
J	0.078	0.188	0.212	0.189	0.066	-0.170
K	0.768	1.399	0.299	0.219	0.012	0.098
L	0.342	0.099	-0.193	0.209	0.002	-0.163
M	0.508	-1.114	-0.128	-0.993	0.039	0.015
N	0.105	-1.834	0.160	-1.914	0.077	-0.038
O	-0.234	0.298	-0.107	0.276	0.026	0.131
P	-0.010	-0.619	-0.081	-0.510	0.049	-0.102

Mean=0; sd=1; i.e. 0 is average; positive scores better than average; negative scores worse than average.

3.2.6 Variations in proficiency across the range of Programme Variability rating quartiles in the 16 cases

The 18 dimensions of implementation in the Programme Variability Rating Scale reflected the holistic approach of the original Sure Start vision to lift communities out of cycles of poverty. The dimensions could be grouped into three broad domains:

- *Holistic* aspects of proficiency (vision, empowerment, communications and ethos)
- *How* processes underpinning programme proficiency (board representation and function, leadership/management, multi-agency working, pathways to specialist services, staff turnover and evaluation)

- *What* of proficiency in service design and delivery (core service provision, targeted service provision, identifying users, reach and strategies to improve reach)

3.2.7 As the evidence from each case study was interrogated for each of the three broad domains, and the dimensions within the three domains, consistent patterns of the characteristics of more or less proficiency began to emerge.

3.2.8 For the purposes of this report, we will report on evidence of proficiency from the four quartiles focusing on one key dimension from each of the three domains:

- Empowerment *(holistic* domain).
- Multi-Agency Working (*how* domain).
- Identifying Users (*what* domain).

Empowerment was selected because of identification at Stage One that proficiency in this dimension was linked with better than expected outcomes for families of both 9-month-olds and 3-year-olds. Multi-agency working was selected because it was a key component of SSLP implementation, but seemed particularly problematic. Identifying users was selected because it was associated with better than expected child outcomes at Stage One. However, to provide a complete picture of the nuances of more or less proficiency across the 18 dimensions, particularly to support the staff of Children's Centres, tables of detailed evidence from other dimensions are included at Appendix E.

3.2.9 The data below and in Appendix E demonstrate that there was consistent, cumulative evidence of more proficiency in each of the 18 dimensions, from the lowest quartile programmes (1) to the highest (4) of Programme Variability Rating scores.

3.2.10 Empowerment (Dimension 4)

Empowerment was the only dimension where significant effects were identified for parent outcomes both for families with 9 month-olds *(More empowerment in the SSLP was related to higher maternal acceptance*) and for families with 3-year-olds *(More empowerment was related to more stimulating home learning environments).*

3.2.11 What was it about this dimension that seemed to mark it out as a potentially significant indicator of programme proficiency and better than expected outcomes? There is a detailed enquiry into, and discussion of, empowerment in the Themed Study *Empowering Parents in Sure Start Local Programmes* (Williams and Churchill 2006)

3.2.12 One important aspect of this dimension was that the seven level statements in this dimension on the Programme Variability Rating Scale related to features of the intention to **empower both service users and providers**. Another important aspect was that the indicators of increasing proficiency were expressions of concrete actions rather than good intentions.

3.2.13 These actions included proficiency in involving **users** progressively in service planning and delivery through volunteering, targeted training, employment

opportunities and competent representation on decision-making committees and Boards. Effective SSLPs were able to articulate underpinning principles and demonstrate practice in achieving a balance between voluntary and paid staff, building in opportunities for community volunteers to support professionals in delivering core services and in managing their own self help groups and peer support networks.

3.2.14 More effective SSLPs also had well developed strategies for **staff** development, maintaining a balance between individual career progression and promoting whole team development, including away days involving as many constituencies as possible in strategic training, decision making and planning.

3.2.15 None of the 16 case study SSLPs achieved the highest rating (7) in empowerment. To achieve a 7 rating an SSLP had to demonstrate that staff were part of *a learning community,* with regular opportunities for changes in staff roles and responsibilities and associated access to relevant professional development. It was perhaps too early in the histories of the programmes for this to be achievable, except for occasional examples of within programme staff career trajectories and promotions.

3.2.16 However the second element in achieving a 7 rating in this dimension was evidence of *mutual respect for contributions of all parties*. Within Quartile 4 SSLPs (those rated as most effective) there was evidence that three SSLPs were demonstrating this sophisticated element of empowerment. Figure 3.2 (Page 31) includes descriptors of aspects of their proficiency in this dimension.

3.2.17 It could be argued that the significance of empowerment was derived from its *dual emphasis on promoting the genuine involvement of both users and providers*. The most effective SSLPs offered both constituencies targeted education/training opportunities so that they could progress to higher levels of functioning in their own spheres of influence at home and work. An *emphasis on education and training* may be one key to explaining the significance of this dimension and its tenuous links with promoting the outcome of *more stimulating home environments.*

3.2.18 A second proposition is that the *element of mutual respect for all parties* was a notable feature of the SSLPs that seemed to us to be the most potent exemplars of the original SSLP vision and its working reality. Where the contributions of parents to child development were genuinely respected and valued within the implementation of SSLPs, there were indications that parents felt more confident in their abilities to make those contributions. They were also more likely to feel a sense of common purpose with service providers. Things were not just done to or for them; they took an active role in improving their own lives and those of their children. The impact of this sense of mutual respect on SSLP parents may explain the link with *higher maternal acceptance* outcomes.

3.2.19 Figure 3.1 includes descriptive summaries of evidence of the range of proficiency demonstrated in case studies in empowerment. It illustrates the continuum of SSLP proficiency from the top quartile (Quartile 4) to the bottom quartile (Quartile 1).

Figure 3.1 Evidence of proficiency in empowerment from the case studies

Quartile 4 High levels of focused training for staff and volunteers; street committees ensure local communities represented; commitment to training/employing local people; family friendly employment (B) Parents and staff empowered by good quality, targeted training; part time volunteer co-ordinator; confident parent chair who will take on local politicians (A)
Quartile 3 Staff training for career enhancement; local parents encouraged to train/find employment; but parent representation features more 'articulate, middle class'; clear distinction made in operations between volunteer and paid staff (I) Radical approach to empowering local people to train, work within the SSLP, set up own businesses; history of empowerment of local communities through political action (H)
Quartile 2 50% of staff live locally; Volunteers encouraged, offered training, but role seems restricted to servicing professionals; away days exclude some professionals and their purpose opaque (L) Strong community development worker, but general apathy amongst parents (beyond a core group) about involvement in SSLP; staff seem disempowered by changes of insider managers and by interference from Local Authority outsider systems. (J)
Quartile 1 Parent Action Group seems well established; some volunteers have progressed to paid work; but lack of clarity about complementary roles of volunteer and professional staff; away days good for bonding, but not focused on strategic planning; some professionals talk is not respectful of local communities (M) Parent forum meetings encouraged but little impact on activities; handful of volunteers; individuals encouraged to pursue training but for their own purposes, rather than for team functioning; clear distinction between staff and volunteers with concerns about hierarchies, linked with ethnicity (O)

3.2.20 Discussion

Confidence to engage in genuinely empowering parents marked out some of the SSLPs as particularly impressive. Where SSLPs were less proficient it was too easy for professionals to go through the motions of doing so by setting up parent forums, committees and link meetings to which only the more 'favoured' parents were invited and 'heard'. Our evidence was that these were often the least troublesome and more articulate parents in the communities, and not representative of the majority of local families.

3.2.21 More proficient programmes had clearly defined principles underpinning the distinctive roles of volunteers and paid staff. They had established routes for local people to make their way through opportunities to gain knowledge, skills, expertise and associate qualifications (and if they wished to do so, to gain employment).

3.2.22 Successful policies on promoting parental empowerment had to embrace the concerns of professional groups. Some professionals felt threatened by the blurring of distinctions between paid and unpaid staff. These professionals expressed anxiety about risks to the quality of services for which they were responsible associated with volunteers. This seemed to be a particular concern for health workers. Effective managers tackled these concerns by ensuring that volunteers were carefully supervised, and systematically trained, to undertake new roles and responsibilities.

3.2.23 A transparent, cohesive and well-funded approach to general and individual staff development marked out the most proficient SSLPs. For staff to feel empowered, they had to be offered both emotional support and practical training to take on radically new ways of working, implicit in the Sure Start vision. They needed to feel confident in supervisory systems at all levels of the SSLP operations. They wanted a fall back position of support from managers if things went wrong in their activities, and yet to be trusted to get on with their work without micro-management. These important features of human resource management were sometimes deployed to middle management level, but good leaders/managers needed to maintain an overall watching brief on them.

3.2.24 Multi- Agency Working (Dimension 7)

Multi-agency teamwork was one of the dimensions of Sure Start work that had attracted many people to apply for jobs in the SSLPs (NESS 2005b). They had perceived for themselves the limitations of operating children's services within 'silos', and welcomed the opportunity to learn about each other's professional knowledge and skills.

3.2.25 Yet the reality was that putting multi-agency teamwork into practice was time consuming. Planning how to make it work involved many meetings to clarify core whole team aims and specific discipline responsibilities to achieve them. The process of putting the plans into operation were challenging, and often frustrating, as the professional identities of practitioners were threatened by changes in their roles. It was perhaps the most difficult of the organisational aspects of effective SSLPs to achieve.

3.2.26 The Programme Variability Rating Scale indicators in this domain included: shared staff training; appropriate balance in agency affiliations/service providers within the team; shared cross agency staff activities (such as joint planning and delivery of some services); co-location, for at least some aspects of their professional work; and teamwork extending beyond the SSLP boundaries.

3.2.27 Figure 3.2 provides illustrative evidence of proficiency in this dimension drawn from the 16 cases. It gives insights into the range of features of proficiency across the four quartiles.

Figure 3.2 Evidence of proficiency in multi-agency working from case studies

Quartile 4

Really good multi-agency work with all mainstream agencies and lots of involvement of local faith based organisations and schools.
Regular meetings and training for different agencies to learn about each other and share approaches.
New build offers co-location with enhanced opportunities to work closely.(B)
Staff from across different agencies actively promote joined up thinking and doing. For example, schools liaise actively with the SSLP. A range of professionals work together in group activities and other workers are sent to the programme to see how Multi-agency team work should be done.
The co-location of wide range of staff in the new building seems key to their effective collaboration.
However health workers and the Primary Care Trust (PCT) in general have been more ambivalent about Multi-Agency Teamwork. For example they defended the territory of their Healthy Living Centre.
They show reluctance to share information, only giving postcodes of new births.
Individual health visitors do appear to have worked alongside SSLP staff comfortably (C)

Quartile 3

Multi agency team meeting weekly. Co-location of workers from different agencies.
Open plan office ensures informal exchanges of information about users.
Good number of referrals from other agencies. Parents perceive that agencies work together flexibly.
But despite rhetoric of multi agency team work, and its overall success, there was evidence of a gulf between early year's education structures and systems and SS staff. (I)
Co-location of staff and Borough Council commitment means multi-agency teamwork does happen.
Networks include voluntary and private agencies, police and housing. But some indications of tensions over funding streams with social services and health mainstream agencies. (G)

Quartile 2

Local authority has promoted multi-agency services through training. Evidence of shared training with partnership (franchised) providers of some services. But problems keeping health on board.
Monthly joint strategic planning meetings between agencies have fizzled out.
Agencies appear to be working within boundaries in parallel, rather than demonstrating multi-agency teamwork in service delivery.(L)
Multi-agency team work established and developing. Ad hoc examples of joint service planning and delivery across disciplines.
Externally, a mental health charity, MENCAP, deliver respite services which Speech and Language Therapist (SALT) attends.
Shared notes between health and SALT worker initiated where previously Health concerns about confidentiality prohibited the sharing of records. But notes not routinely shared with outreach workers.
Teams tend to work 'alongside' rather than with each other despite co-location. But limited links with statutory agencies. No Social Services or Housing representation on Board. Difficulties with lead body.

Quartile 1

Despite shared buildings, services offered in boundaried, parallel ways rather than in multi-agency teams.
Strategic planning at financial streams rather than visionary levels and uneasy relationships underlie discourse at meetings.
History of an initiative based on Single Regeneration Budget in area caused resentment when new SSLP services/resources first came into the area.(N)
Limited evidence of planning jointly for multi-agency teamwork in delivery of services.
But good practice demonstrated in the 'Cause for Concern' meetings where professionals come together to discuss and implement care plans for the most in need.
Communications and information sharing between agencies rudimentary, not helped by staff seconded from Primary Care Trust and SSLP working in separate buildings.
No collective inter agency monitoring or evaluation of service impact.

3.2.28 Discussion

Evidence from the 16 cases indicated that even within the highest scoring quartile, there could still be barriers to effective multi-agency work, particularly from health workers. New Sure Start buildings offered positive opportunities to plan new ways of working together, with shared entrances and administrative offices for practitioners and, in some multi-purpose spaces, for the delivery of services. Yet, as with open plan schools where shared teaching spaces were soon demarcated with cupboards and room dividers, we saw spaces designed for generic service delivery being re-assigned for specific single agency purposes.

3.2.29 For example, in one SSLP play workers were persuaded that their services were too noisy to be run alongside clinics. Health visitors argued that they needed demarcated spaces for dealing with confidential information and that the noise from the children distracted them. We saw several examples where community cafes, which had been designed in new Sure Start buildings as central meeting areas with open access for all users and providers of services, had been restricted by SSLP staff to operating within minimal hours. This was sometimes justified on health and safety grounds. A parent told us: '*They shut our café down because they said it was too risky to have hot drinks around where there were so many kids.'* In other SSLPs we were aware of office spaces designated for shared team functions being divided up by floor to ceiling screens. For example in one newly built Sure Start building health visitors had insisted they were moved out of the shared open-plan office space into a room designed as clinic space. They argued that their work was *'too confidential'* to be done in shared spaces. So agencies began to retreat back into their silos and work in parallel with each other.

3.2.30 It took real commitment for multi-agency teams to work their way through the pain of negotiating new ways of working to the gain of making it happen on the ground. Sustaining this commitment was dependent on strong leadership with a clear vision of the long-term benefits of joint working. When managers systematically set up joint training for their staff, where they were able to explore, confront and understand why learning to work together was so complex, leaders/managers were more likely to be successful in driving the agenda for change forward.

3.2.31 Overall our evidence was that this is a feature of proficiency where leaders/managers still have much to do to make the vision of integrated services a daily, working reality.

3.2.32 Identifying Users (Dimension 11)

At the first stage of the Programme Variability Study for all 150 SSLPs rated, *Better Identification of Users was* related to *higher non-verbal ability scores for 3 year-olds.*

3.2.33 Ideally a SSLP should have been able to identify all potential and new universal users and also have robust systems in place to identify and target special needs users. Many SSLP managers expected that the Primary Care Trusts would pass on details of live births to them, since first contact with *new-borns* is routinely through Health Visitors and midwives. In reality the case studies have shown a

different picture. In some cases Primary Care Trusts simply refused to allow access to their databases, often on grounds of confidentiality. With no central database, the process of identification of new-borns had to rely on individual goodwill of the midwives and the inventiveness, creativity and networking ability of programme staff.

3.2.34 When new families with *children under 4*, who were potential users of services, moved into Sure Start areas, there was a need for systems to first identify them and then implement strategies to attract them to SS services. This was particularly important where populations were transient, for example in areas hosting refugees or asylum seekers or areas with high levels of rented accommodation. This aspect of identifying users was dependent on reciprocal exchange of information between statutory and voluntary agencies beyond the SSLP systems. It was pivotal to achieving good reach figures. Sadly there were few examples of systemic co-operation between agencies beyond the SSLP organisation, even within the top two quartiles of PV programme proficiency.

3.2.35 Figure 3.3 provides a summary of the evidence related to proficiency in this dimension from the cases.

Figure 3.3 Evidence of proficiency in identifying users from the case studies

Quartile 4 Good centralised database/health systems for identifying newborns/users and lots of follow up outreach / family support workers. All children visited at 6-8 weeks, 9 months and 12 months and information analysed and used to target specialist services to families. (B) In order to identify potential users, SSLP has own database, which appears to be systematically updated and interrogated. They have established systems for dealing with confidential information and exchange with other agencies and use local networks strategically to locate new users. However they are constrained by Primary Care Trust refusing to pass on information about new birth addresses, and a general lack of co-operation from Primary Care Trust about access to their database justified in terms of data protection act. Consequently they have to rely on the good will of midwives for information given informally. They recognise the need for more outreach workers from the SSLP team to identify users. (C)
Quartile 3 Paper based Red book system seems effective for identifying new users. Health visitors make first contact with families with new babies and routinely get consent forms signed for Sure Start workers to contact them. The system efficiency is sustained by weekly meeting at clinic to discuss clients. Good referral system from other agencies. Have a database, but no evidence that Primary Care Trust share it. (I) Good centralised database drawing mainly on health records, audited and replaced regularly. But transient population and frequent family name changes complicate the tracking of families. (G)
Quartile 2 Central role of health visitors for referrals. Newborns are recorded on centralised database. Information on 3-year-olds gained from nurseries and pre-schools, but ad hoc rather than in formalised systems. Family files checked regularly by key worker, especially for those accessing specialist services. (L)

Outreach and health workers take the lead in identifying users. Active networking of Outreach manager via baby clinic identifies potential new users. Mainstream systems such as RICHES (a health system) database are used, and range of referral systems. There are links with hospital to identify pregnant women. Evidence of limited links with Social Services and Housing. SSLP has potential to track individual usage but is not doing so currently. (K)
Quartile 1 In principle Health Visitors are main source of identifying users, but administration of data seems poor with previous officer leaving through stress. Reported problems gaining information from health service about children in area. (M) Have effective database to monitor take up and use of SSLP services, but have to pay Primary Care Trust for initial data on births. Social services and education seem marginalised in information sharing. (N)

3.2.36 Discussion

Identifying users appeared to be a significant dimension of service proficiency and was linked with strategies to *improve reach, leadership* and *general ethos* at Stage One of the Programme Variability study.

3.2.37 Exchange of information between agencies appeared critical to proficiency. It was particularly helpful for SSLPs to have established links with hospitals and General Practitioner surgeries to identify the newly pregnant women, and be informed of all new births in the area in a systematic way. This allowed programmes the opportunity to make the first home visit promptly and offer support at a time when it was most needed. At this stage health visitors took the lead. In some models of identifying users we observed, generic family support workers supplemented specialist Health Visitor home visits to mothers with babies to diagnose the family needs and signpost them to SSLP services.

3.2.38 Programmes who did not have access to Primary Care Trust databases, or other ways of identifying new babies, struggled in terms of delivering universal services at this critical time for attracting users to their services. They also missed out on opportunities for identifying and targeting specialist user needs at the earliest possible opportunity.

3.2.39 Where early identification was possible, programmes had better opportunities for encouraging use of preventative intervention (for example to promote giving up smoking in pregnancy, breast-feeding, hygiene and safety in the home). Thus early identification of users, and clarity in diagnosing and addressing their needs, resulted in offering more ‘dosage’ of both universal and specialist Sure Start services.

3.2.40 Evidence from the qualitative data in the case studies indicated the importance of pro-active strategies for identifying users. Effective strategies identified from the case studies included:

- *negotiating agreements with Primary Care Trusts for systemic access to health information, including the newly pregnant and live births in the area;*
- *well established inter-agency co-operation in regular sharing of information about local families;*
- *administrators who were skilled in Information Technology and able to set up, maintain and most importantly interrogate databases proficiently;*
- *Or effective paper based systems with whole team ownership (with confidentiality protocols built in) of the processes of recording, accessing and using information.*

We will now offer two brief case study descriptions to exemplify features of good practice across the 18 dimensions of proficiency.

3.3 Case studies offering exemplars of good practice across the dimensions of proficiency

3.3.1 Programme A

3.3.1 Context

This Round 2 SSLP was located in the South West of England and was categorised as Local Context Analysis type *Typical* (that is average in all the socio-demographic indicators compared to other Rounds 1-4 SSLPs). There were 87 SSLPs (out of 524) categorised as typical (i.e. 34% of Round 1-4 SSLPs). The two wards covered by the SSLP area have a predominantly white population.

3.3.2 This programme was based in one of the largest estates in Britain. Housing is 1940s to 60s council and ex-council house semis and terraces, mostly with gardens. There is a library, swimming pool, police station, community centre, several churches, health clinic and healthy living area. There is a regular bus service to the city centre. The only secondary school in the area was closed down as a failing school. The small parade of local shops shows signs of vandalism and neglect and the public house has been closed by the police.

3.3.3 The area is in the poorest 30% of wards in the UK. A local cigarette factory and mill have closed and 45% of residents do not work. Teenage pregnancy is more than twice the average for the city. There is also the highest number of children on the child protection register in this area of the city. Severe injuries to children are higher than the average for Rounds 1-4 by Local Context Analysis measures.

3.3.4 There have been a series of regeneration projects in the area, but these short-term initiatives have left many residents cynical about the long-term benefits and sustainability of Sure Start Children's Centres. However, there is evidence of community commitment to improving the area in notices about local meetings and community groups displayed in the library, community centre and post office.

3.3.5 Rated as Quartile 4 in the Programme Variability Study, it was amongst the most proficient programmes in our sample of 16.

3.3.6 The 'How' of programme implementation

The partnership built on the *inherited strengths* of a history of well regarded City Council *services for young children.* The City Council was the accountable body for the SSLP and minutes of the Board indicated that meetings were *well and regularly attended by representatives from a balance of agencies,* excluding social services. *Parents* were routinely and actively involved in the Board and related committees. Some of these parents had become articulate advocates for services for young children and families on the estate. As one parent said to us, *'I'd never have been brave enough to speak out for children around here if I hadn't got involved with Sure Start'.*

3.3.7 The transformation from SSLP to Children's Centre status, and related funding threats, have generated fierce debates about sustaining the benefits both staff and parents feel have been gained from the Sure Start vision and ways of working.

3.3.8 For example, the SSLP had *prioritised training for staff and volunteers*. An extract from an interview with the training officer gives a flavour of changing priorities: *'Our training programme has been fantastic. We had a very generous budget of £15,000 a year. We have had at least one free in-house training session a month for interested professionals and parents who are active volunteers. We have provided funding for staff and Board members to attend conferences all over the country. Our budget is to be cut to £1000 per year. And they want to replace me with a teacher.'*

3.3.9 The *programme manager* had nursery nurse, childcare and management qualifications. She was appointed in 2001, and oversaw the development of the SSLP. She described her style of management as *'democratic and motivating'*. She had built up a *strong senior management team*, each with responsibility for respectively Family Support, Finance and Resources, Training and Childcare. Each senior manager was *well qualified* in related fields of expertise. Overall leadership and management were of consistently high quality and were rated as exceptional by the staff we interviewed.

3.3.10 *Staff turnover was low* and the staff we interviewed were knowledgeable both about their activities and the characteristics of their service users. There was evidence of agencies working well together, with regular shared meetings and training events.

3.3.11 The inherited and refurbished buildings from which services were delivered appeared from the outside dull and somewhat uninviting. But within them the layouts and appearance were bright, clean and inviting and *the staff friendly and welcoming.* The SSLP also used rooms and facilities in buildings throughout the estate, which were already well known and used by the community. Activities were held in the community centre, primary schools, early years centre, library and swimming pool. This ensured that *some services were within walking distance for all families.* Word of mouth was the most successful way of promoting services, but the SSLP produced a range of up to date, non-patronising and colourful leaflets. Posters *advertising activities* and events were displayed at the entrances to all the buildings they used.

3.3.12 The 'What' of service delivery

Overall we saw a strong emphasis *on promoting children's language development* in this SSLP service menu. We also saw the SSLP using established schemes with track records of impact. The approach of the programme prioritised early childhood education, but mediated activities in centre based services by involving parents in replicating activities at home.

3.3.13 Figure 3.4 demonstrates the range of activities, venues and providers of the services delivered by the SSLP. The number of services reflected an even distribution between family support (12) and childcare play and learning (10). The number of health services appeared low (3), but routine mainstream regular health visitor and midwife services are not listed here.

3.3.14 Early learning and play services for children included a project based on the well established literacy programme called Peers Early Education Partnership (PEEP). PEEP was delivered as a group session by a mix of professionals and parent link workers, but there was also some home delivery to families lacking the confidence to attend groups. A speech and language therapist attended various groups and home visited families with children with speech and language problems/delay. There was also a Bookstart scheme delivered by Sure Start workers. The scheme offered free books for children up to 2 years-old and regular access to a Toy library. There were close links with primary schools, in particular with staff in the Foundation Stage Units.

3.3.15 But there was also a strong emphasis on promoting *children's physical development*. The activities included Jungle gym, gym tots, swim tots and access to a forest school where there is an emphasis on playing and learning outside. Additionally, the SSLP negotiated for a children's area in the local park.

3.3.16 There was a *strategic mixture of centre based and outreach services*. Skilled and knowledgeable staff liaised as a team to diagnose the needs of individual parents, and children. Family circumstances and constraints were taken into account. They geared their services to address these needs at group and individual levels, but were also aware of the need to check regularly for the cost effectiveness of services (for example by monitoring the number of home visits made to a family, or the attendance figures for group sessions). Outreach and centre based work was closely aligned so that activities offered in both contexts were under-pinned by a shared rationale and sense of purpose. Health staff actively promoted Sure Start activities during their routine visits to the homes of all new-borns.

3.3.17 The *reach figures* for the SSLP were consistently good. The Finance Officer had developed a database that generated accurate figures about the number of people using the services. Analysis of the figures was fed back into in-house monitoring and evaluation systems. For example when staff realised that they were not attracting teenage parents to activities, they tried a series of different approaches until one worked.

In this table place names (e.g. P.Building, C.P.School, H.L.Centre) have been anonymised.

Figure 3.4 Services delivered by Programme A

Service	Key Deliverer	Frequency & Location	Comments
Neighbourhood Nursery & Crèche	SSLP	8.00 am -6pm, Monday-Friday. 12 places 3-4 yrs. 18 places 18mths to 3yrs and 6-place baby room. £15 per half day session. Venue: P building	80% of places go to parents who work in the area (But not necessarily live in the area). Subsidies available for local families 20%.
Keeps 1's, Keeps 2's, Keeps 3's, Keeps 3 to 4's.	Delivered by SSLP Activity Workers Parent Link Workers, (in some family homes), Crèche Workers and Keep Community Practitioners (nursery staff at CP school)	1 hour termly sessions in local venues and schools.	9 groups. A learning project based on Peep (Oxford) SSLP hoping to secure funding to employ a Keep Foundation worker to co-ordinate and support Keep working in nursery classes throughout area
Bumps & Babies with Keep	SS Midwife and Workers. (April 2006 Midwife has now left, SSLP is hoping the Community Midwife will take over the group)	2 weekly groups held at the EY Centre and the HL Centre.	A parent craft and early years group for pregnant mothers and partners and babies up to 1 year, followed by Keep for babies. Established links with Nutritionist to run weaning sessions within the group.
Bib Club	SSLP mothers and SSLP Activity Workers (support only) Additional funding found by mothers.	Weekly sessions held at the HL Centre	Some mothers now qualified as Mother Supporters and offer a phone support line for breastfeeding mothers. 1 is qualified as a Breastfeeding Counsellor.
Chill out	SSLP Activity Workers and Crèche Workers.	Weekly session held at PH	Drop in session for parents. Crèche workers look after the children while parents discuss health, benefits etc, and enjoy breakfast together.
Childminders Support Group	Run by a group of childminders and Co-ordinator (Children's Information Service) The post is part funded by SSLP	Weekly session held at PH	A group of childminders that meet to support each other while the children socialise. Free training offered (Quality Assurance)
Chat about	SSLP Activity Workers	1 monthly session held at M. Free buffet and Crèche.	Group for parents to talk and help plan SSLP services.
Me & My Dad	SSLP male Activity Worker	Weekly term-time only session held at PH. One-off evening and weekend sessions held regularly.	Supporting male carers and encouraging them to get involved with their child's development.

Jungle Gym.	SSLP Activity Workers.	Weekly sessions term-time only held at SHCS.	Structured activities to encourage physical development. Active participation from parents.
Gym Tots	SSLP Activity Workers and professional coaches.	Weekly sessions term-time only held at NLIS	Structured activities for children to encourage physical development.
Swim Tots	SSLP Activity Workers and qualified Swimming Instructor	Weekly session term-time only held at FBS.	Fun and confidence building sessions for parents and children.
Stepping Stones	SSLP Activity Worker in partnership with Early Years Centre Inclusion Worker.	Weekly session held at PH (invite only)	Offers support for parents and children with disabilities and additional needs.
Forest School	SSLP Activity Worker in partnership with Independent Sector and Nursery School	Weekly sessions held at INS, NLNS, CIS and EYC.	Introducing children to playing and learning outside.
Tot shop	Parent Volunteers.	Weekly held at FCC	Weekly sale of children's clothes and toys.
Toy Library	SSLP	CC opening hours held at FCC	Available to all family members.
Credit Union		CC opening hours held at FCC.	Collection point for families.
Parent Link Scheme	SSLP Parent Link Workers	Daily home service.	Support for families and children under 4.
Speech and Language Support	SSLP Speech & Language Therapist (contract ends April 2006)	Various SS groups and home visits.	S&L Therapist attends various groups to offer informal support and advice. Works with several families in their homes.
Family Learning	SSLP Tutor Organiser	Various venues around the SSLP held on a regular basis	Informal and accredited courses for parents.
Crèche Facilities	SSLP Crèche Workers	Various venues around the SSLP	SSLP provides crèche support to various activities and groups.
Home start	Home start	Family homes	SSLP pays for a Co-ordinator to recruit and train Home start volunteers. (Expires April 2006)
Book start	SSLP	FCC	SSLP funds free books for children up to 2 years.
Family Group Conference Co-ordinator	Part funded by SSLP	Sessions held at PH	Employed by Barnardos to co-ordinate the Family Group Conferencing Project for area.
Domestic Abuse Response Co-ordinator	Part funded by SSLP	Based at the HA at FCC	Team of volunteers and Co-ordinator.
Family Service Co-ordinator	Part funded by SSLP		Family support worker working with family members affected by drug and alcohol issues.

Playgroup Support	Small grants of £500 each	6 Playgroups and toddler groups.	SSLP has made funding available to support local playgroups and expand groups.
The Male Co-ordinator Is this correct?	SSLP funding	Garden area	SSLP has worked with the centre to develop a children's area in the garden.

3.3.18 Programme B

3.3.18 Context

Programme B, a trailblazer SSLP, was located in a northern city and was Local Context Analysis type Indian Sub-continent. This is the smallest cluster, at 28 of the 524 SSLPs, in the Local Context Analysis typology and comprises 11% of the total. There are a number of distinct communities, some self-contained and requiring specialist services. Some of the communities were second generation Western Pakistani family groups with high aspirations for their children. Other groups were newly arrived and in the early stages of adjusting to different life-styles, and some had low levels of English usage. The population break down in 1999 was reported as Pakistani 58.8%, White British 19.9%, Bangladeshi 9.2%, Indian 5.5%, Black Caribbean 0.5%, Black African 0.3% and Chinese 0.1%.

3.3.19 There are 600 households with an estimated 1600 children under 4 in the SSLP area. Housing is mainly terraced, owner occupied or rented, and there are still many remnants of factories and industrial units. The area is hilly, making walking access challenging. The main road through the area is lined with shops, faith based organisation centres and community venues.

3.3.20 The area has one of the highest levels of health inequalities recorded in Britain. Professionals reported high levels of domestic violence and mental health problems, with treatments complicated by cultural taboos on admitting to problems. Key Stage 1 (when children are 7) SATS results for English are good, but for maths disappointing. There is slippage in results by the end of Key Stage 2 (when children are 11). There are a high number of children in the area designated as having disabilities or additional educational needs.

3.3.21 This SSLP had some of the highest scores on Programme Variability Ratings in our sample of sixteen cases and was within Quartile 4 in the Programme Variability Study. The impact outcomes for children in the area were also very good, particularly on both verbal and non-verbal British Ability Scale tests.

3.3.22 The 'How' of programme implementation

Overall the emphasis of this programme was on *improving health outcomes*. The over riding impression in this programme was of sophisticated levels of *sensitivity and response to the diverse cultural and faith characteristics of the communities*, including extensive energy deployed *to meet the language needs of families whose mother tongues were not English*.

3.3.23 The SSLP was characterised by a strong sense of *shared vision* amongst the staff and users and a history of genuine community involvement in decision making. The *Board had good representation and attendance* from the mainstream agencies and parents were trained to understand and contribute actively to Board processes.

3.3.24 When *conflicts* have arisen, as inevitably they would in such a complex mixture of communities, they were confronted and attempts were made to resolve rather than suppress them. There was a particular concern, for example, that more attention needed to be paid to the needs of a tight knit Bangladeshi community in the area. There could also be resentment from the local White British community that resources were deployed favourably to the Asian communities.

3.3.25 *Strong leadership* was a feature of the programme. There had been two managers. Their qualifications were in law and community work. They had worked together for a substantial period of the intervention, with one as Deputy Manager, so that there was overall consistency in the approach to managing staff and services. Staff were articulate about their relative and complementary strengths as effective managers.

3.3.26 There was a *strong senior management team* with team leaders for Family Support, Community Development, Health and Early Learning, Play and Childcare activities, each well qualified in their fields. There were clear lines of accountability for day to day operations of services. There were effective and transparent systems for staff appraisals and supervisions.

3.3.27 The *staffing was stable*, with many having been in post for 6 years, though recent changes to Children's Centre status had destabilised what had been a remarkably cohesive staff. Staff were recruited to *maintain representation of the cultures and faiths of the area communitie*s as well as for *proven professional expertise*. Family *friendly working practices* meant that many staff were on part-time contracts, and a senior manager pointed out that this was particularly challenging for managing the workforce in the best interests of service users. All staff were given *training in community development*.

3.3.28 The programme was rated a 6 for *empowerment.* Initially parents were involved in planning services but not in delivering them. For example parents were taken to Bristol to observe a Fun Bus in action when the idea was floated of a playbus for this area. When we did the fieldwork, several sessions, such as breast feeding peer support group, a Dad's group and Special Educational Needs group were led by parents.

3.3.29 The programme was rated at 6 for *multi-agency/integrated* teamwork. In interviews with staff they reported that before Sure Start there was a lot of 'boundary defending' between agencies. One practitioner told us*: 'We were pioneers in trying to make it work on a day to day basis'*. Now Health, the local authority children's services, social services and the NSPCC team up for training. We found evidence of joint planning with Social Services. Health worked closely with the Sure Start team and had given training to all staff on oral health and weaning, first aid and child protection and mental health. There were full team meetings with other agencies every two weeks.

3.3.30 The practitioners told us that being *co-located in the new Sure Start building* helped make multi-agency teamwork a reality. Passing on information was effective on a face to face level. As one professional said: *'so much easier than chasing someone by phone and leaving endless messages'.* They all worked on responding to referrals and contributing to generic family files.

3.3.31 The programme was strong on home visiting and different from other programmes in that they '*work as long as is needed in the home due to the cultural needs of the area'.* But outreach work was complemented by centre based activities led by a wide range of professionals.

3.3.32 The 'What' of programme implementation

This programme's emphasis on health was demonstrated in *health education* activities as well as *health-related services*. These included a Diabetes drop in clinic, diet advice and weight management and women only swimming classes. There were sessions for breast-feeding groups and baby massage. These were used to promote baby related health issues.

3.3.33 There were a number of *parent education* classes such as English as a Second Language, GCSE Maths and English, Information Technology courses, National Vocational Qualifications for working with children, Parenting courses and Art therapy. There was a 'Starting School Together' course to help both parents and children get ready for school.

3.3.34 The programme was characterised by an active *physiotherapy service* for children with a purpose built sensory room. There were activities to promote children's *physical development* such as 'active tots' and 'bouncy babes'. There was also an active programme of *speech therapy*, with some centre-based and some outreach activities, depending on family needs and circumstances. These two services were particularly important in responding to the high level of young children identified in the area as having *disabilities or additional needs.*

3.3.35 A playbus was key to delivering *high quality play and early learning* activities. The bus went out to 6 venues within 1.5 square miles and parked in the same place at the same time each week. The aim was to give the children and parents a taster for pre-school education. The principle was to take the service out to the community and in the long term to coax parents into bringing children to centre based activities. The Playbus development worker was highly qualified and inspirational. She told us: *'The playbus vision is to offer the community a taste of pre-school education, particularly where parents are isolated and may not feel able to take their children to a centre-based service. The idea is to bond with the families and perhaps lead them into using other Sure Start services. Siblings can also attend. We are out there same time, same street corners every week. Reliability is key to our effectiveness.'*

3.3.36 Figure 3.5 lists the range of services and activities offered by this SSLP with indications of providers, locations and regularity and duration of treatments. Extensive outreach services were running parallel to these centre based activities.

In this table place names (e.g. M.St and D. College) have been anonymised.

Figure 3.5 Services delivered by Programme B

SERVICE	KEY DELIVERER	FREQUENCY & LOCATION
Playbus	Playbus leader, SSLP * observed	Mon – Children's Centre 1-3 Tue – M. St 1-3 Wed – Kwik Save car park 10-12 Thur – B, St 1-3pm Fri - Nursery session 10-12 (booked)
Jobcentre plus	Job Centre Staff for SSLP	Children's Centre 1-3pm Tuesday
Diabetes drop in	Dietetic department for SSLP from Health	Children's Centre Weds 2-4pm
GCSE maths/English ESOL for men/women. Working with children Level 1-2 & NVQ's.	D. College for SSLP * observed	Children's Centre, range of times
Bangla group	SSLP staff	Children's Centre by arrangement
Keyhouse project	SSLP staff	Children's Centre Tues 9.30-4pm
Starting school together- parenting course	Family support co-ordinator, SSLP.	Children's Centre Weekly 10-12 by arrangement (4 sessions)
Early Birds	Speech and language worker, SSLP	Children's Centre Thursdays 9.30-1pm
Art therapy group	Health visitor co-ordinator, SSLP	Children's Centre Mondays 2-4pm
Baby café	Health Visitor co-ordinator & breast feeding advisor, SSLP	9.30-12 BCC Tuesdays
Baby massage	Health Visitor /co-workers	Children's Centre ;Fri 10-12
Byron parent and toddler	SSLP child care staff	Children's Centre; Wed 1-3
Parenting course	Assistant family support Worker	Children's Centre 6 weekly 2 hour sessions by arrangement
Weight management	Dietician	Children's Centre; Mon 10-12
Parenting drop in	Assistant family support Worker	Children's Centre,Tues and Thurs all morning
On track clinic	Health Visitor and Midwife teams	Children's Centre, 2 x weekly (one am, one pm)
Community resource drop in	Family support coordinator	Children's Centre, drop in sessions
Sessions for Physio, speech and language	Physiotherapist and assistant,	Children's Centre, drop in sessions

and dietician	Speech and Language Therapist and assistant, Dietician (SSLP staff seconded from Health)	
Playgroup	SSLP child care and early learning/play staff with relevant qualifications and mother tongues	Children's Centre Thurs 9.30-11.30 & 1-3 Wed & Frid 1.30 – 3pm
Single parents group	SSLP Family Support Workers	Children's Centre 9.30-11.30 once per week
Active tots group	Physiotherapy and Play workers (SSLP)	Children's centre once per week
Bouncy babes group	Physiotherapy and Play workers (SSLP)	Children's Centre once per week
Saturday dads' group	Dads' worker, SSLP volunteer parent and helpers	Every Saturday morning at Children's Centre and some evenings
Basic IT	D College for SS	Regular one offs or related sessions 1-3pm (10 places available)
Women only Swimming sessions	Sports Centre staff for SS	Swimming pool sessions, once a week

Observation of Playbus session

The aim of services delivered from the playbus was to build up relationships of trust with families and communities and to encourage them to use other SSLP services. The playbus offered high quality early learning and play facilities to young children whose parents were unwilling or unable to take them to group settings. The playbus development leader was well qualified and working still on additional qualifications, with experience of teaching at school and further education levels. She was articulate and knowledgeable about the communities in the SSLP area and had a strong commitment to the vision of Sure Start. She herself drove the playbus to 6 street corner venues within a 1.5 square mile radius on a reliable regular weekly basis. A bi-lingual support worker (mainly Urdu or Bangla speaking) was always there to interpret in the dominant language of the locality. The SSLP also had efficient systems of involving parent volunteers in translating and interpreting.

The bus was set up for a mixture of informal play based learning activities and a science activity. Children were brought to the bus by their families and greeted with enthusiasm. Siblings from some larger families were welcomed onto the bus without fuss. The children were confident to stay and quickly settled to enjoy the activities on offer. The sessions included a strategic mix of adult directed and child selected activities. Careful records were kept of what the group and individual children had achieved. The development and support worker planned activities together weekly drawing on this evidence base. Records were then passed on to the group setting or school that the children attended when they were older.

3.3.37 Key Messages from Stage 2 Results

The rich and detailed evidence of levels of proficiency accumulated from the 16 case studies confirmed the ratings of these SSLPs (based on less extensive, largely paper and telephone interview based evidence) at Stage One. The ratings on the 18 dimensions and at the overall four quartile levels at the two stages remained remarkably consistent. Findings at Stage 2 confirmed that programmes operated across the board satisfactorily, well or poorly. The findings, based on a mixture of

detailed quantitative and rich qualitative data confirm that Children's Centres need to implement the whole Sure Start model to deliver proficient and effective services to the families of young children.

3.3.38 Important underpinning features of overall proficient programme implementation were:

Governance and leadership: Reflecting a range of stakeholders, showing sensitivity to local communities, demonstrating flexibility in responding to changes in national and local policies, with managers/leaders with skills (or ability to buy them in) in finance, project management, human resources and IT systems.

Ethos: Demonstrating a welcoming and inclusive atmosphere, with friendly and knowledgeable staff, having buildings which are attractive and user friendly within walking distance for users.

Capacity to empower providers and users of services: Engendering mutual respect for the contributions of providers and users:

- providing high quality training for volunteers (including training to contribute effectively to board meetings/functions) and paid staff
- community development training for all staff: whole programme away-days with clear aims and objectives for the day
- achieving a balance between levels and types of service providers, services including self-help groups run by user
- Services tuned to a wide range of users (including for example fathers separated from their children, grandparents, teenage parents, prisoners).

3.3.39 Evidence of the nuances of proficiency in specific dimensions are displayed in Appendix E, within the two case studies and in the discussion of empowerment at 3.2.10, multi-agency teamwork at 3.2.24 and identifying users at 3.2.32. These will be helpful to Children's Centre managers and professionals charged with rolling out high quality services for parents and young children.

3.3.40 Particularly important features of programme proficiency linked to high levels of effectiveness in attaining impact outcomes were:

(1) Auditing local needs in order to tune local services to community priorities

The most effective SSLPs had a firm understanding of the needs of local communities and a clear vision and commitment, shared between providers and users of services, about how to meet those needs. They were able to respond to groups within communities with sensitivity. But they were pragmatic in offering parallel sessions tailored to the needs of different constituencies within the SSLP area. For example, they built on the historical strengths of localised playgroups (in a local church hall for example) or health clinics (in GP practices). But they also offered regular opportunities for constituencies to meet together. These could be large scale events such as the celebration of festivals, story times at libraries, well-being days at sports centres or days out to leisure venues.

The least effective SSLPs made token attempts at listening to the voices of local community members, involving 'hand picked' parents and providers in strategic decision making. They were unable to respond flexibly to community needs and preferences for services. Providers found it difficult to hear the voices of local users and to make adjustments to their traditional ways of delivering services.

(2) Identifying users and targeting those with specialist needs as early as possible

The most effective SSLPs had meticulous systems for identifying all potential users. These included shared database or paper based information about new births and children under four years old across Health, Education and Social Services systems. The take up of services and trajectories of parents and children were tracked using files common to all SSLP workers, with robust confidentiality protocols. All front-line staff were trained in first tier identification of additional needs and child protection and knew to whom they should refer concerns, often within guaranteed time scales. Referrals were acted upon quickly and careful records kept of action taken.

The least effective SSLPs had systems for identifying users and targeting specialist needs which were dominated and filed (usually on the grounds of confidentiality) by one agency, with limited access for other key workers. Each service ran its own attendance monitoring systems. Systems for targeting specialist treatments were ad hoc and there could be unacceptable delays between referrals and treatments. There was little evidence of close liaison between centre and home-based records of treatments and progression.

(3) *Allocating and training appropriate providers to deliver services*

The most effective SSLPs recruited and offered training to providers who demonstrated appropriate professional qualifications, experience of and sensitivity to working in the type of area in which the programme was located and personal qualities (such as life experiences or cultural/faith characteristics) related to the characteristics of the local communities. They had a commitment to encouraging local people to volunteer, attend training and move on to employment opportunities, often within the SSLP systems. They had a sound grasp of the cost benefits of deploying specialist treatments delivered by specialist staff when it was pertinent and cost effective to do so. They had a clear understanding of how generalist workers could be deployed, working in parallel with specialists, to deliver aspects of treatments within careful supervision/management systems.

The least effective SSLPs had inconsistent or ad hoc approaches to training volunteers and paid staff and demonstrated unacceptably high staff turnover. They wasted the resources of specialists by deploying them too often in generalist roles. They had limited understanding of how best to deploy the reciprocal strengths of generalist and specialist workers in the best interests of clients.

(4) Managing multi-agency teamwork at service delivery levels

The most effective SSLPs had support from local authority senior managers to translate policy for joined up service delivery into practice. Managers ensured that providers received both practical training and emotional support as their roles and responsibilities changed within multi-agency teams. Teams had regular joint agency staff training and meetings to plan actions associated with shared service delivery, protocols and records. They were able to work together in buildings at least some periods of the week.

The least effective SSLPs retained divisive blame cultures from single agency service histories. There was a reluctance to share information. Despite being co-located in shared buildings, staff maintained physical boundaries between discrete agencies in the ways they used spaces and furniture. Agencies operated in parallel rather than in joint ways of planning and delivering services. Managers were unaware of the training needs of those preparing to work in radically new ways in multi-agency teams.

(5) Sustaining service use and increasing reach figures (including accessing the 'hard to reach')

The most effective SSLPs set up and ran effective monitoring and evaluation systems using appropriate techniques. They often had an officer who was engaged in setting up, managing and strategically using databases to measure service use at group session, individual family and child levels. They fed information back regularly to the manager, senior management team and Board membership to inform strategic decisions about the cost effectiveness and impact of initiatives. Services were routinely adjusted to take account of this evidence base. To increase reach figures they used a wide range of user friendly publicity materials, door knocking, peer group buddying and outreach work. They consistently addressed the imperatives of targeting vulnerable and hard to reach families. Some publicity was generic to attract a wide range of families to services. Other publicity was personalised to attract families identified as having particular needs/preferences, often diagnosed by outreach worker home visits.

The least effective SSLPs had low levels of in-house or external evaluation. They had poor quality or patronising publicity material, which was not updated regularly. There was poor signage to buildings and services. They had low levels of commitment to increasing reach figures, particularly to include the hard to reach families or particular ethnic or cultural groups, preferring to remain within the comfort zone of replicating services for regular, repeat groups of users built up over time. These user groups were often perceived by non-users as cliques (identified by, for example, ethnicity or territorial characteristics) or as an elite/specialised group (for example as 'snooty types' or as 'too needy').

3.4 Discussion

3.4.1 What then did the case studies add to evidence from Stage One of the Programme Variability Study?

3.4.2 The case studies offer detailed qualitative evidence, based on fieldworkers' extensive conversations with service providers and parent users and on their observations of services being delivered in a range of different community, geographical and programme implementation contexts. Inevitably, there is some reliance on making value judgements of various kinds. But such judgements have been based on robust evidence, collated, analysed and interpreted by a team of skilled researchers, by now familiar with SSLPs across the country, and the findings are reassuringly in keeping with evidence from previous stages of the NESS evaluation.

3.4.3 The evidence provides instructive and useful examples of the realities of how the more proficient programmes confronted and overcame the challenges inherent in putting the Sure Start vision into practice. The evidence also offers insights into less proficient and less effective ways of working, and these examples may help Children's Centre managers and professionals to avoid making similar mistakes.

3.4.4 The next chapter will focus on Stage 3 of the Programme Variability Study when we turned the microscope up to explore the proficiency and potential effectiveness of services.

CHAPTER 4 - RESULTS 2: UNDERSTANDING HOW VARIATIONS IN SERVICES IMPACT ON PROFICIENCY AND EFFECTIVENESS

4.1. Implications for Children's Centres from Stage 3:

- Children's Centre managers and practitioners can learn from models of proficient services inherited from Sure Start Local Programmes.
- Service uptake is dependent on tuning into local community needs and preferences.
- Information about universal services needs to be embedded routinely in health visitor and midwife protocols for home visiting all newborns and advertised for parents of children under school age in local GP surgeries, post offices, community centres and shops.
- Specialist services need to be targeted at point of need and monitored for impact by paper or electronic based systems for multi-agency team members to exchange information on a regular basis.
- There needs to be cohesion between principles and practice in centre-based and outreach services.
- Reach figures, particularly for the so-called hard to reach, were disappointing in many SSLPs.
- Children's Centres need to address barriers to non-use. Some barriers are specific to certain groups - for example fathers or working parents - or based on the attitudes of staff to changing their own traditional ways of working – or practicalities such as location, timing and format of centre and satellite building based services.

4.1.1 For the third and final stage of the Programme Variability Study our aim was to identify *good practice in services within the context and structures/systems of emergent Children's Centres*. Therefore, we focused on the *perspectives of those who were delivering and using services* in 12 Children's Centres. The twelve centres were selected because they had a history of SSLPs categorised as proficient on the Programme Variability Rating Scale, and had better than expected child and parent impact outcomes from the Impact Module data. In particular we identified SSLPs that had become Children's Centres with better than expected child outcomes (in relation to others in the sample of 150 SSLPs in the Impact Module longitudinal study).

4.1.2 For this third stage of the Programme Variability Study we had several related questions:

- ***What services*** *were delivered by 12 proficient Children's Centres within the last 12 months?*
- *What were the* ***perspectives of providers of core services*** *in Early Learning/Play and Childcare, Health and Family Support of what works in their services delivered from the Children's Centres?*
- *What were the* ***perspectives of users*** *of these services on what works?*
- *What were the* ***perspectives of non-users*** *of services in the area?*
- *What systems did the Children's Centres have for* ***tracking the dosage of services*** *for individual children?*

4.2. Characteristics of the sample of 12 Children's Centres

4.2.1 Table 4.1 gives the 12 Children's Centre characteristics by community level types and region.

Table 4.1 Characteristics of the sample of 12 Children's Centres by community level type and government region

Programme	Community Level Type	Government Region
1	Less Deprived	North East
2	Typical	North West
3	Indian subcontinent	Yorkshire & the Humber
4	Most Deprived	North West
5	Typical	East Midlands
6	Typical	Yorkshire & the Humber
7	Least Deprived	North East
8	Ethnic Diversity	London
9	Typical	South West
10	Typical	South East
11	Ethnic Diversity	West Midlands
12	Indian subcontinent	London

4.2.2 Table 4.2 gives the Programme Variability Rating Scores by quartile (where 4 is the most proficient and 1 the least proficient). We included two SSLPs in the median low quartile because their child outcomes were high and they gave us access to regions that might not otherwise be represented in our sample.

Table 4.2 Programme Variability Proficiency Rating of the sample of 12 Children's Centres by quartile

Programme	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
PV Rating	4	4	3	4	2	3	4	3	4	3	2	4

4.2.3 Table 4.3 gives the Impact outcomes for the Children's Centres as measured when they were SSLPs. The Impact measures include three child outcomes for 3-year-olds (British Ability Verbal and Non-verbal Ability and Social Competence) and three parental measures (Maternal Acceptance for families with 9 month olds and Home Learning Environment and Maternal Acceptance for families with 3-year-olds) from the Impact cross sectional study (NESS 2005a).

4.2.4 A score of 1 is considered good and above 1 very good. For example, programme 4 has good scores for Verbal Ability (1.25), Non Verbal Ability (1.44) and Home Learning Environment (1.00). Whilst not all twelve programmes had good impact scores across the board, almost all had good scores for 3-year-olds' verbal and non-verbal ability. We considered these as robust indicators of better than expected child outcomes.

Table 4.3 Impact Scores for the 12 Children's Centres

Programme	Verbal ability 3 yrs	Non-verbal ability 3 yrs	Social competence 3 yrs	Home learning environment 3 yrs	Maternal acceptance at 9 months	Maternal acceptance at 3 yrs
1	-0.08	.71	-0.15	1.29	0.07	-0.01
2	1.45	1.44	0.14	1.38	0.07	0.14
3	0.64	1.04	0.06	-0.72	-0.02	0.03
4	1.25	1.44	-0.08	1.00	0.01	-0.00
5	0.89	1.47	0.24	-0.16	0.04	-0.07
6	0.77	3.00	0.45	1.7	0.05	0.13
7	0.58	1.03	0.11	0.28	0.04	0.07
8	1.21	1.22	0.02	0.81	0.02	0.09
9	1.77	1.64	0.29	0.54	0.04	-0.05
10	1.51	1.98	-0.06	-0.01	0.00	0.03
11	0.68	1.17	0.02	0.85	-0.05	0.06
12	0.66	.18	0.69	0.37	-0.12	0.07

Mean=0; sd=1; i.e. 0 is average; positive scores better than average; negative scores worse than average.

4.2.5 Evidence from the evaluations of the Head Start intervention in the USA indicated that achieving health targets was always problematic (Love et al 2002). Access to health data for the NESS evaluation team was dependent on access to and the quality of local hospital records. Nevertheless we felt it was important to interrogate evidence of any shifts over time in targets for improving child health in the 12 Children's Centres. They had demonstrated better than expected outcomes on child development indicators. Perhaps their child health outcomes might also show modest gains?

4.2.6 Drawing on the Local Context Analysis module data, we explored two snapshots in time of reported hospital admissions for children 0-3 in the years 2001-2 and 2004-5 for three key indicators of child health: gastro-enteritis, lower respiratory syndrome and severe injury. It is important to stress that exploration of these data from a small sample of twelve Children's Centres was tentative and not generalisable to all SSLPs/CCs. Analysis of the results showed such erratic results for these indicators, with no single programme achieving consistently improved health outcomes overall, that we discounted the usefulness of this source of evidence.

4.3 What services were delivered by the Children's Centres within the last 12 months?

4.3.1 A service list was compiled to calculate the number of services for each programme under three headings: Support related services, Health related services, Early Leaning, Play and Childcare related services. Fifty individual services were listed (see Appendix F). The list was based on evidence of services offered by a range of centres/SSLPs from Implementation survey data and the first two stages of the Programme Variability Study. Managers or administrators were asked to identify which services had been delivered within the last 12 months. The programme manager, in some cases with the researcher on site or by telephone, checked the service list. Table 4.4 shows the number and distribution of types of services offered by each programme.

Table 4.4 Number of core services by type across the 12 Children's Centres

Programme	Family Support	Health	Play and Childcare
1	9	14	11
2	9	16	10
3	11	7	12
4	10	16	16
5	6	14	8
6	9	11	11
7	Missing data*		
8	9	14	11
9	7	6	12
10	5	9	6
11	7	4	7
12	7	12	7

* Information not returned to researcher despite repeated requests

4.3.2 This list was compiled on the basis of services offered during the last twelve months. During the transition from SSLP to Children's Centre status managers reported that some former SSLP services had been withdrawn due to budget or staffing cuts or changes in local authority policy. Overall centres were offering more Health and Early Learning, Play and Childcare services, though most were offering a balance across the three core service types.

4.3.3 Programme 11, which appears to be atypical in its service provision, was in an area of diversity characterised by many cultural, religious and linguistic groups. There were high levels of refugees and asylum seekers in the area. The Children's Centre appeared to be offering few services, with only four in health, and predominantly focused on parenting support. However, routine health visitor and midwife services were still sited in a centrally based health centre. And other services in the area were traditionally offered by local and national charities and voluntary organisations which had the trust of vulnerable groups within the communities. The Children's Centre was working with sensitivity to co-operate with providers of established provision in the area. It was a good example of 'what works' being tuned to the characteristics of a particular group of people, in a specific context, at a particular point in its socio-economic-cultural history.

4.4 What were the Perspectives of Core Service Providers on what works in their services?

4.4.1 It was assumed that key providers of health, pre-school and family support services would be the most knowledgeable and experienced professionals in the field to provide the kind of information required to answer the question ‘what works?’ in terms of the pragmatics of routine service delivery.

4.4.2 A structured interview schedule was designed to elicit the views of service providers. It was administered either face-to-face or as a telephone interview (See Appendix G). The themes were identified from a review of what works in services for families in areas of deprivation (see Chapter 1 for details) Themes addressed were grouped under:

- the rationale for the service
- service location and format
- service use and reach
- Service quality and impact.

The interview schedule in Appendix G is a useful reference point for interpreting the graphs that follow.

4.4.3 Interviews were conducted with one each of the service providers (in the areas of health, pre-school and family support) in each Children's Centre. Questions focused on a particular service (e.g. a teenage parent group, a play session, an ante-natal class). Thirty-six interviews were conducted over all. Responses were not provided by every interviewee for every question. The numbers of responses to questions are indicated in the graphs.

4.4.4 In each graph Health refers to core services offered by health visitors, midwives, nutritionists, occupational therapists, speech and language therapists or physiotherapists. Early Learning/Play and Childcare refers to professionals delivering core services such as pre-school playgroups, crèches, play sessions, day-care, parent and toddler groups, and literacy and language programmes aimed at children and their parents. In the graphs these services are referred to in the key by the shortened form Play. Family Support refers to services offered by family workers, social workers or generic outreach workers to support whole family well-being and functioning such as debt counselling, counselling, parenting programmes, mental health support, advice about drug and alcohol abuse, advice about training and job opportunities.

4.4.5 The questions were designed to elicit data that could be subject to both quantitative and qualitative analysis. The quantitative data were analysed using SPSS computer generated statistical analysis and the qualitative data by thematic analyses. The results are indicative, but useful in suggesting trends that might be explored in the larger sample of 150 SSLPs in the longitudinal study to explore relationships between Children's Centre services processes/treatments and Impact outcomes.

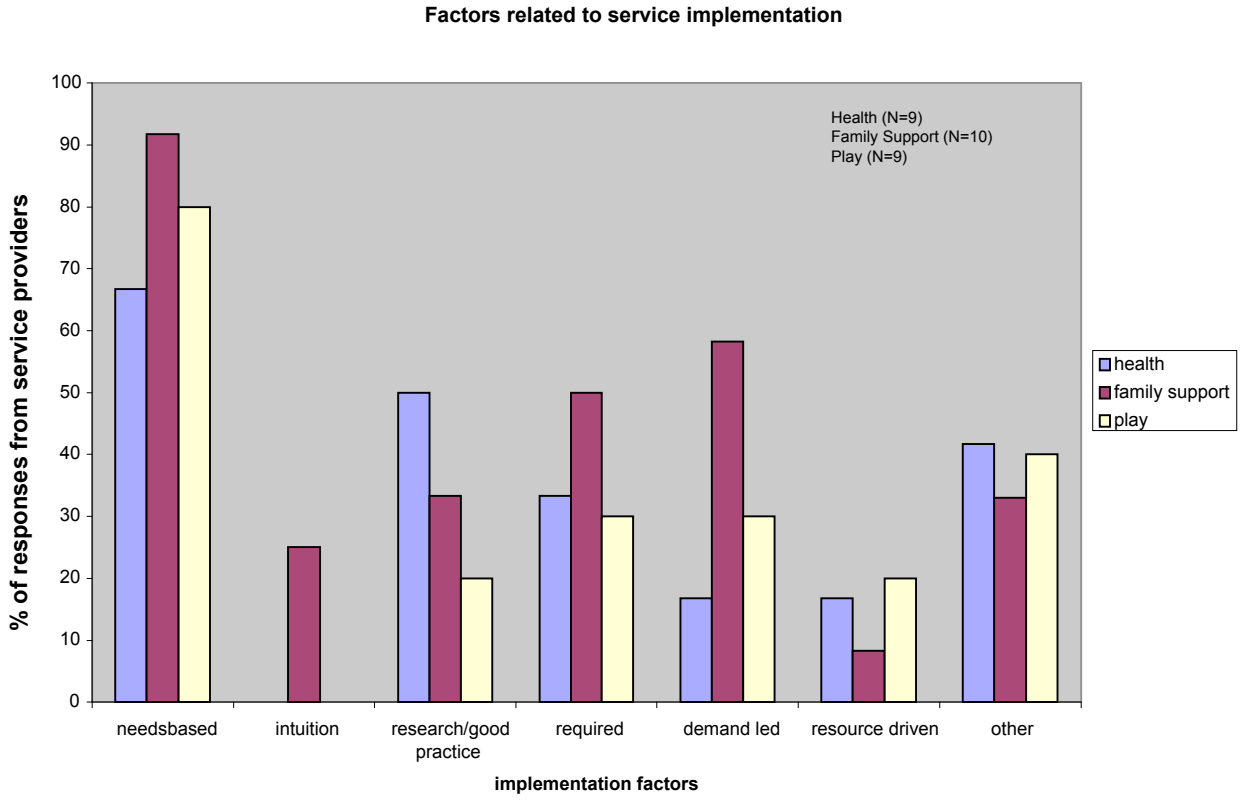
4.5 Results

4.5.1. The Rationale for the Service

4.5.1. Providers' Views on why the service was introduced?

Figure 4.1 shows results of asking providers why their service had been introduced.

Figure 4.1: Why was the service introduced?



Reasons for introducing the service

4.5.1 Sure Start Local Programme and Children's Centre Guidance emphasise the importance of auditing local community needs and preferences before planning and implementing services. Providers reported that their services were predominantly needs based, but with slightly less emphasis on needs reported by Early Learning, Play and Childcare providers. By *needs based* they meant services were introduced through community consultation and after identifying gaps in local services. By *demand led* providers meant that parents requested these services. There were some interesting differences between the providers from each of the core services. Family Support was the service most likely to be reported as needs based and demand led, but they reported that the rationale was also based on *intuition*. By this they meant that family support outreach workers were 'getting a feeling' from home visits for what services were required. Services related to Health, such as breast-feeding or baby massage, were reported as more likely to be *research/evidence based*, as might be expected within a medical culture. These differences in core service providers' responses reflect both the pragmatics of their service delivery requirements and the cultures of their professional agencies and disciplines.

4.5.2 Themes from service providers' comments on the rationale for services

The format of the interview schedules allowed for additional comments from respondents to be recorded and analysed. Listed below are the key themes emerging from analysis of the qualitative data related to the rationale for service implementation. The themes reflect the collective wisdom, expertise and experience of the providers of core services in the 12 Children's Centres. They contain important messages for those developing services for Children's Centres.

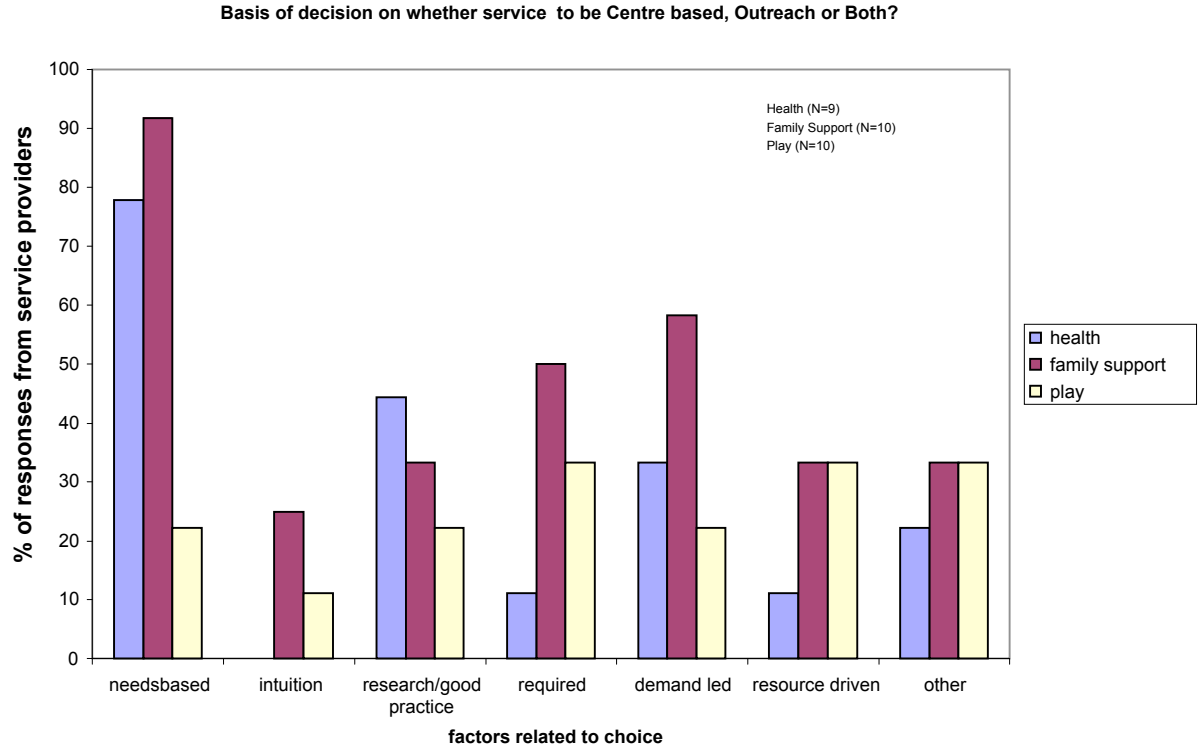
Planning services

1. Clear aims and objectives should underpin services.
2. It is important for all those delivering services to be committed to the vision and ethos of the centre.
3. Decisions about services should draw on research evidence of effectiveness or examples of proven proficient practice.
4. Service providers should have a good understanding of community characteristics and needs and respond accordingly in planning services.

4.5.3 Service location and format

Providers were asked what drove their decisions about the location (centre based, outreach or both) and format (e.g. drop-in or workshop) of their service?

Figure 4.2: What drove decisions about whether their service was centre based, outreach or both?



4.5.4 Figure 4.2 indicates that health and family support service providers reported that their decisions about whether to offer services as outreach, centre based or both were driven predominantly by analysis of needs of families within the community. Early Learning/Play and Childcare providers reported a wider range of influences on their decisions. Again Family Support workers reference intuition as an influence, with Early Learning/Play and Childcare referencing intuition to a lesser extent. Health workers were more likely to reference research/good practice, and Family Support workers were more likely to reference demand (picked up during home visits perhaps?) and statutory requirements (perhaps in response to child protection protocols?). Resources (most often meaning staff availability) appeared to influence decisions more for health and family support workers.

4.5.5 When we analysed the qualitative data entered in this section of the questionnaire we identified some useful characteristics common to these 12 proficient Children's Centres as:

- providers had principled reasons, underpinned by a feel for the cost benefit analysis, for offering outreach, centre-based or both as service locations.
- there were systems for outreach workers offering individual one to one services in homes to exchange information on a regular basis with the providers delivering group services in the centres.
- there was a common set of professional beliefs, values and attitudes across outreach and centre based services.

4.5.6 Key themes that emerged from analysis of the qualitative data are listed below.

Key themes that emerged related to the location and accessibility of services

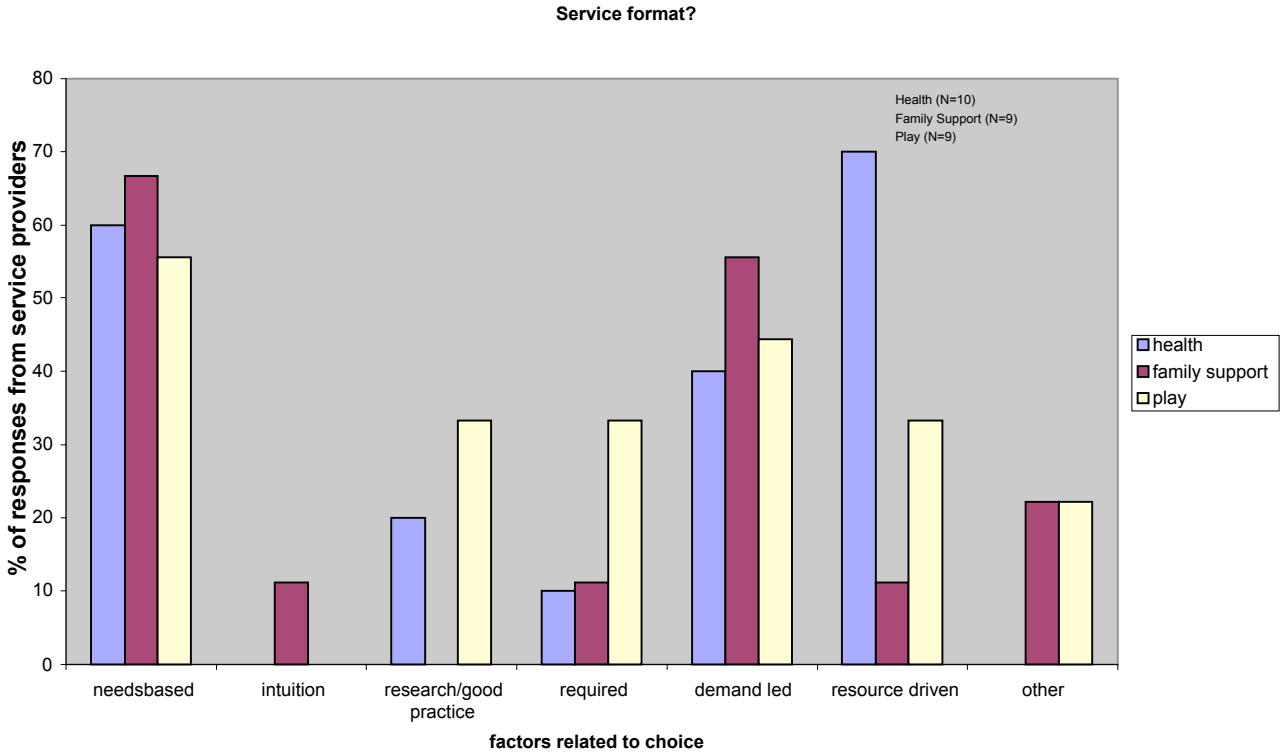
1. Venues for services should be at the heart of the community: central and visible with family friendly facilities.
2. It is important to build on the familiarity of buildings already well used by families with young children in the community, such as community centres, church halls, libraries and clinics.
3. Satellite venues take services out to different parts of the community making access easier for families with young children but also may address cultural/social barriers within the locality.
4. Transportation and childcare are key issues for vulnerable families in gaining access to services.

4.5.7 Providers' views on the appropriate format for their service

We asked the providers how they made decisions about how they delivered services. Figure 4.3 shows that all providers reported that factors relating to choice of service format (e.g. drop in session, course, workshop) were needs based and demand led. We were interested to see that there were so few references to research/good practice in making decisions about the format of services (and in the case of Family Support workers none). It is perhaps indicative of a lack of accessible research in the field about the practicalities of delivering service

activities. The health service providers were most likely to claim that resources drove the format of their services. This is likely to refer to staffing. At this point of transition from SSLPs to Children's Centres, managers and professionals were reporting difficulties in renewing contracts with health visitors and midwives. Many Primary Care Trusts were in financial difficulties and were reluctant to commit key workers to Children's Centre contracts. There is a key message here for Children's Centres in their attempts to maintain appropriate levels of health related staffing. There is likely to be resistance from the National Health Service to seconding their staff because of their financial constraints.

Figure 4.3: What influenced decisions about the format of services?



4.5.8 Analysis of the qualitative data in this section of the questionnaire revealed the following important messages for Children's Centres.

Delivering services

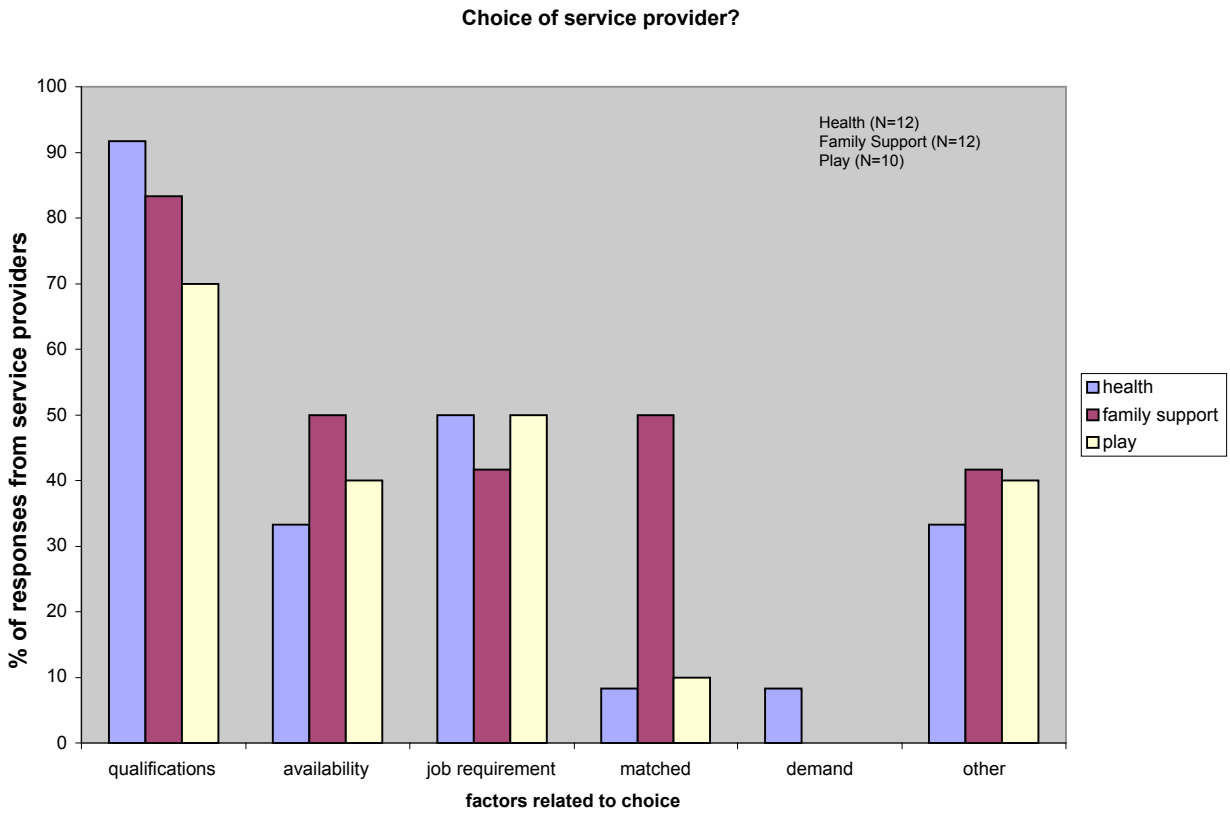
1. Signposting and delivering services in a non-stigmatised way is important.
2. Multi-agency delivery of services is effective in enabling parents to access a range of expertise at any one time and may be more cost effective.
3. Centres should aim for a balance of services between informal groups to promote general health and well being and more focused structured sessions for specialised purposes.

4.5.9 Providers' views on what informed the choice of who would deliver their service?

Figure 4.4 indicates that the most important factor reported by all core service providers, especially for Health providers, as informing the choice of who would deliver a service was appropriate qualifications. Family Support providers were most likely to indicate that matching (for example in terms of gender, culture and faith) the characteristics of providers with users was important. But all providers referenced the availability of staff and the nature of the job requirements as important. The shortages of qualified staff to deliver children's centre services reported by managers of the 12 centres reflects a national problem. There are important implications for the training staff at both initial and in-service stages to work within multi-agency teams to deliver services for children and their families. There are also lessons to be learned about the recruitment and selection of staff with appropriate personal characteristics and attitudes to users.

4.5.10 When we analysed the qualitative data we identified that proficient Children's Centres had staffing policies which reflected the imperative to employ at all levels, including in leadership/management roles, staff who represented the characteristics of local communities in the area.

Figure 4.4: What informed the choice of who would deliver the service?



4.5.11 Multi-agency teamwork

Providers were asked about the extent to which they worked within multi-agency teams. Of the 26 service providers who responded to the question, 16 including those delivering health services, reported that they were 'very much' part of a multi-agency collective in service delivery. This is encouraging when there have previously been concerns that health personnel were reluctant to embrace the practices of multi-agency teamwork. When asked in what way they were working within the teams, they responded: joint planning and delivery of services, referrals (both informal and formal) and joint instigation of care plans.

4.5.12 Below is an example of proficient multi-agency teamwork.

Multi-agency service delivery

An example of good multi-agency work was found in a Children's Centre that ran a baby club weekly, across a whole morning. Staff from family support and health, working alongside each other delivered the service.
The format was treasure basket play, baby massage and a visit to the sensory room.
A variety of practical help and advice was routinely given alongside baby club activities.
Particularly well used was advice about breast feeding, weaning, sleep and baby's routines.
Signposting to other services was frequent.
Specialist advice was on hand immediately from staff based in the on-site multi-agency team. A dental hygiene worker was observed dropping in to enquire about any babies with new teeth. A certificate and dental goody bag were given to babies with new teeth.
The atmosphere was informal, conducive to facilitating peer support and asking for help and advice. There were plenty of comfortable places to sit with babies and chat and a snack was provided for parents.

4.6 Service Use

4.6.1 Who are the main users of their services?

4.6.1.1 The second section of the questionnaire focused on providers' views on service uptake, reach and sustainability. We particularly wanted to focus on this aspect of their services since reach figures in general had proved to be low in our findings at Stage One and Two of the Programme Variability Study.

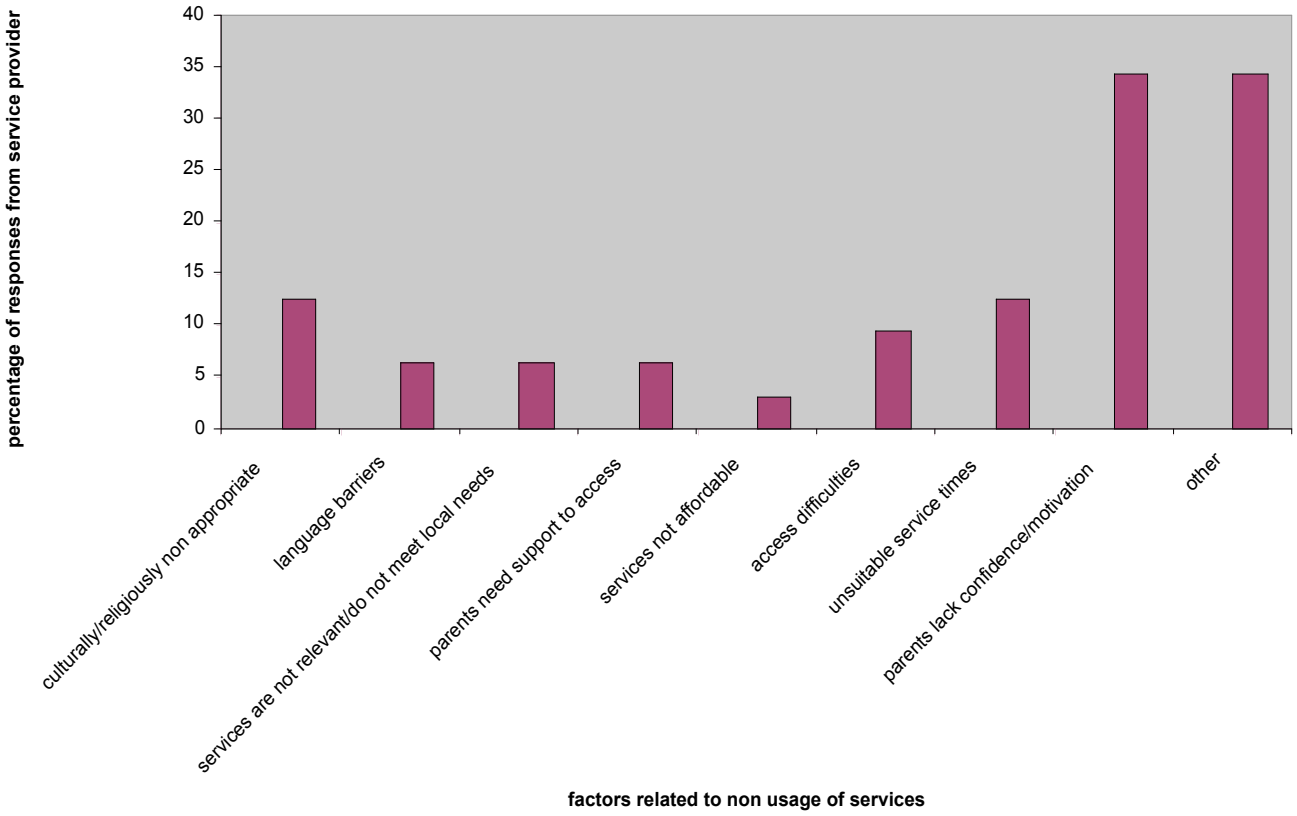
4.6.1.2 Providers were first asked to identify their main service users. They reported that main users were families of all types with children under school age. But providers qualified this universal, non-stigmatised approach by also nominating the family types they targeted for specialist services. These included: the newly pregnant, vulnerable families, teenage mothers, fathers, single parents, carers in specific groups (e.g. grandparents, child minders, travellers and asylum seekers).

4.6.2 Who is not using services and why?

4.6.2.1 We questioned providers about who they were not reaching with services and why. Figure 4.5 summarises responses. In the same way that teachers tend to blame familial or community characteristics for the non achievement of children in their classrooms, 35% of these experienced service providers' responses focused on parental lack of confidence/motivation as the key causal factor for non-usage of

services. They seemed unwilling to attribute non-use to features of their services over which they had control. The issue of cultures/faiths and language barriers not being compatible with the way services are delivered arose in 17% of responses. Twelve per cent cited unsuitable service times as a factor deterring use. When we explore non-users' perspectives later we find that unsuitable service times was an important factor for them too, particularly if they were working, or if they had several children with different attendance patterns at playgroups, schools or daycare. The other category Fig. 4.5 relates mainly to providers citing factors specific to particular services. An example is where alcohol/drug users who were not in a rehabilitation programme would not allow their children to be accessed by providers associated with Social Services; or where those involved in criminal activities were reluctant to give their names and addresses in order to attend services.

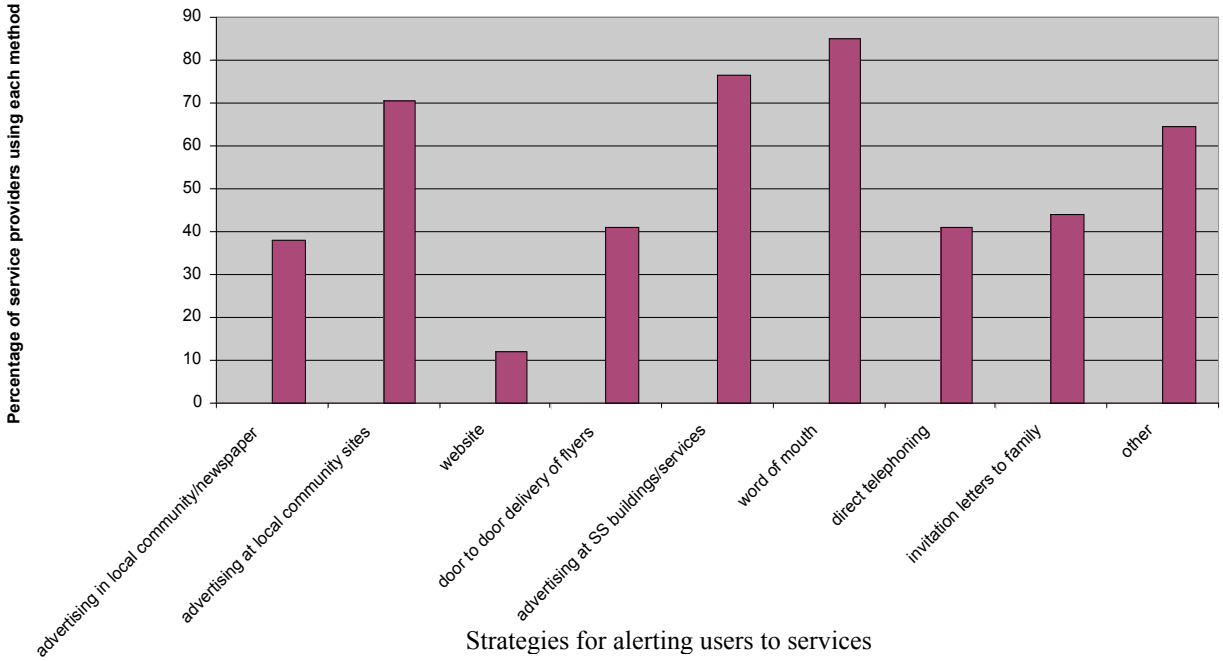
Figure 4.5: Reasons from all service providers for people not using services



4.6.3 How do users get to know about services?

4.6.3.1 Figure 4.6 summarises all service providers' responses to this question. They recognised that their most potent way of attracting new users was through word of mouth. But a range of general publicity strategies was also cited: posters in local buildings, including the centre, advertising in local papers, leaflet dropping. They targeted families individually by telephone or letters of invitation to attend services or days out. Websites were used less often, an indication that service providers perceived that many families in the communities were likely to be excluded from routine internet access.

Figure 4.6: How do users find out about services?



4.6.4 We identified that the most proficient Children's Centres had clearly articulated strategies for signposting services for users. We give an example below of a Children's Centre that had inherited a robust SSLP system for attracting users to their services, based on strategies deployed by a well-qualified community support worker who was employed specifically for this role.

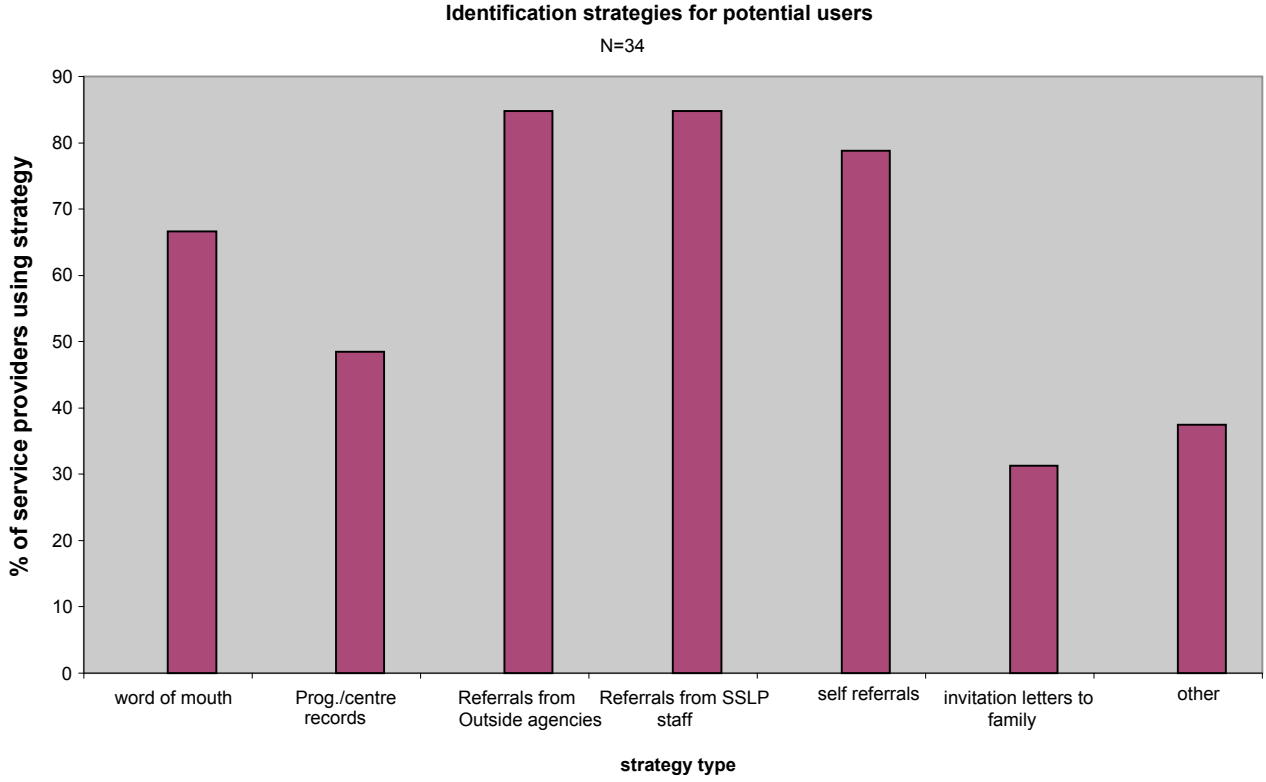
Signposting users to service

The Programme Manager had identified that a Sure Start brand name was not visible within the communities around the centre. She employed an additional person to address this problem. Her role was designated as a Community Support Worker. She was charged with visiting every new birth at the family home and every 'mover in' to introduce them to the purposes of Sure Start and the services on offer. The Primary Care Trust provided information on new births in the area. Good links had been established with the Housing Association (owners of a large proportion of houses within SSLP area) in order to identify new tenants. Additionally, since the Community Support Worker had a background in community nursing, she was qualified to make informal assessments of the families' needs. If the Community Support Worker diagnosed that additional support was needed, she referred and/or signposted the family to the appropriate person. During the initial visit (and with the parent/carer's permission), the Community Support Worker completed a Sure Start registration form. This form was passed onto the Monitoring Officer who entered the families' details onto the Programme's database. This ensured that the family received up to date information on forthcoming events and services. Following the implementation of this approach to signposting, the benefits were immediately evident in increased reach figures.

4.6.5 How do providers identify users who might benefit from services?

Beyond the general strategies for attracting users to services, we wanted to know how providers targeted users who might benefit from specific services. Figure 4.7 summarises the responses. Three quarters of the responses (28) cited the strategies of *referrals* from *outside agencies* and from *SSLP staff* and *self-referrals*. *Word of mouth* was also an important strategy. But to gain acceptable reach figures, centres had to also use the more formalised procedures of interrogating their *monitoring systems*. These systems were usually established by *efficient records/databases* of new births and incomers to the area with young children. Strategies were in place to actively recruit reluctant users; for example with follow up letters pursuing those who had not yet attended services. Two examples of proficient monitoring systems are given below at 4.6.6.

Figure 4.7: How do providers identify users who might benefit from services?



Strategies for identifying user

4.6.6 Proficient systems for tracking individual service use

We offer two examples shown to us by administrators, one electronic and one paper based, of proficient systems for tracking service dosage. They had the virtue of not overwhelming busy professionals with additional paperwork.

Paper based system for tracking service dosage: The red book system

Since 2004 all new parents were offered a consent form by the Health Visitor (seconded from the Primary Care Trust) on her routine new baby visit. The consent form was placed inside the Red Book where all the new baby's details were recorded. All new birth Mums completing consent forms received a home visit from a family support or outreach worker within one month, who was then able to refer the family to other services. Sure Start paid the administrative costs of managing this agreement. This system was maintained by a weekly (previously fortnightly) joint meeting with health visitors from the local clinic. The health visitors needed to be positive and encouraging about what Sure Start offered to sustain the volume of Mums signing the consent form.

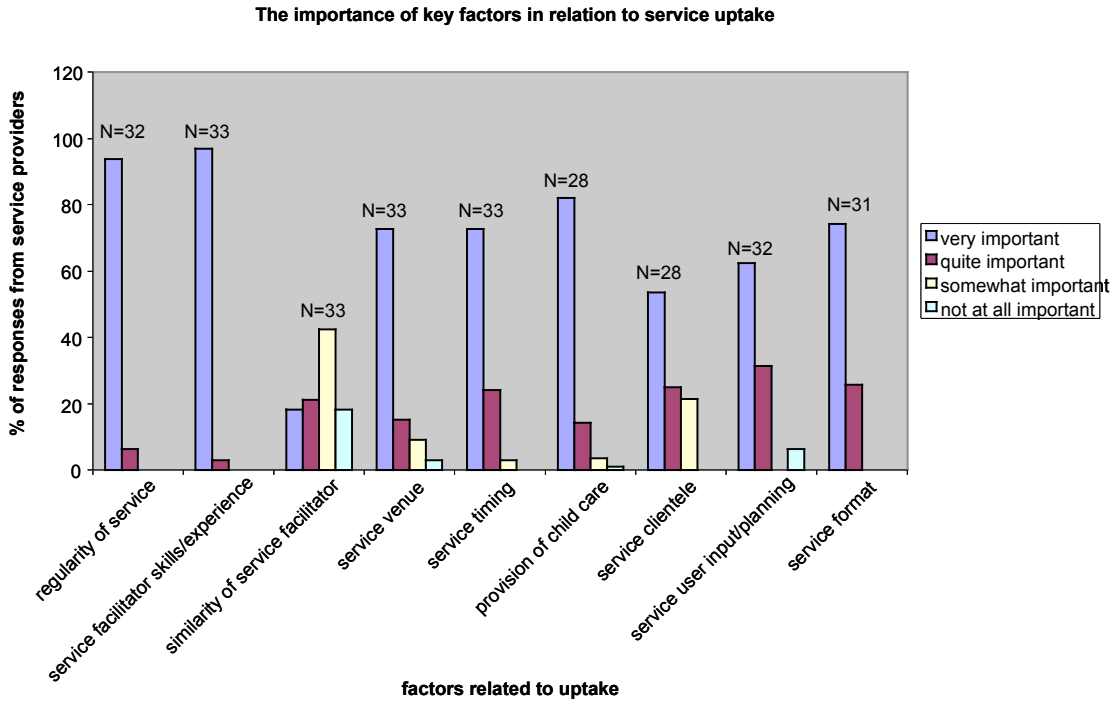
Electronic system for tracking service use

The SSLP commissioned a bespoke database that used the Soft Smart software package. The Monitoring Officer oversaw the running of the database. Within the SSLP area, the Community Support Worker visited every new birth and every 'mover' in. The PCT and Housing Association provided all the information to facilitate this. At each visit (and with parental permission), the Community Support Worker completed a Sure Start registration form. The Monitoring Officer entered the data from this form onto the database. The SSLP was then able to keep the family abreast of any new (or existing) service information. In addition to this, every service provider was required to complete a monthly monitoring form that recorded each time a particular family accessed their service. In the case of outreach work, the number of visits made to the family home during that monthly period was recorded. This information was logged onto the computer for each individual family registered on the database. From this, the Monitoring Officer was able to run specific queries to generate information both at individual family level and at individual service level (e.g. the number of times Mrs Smith has used the Tumble tots service). As acknowledged by the programme this system was not without its limitations. For example, the database did not record if a child was no longer living in the family home. In addition, data sharing across agencies was limited and despite its obvious benefits some staff complained about the volume of paperwork involved.

4.6.7 What key factors contribute to services being taken up by users?

Providers of all three core services were asked to rate 9 items related to what attracted users to their services on a 1-4 scale, where 1 was not at all important and 4 was very important (See Appendix G, item 11 for details). Figure 4.8 summarises their combined responses.

Figure 4.8 What factors contribute to the uptake of services?



Rating of importance on key factors in uptake of services

4.6.8 The features ranked as important for the uptake of services reflected the pragmatics of the operational constraints from the perspective of providers. The factors identified as *very important* were in rank order:

1. the *skills and experience* of the person delivering the service,
2. the *regularity* of service delivery,
3. the provision of *childcare*,
4. of equal importance the service *format*, the *venue* and *timing*.

4.6.9 Despite earlier claims that user needs and demands drove their decisions about service delivery (see Figures 4.1 and 4.2), factors related to the user perspective appeared to be less important to providers when they responded to this ranking exercise. They were in rank order:

1. *involving users* in planning services,
2. the *nature of the clientele* itself,
3. *matching* the characteristics of service providers and users.

4.6.10 Initiating use/accessibility

When we analysed the additional comments made by providers on attracting users to services they reported that types of non-users tend to be specific to the communities. But two groups continually cited as non-users were *fathers*, because of the perception of services being dominated by a female culture, and *working parents* due to timing of services mostly during school/working hours when they were not able to access services.

4.6.11 Parents may need support to access services either due to practical and/or emotional limitations. For example a *practical problem* would be help in getting down several flights of stairs with a buggy and young children or transport to services. *Emotional support* would be to go and collect a user from home for their first few attendances at services when they lacked confidence.

4.6.12 Increasing reach

We analysed additional comments made by providers on the crucial challenge of increasing their reach figures. They cited the following strategies to increase reach:

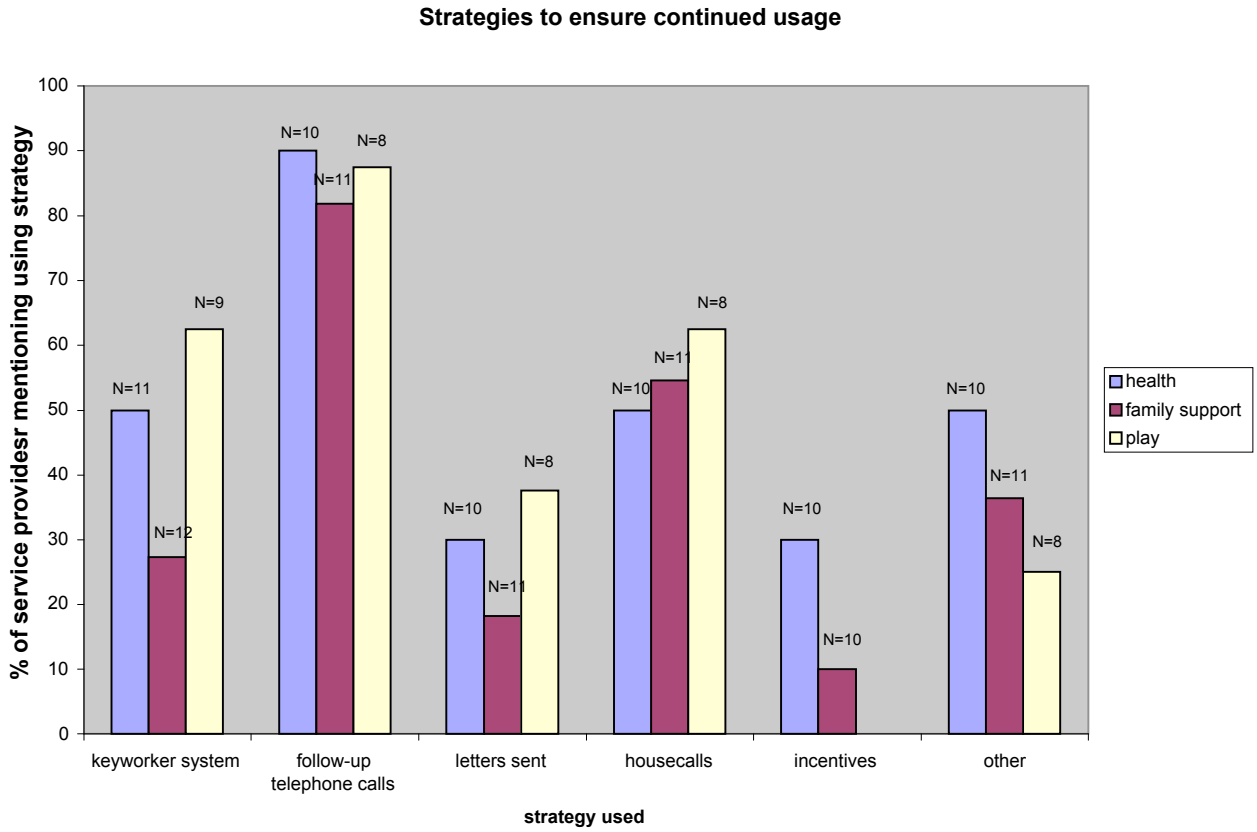
1. Continual signposting of what is on offer to all potential users across services and agencies.
2. Employment of a worker whose role is to introduce services to every family with a new born and every mover with young children into the area.
3. The use of peer support workers or buddies to spread the word.
4. The use of everyday well-used community settings to advertise services such as the local mini-market, post office and primary schools.
5. Texting to contact young teenage parents.
6. Recognition of the importance of addressing social/cultural barriers to reading publicity (e.g. for those with learning difficulties or mother tongues other than English) and incorporating additional strategies, such as door knocking or telephone messaging, to address their needs.
7. Recognition of the limitations of using a programme/centre databases for distributing publicity. For example, mail shots will only be sent to registered users and are therefore unlikely to attract non-users. A range of mail shots is likely to be needed, each targeting specific groups.
8. The importance of sensitively targeted publicity to attract specific community groups to services, especially the 'hard to reach'.

4.6.13 How do providers maintain attendance at services?

We know that interventions are only effective when treatments are sustained over time. Erratic access to treatments is not likely to result in positive outcomes. Having attracted users to services the challenge was then to maintain regular usage. We asked providers how they maintained attendance at their services.

4.6.14 Figure 4.9 summarises the responses of the service providers in Health, Early learning/play/childcare and Family Support to this question. The strategy cited most by all core service providers was the use of *follow-up telephone calls*. Providers of pre-school services were most likely to report using a key-worker system. Key workers sent out *letters* and made *house-calls* (as well as making *follow up telephone calls*) to encourage attendance. Health staff offered *incentives* such as ‘free dental care bags’ and Sure Start beakers (to encourage weaning) and family support workers offered fresh fruit and biscuits at sessions.

Figure 4.9: How do providers maintain attendances at services?



Strategies for maintaining service use

4.6.15 Centres were most successful at maintaining attendances when they had systematic and successful strategies (inherited from the SSLP) to ensure continued attendance at services and sustained dosages of treatments. This often involved a ladder of opportunities for users as they progressed from one kind of service to another. An example is given below.

Maintaining service usage

A Children's Centre, based in the North West had a programme of services that followed a natural progression through pregnancy, childbirth and subsequent childhood developmental stages. Parents were signposted during pregnancy, by an overstretched mainstream hospital antenatal service, to the programme's course of antenatal classes. As the course came to an end, parents were given a tour of the Children's Centre building, introduced to staff, and given information on breastfeeding groups and the baby club. Parents then felt comfortable about returning to the centre with their newborn child. As their child grew, they were signposted to weaning parties, library services, cooking for toddlers, toddler gym, stay and play groups, nursery and pre-school.

Supplementing these universal services was a parallel selection of targeted services, such as soft play, adult education and classes and a sensory room.

Retention and exit strategies

4.6.16 Providers were asked to elaborate on retention and exit strategies for their service users.

4.6.17 Providers reported that their centres had good 'moving on' and 'exit strategies' to ensure that once the family completed a particular course or finished with a particular service, they were signposted on to the next developmentally appropriate course/service. Action plans were drawn up with parents and continually reviewed. Some services naturally followed on from one another. For example in one centre an antenatal parenting group were encouraged to move on to a baby café. The groups then moved on together to Stay and Play sessions with their toddlers. Both the children and their parents formed lasting friendships. For some, the services followed through right until the children started school together.

4.6.18 To retain users, incentives were offered in the form of certificates, gifts, vouchers towards day trips and food. For example in one setting parents who completed a cooking course were given a recipe book. Sometimes the incentive was the opportunity to volunteer, to become a breast feeding counsellor or peer educator for example, or to help out in playgroups or crèches. For some parents these volunteering experiences led to formal training and jobs within the centres.

4.6.19 One programme used incentives more like a carrot and stick. Parents were only allowed access to crèche facilities and respite care if they signed up to some education and training offered by the centre.

4.6.20 Maintaining service use

Additional comments from qualitative data gave us more insights into the pragmatics of sustaining service use. Comments included:

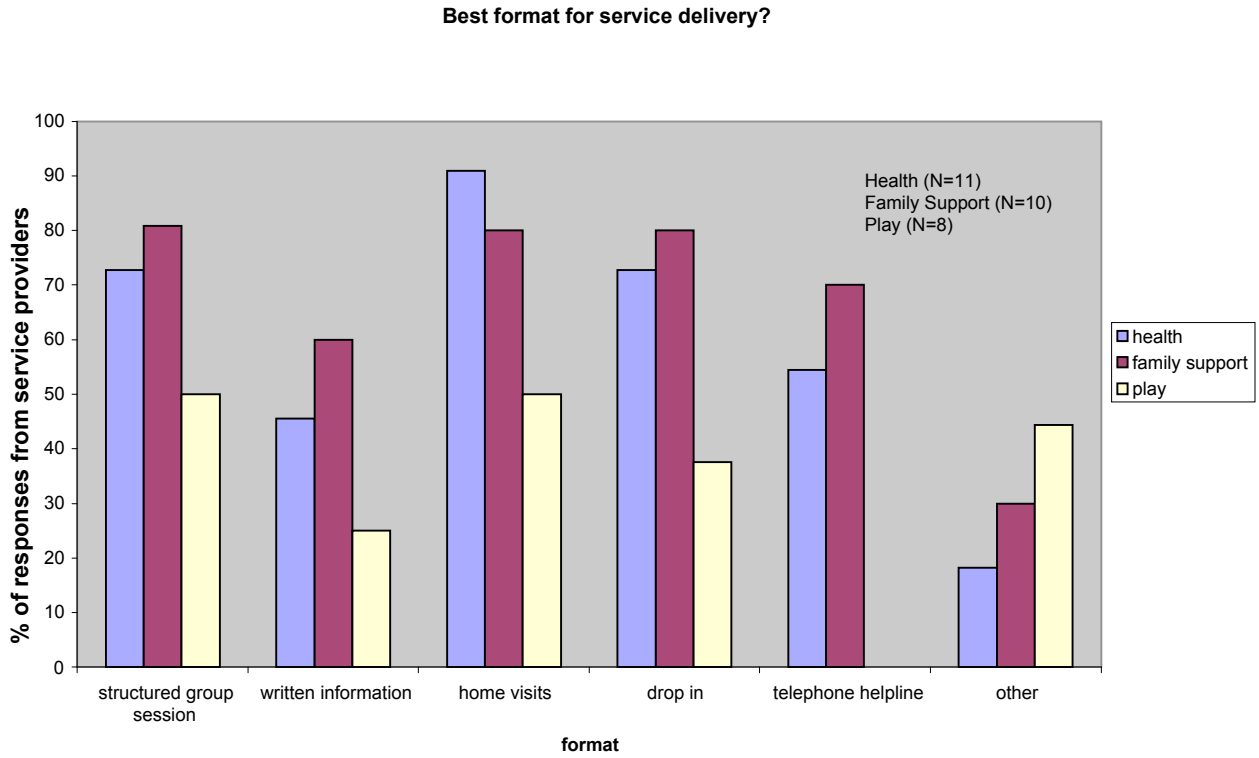
1. Service providers should understand the limitations within the communities they serve and respond with sensitivity. For example there may be social/cultural/emotional barriers to users attending services. Family dynamics, such as chaotic lifestyles, may make it impossible to keep set appointments.
2. Service providers should continue to deliver inherited services with a history of engaging users within the community and trust built up over years. If they plan to 'enhance' successful services, they should consult users before doing so.
3. Services should be continually evolving in response to patterns of use or non-use and changes in local demographics.
4. Service delivery formats (e.g. whether delivered in centre based group sessions or home based 1:1) should be tailored to meet individual and family needs.
5. Incentives work in sustaining the use of services (e.g. free childcare places, refreshments, vouchers, completion certificates, recognised qualifications). Experienced trainers reported that qualifications could be a particular incentive for men who tend to be attracted by short term but tangible outcomes from attending services. Women users, still most likely to be the main carers of children under 4, tend to have longer term goals.

6. Empowering groups within communities, such as teenage parents, travellers and carers of children with disabilities or additional needs, to set up their own groups is an important long term aim.

4.6.21 Outreach

We wanted to explore in detail providers' views on outreach and home visiting. Figure 4.10 indicates that outreach/home visits were rated as important as a format for service delivery by 90% of health and 80% of family support service providers. But a similar number also rated structured group sessions (at 70% and 80% respectively) as the best format for delivering services. Even with the smaller number of respondents from Early learning/Play/Childcare services to this question, there was relative consistency across the three core service areas. Overall their responses indicated that it was desirable to maintain a balance between centre based group activities and 1:1 home based systems. Drop-ins were also rated as important, with written information seen as less important. Telephone helplines were rated as important by Health and Family Support providers, but less important to those working in the field of Early learning/Play/Childcare. This was likely to be because those delivering Early Learning/Play and Childcare perceived their role as working directly with the children.

Figure 4.10: What is the best format for delivering services?



Best formats

4.6.22 What did outreach activities look like?

All 36 service providers delivering health and family support services reported that they were involved in outreach work. A smaller number (24) from Play, Childcare and Early Years reported that they were involved in outreach. Where they were, home visiting was often aimed at supporting children's transition to pre-school/school. Far fewer early learning and play activities were delivered on a one to one at home, the exception being schemes such as Playlink (a scheme for taking play opportunities into children's homes on a weekly basis) and Portage (targeting children with additional needs or disabilities).

4.6.23 We wanted to explore their perspectives on the details of their outreach activities. It seemed to serve such an important role in providing appropriate services for families: at different stages of their parenting (for example in the immediate postnatal period or at times of family crises); with different parenting challenges (for example parents of disabled or chronically ill children); with different levels of confidence in their parenting (for example those with post natal depression or low levels of self esteem) and with specialist needs (for example families where there was domestic violence, criminal activity, drug or alcohol abuse or child protection issues).

4.6.24 We had many comments from the service providers giving us their perspectives on outreach and home visiting such as:

1. Outreach work is not just about delivering the intervention treatment. It has many facets including:
   - Informal/formal assessments.
   - Signposting to services.
   - Accompanying users to appointments e.g. in hospital/schools.
   - Assisting in arrangements for the transition process to pre-schools/schools.
   - Handholding users to get them to attend groups.
   - Delivering a specific intervention.
   - Setting up strategies to cope with crises.

2. Outreach is not only about delivering services in the home. Taking services out into the community is also outreach. An example is taking a toy library into a local school or health centre.

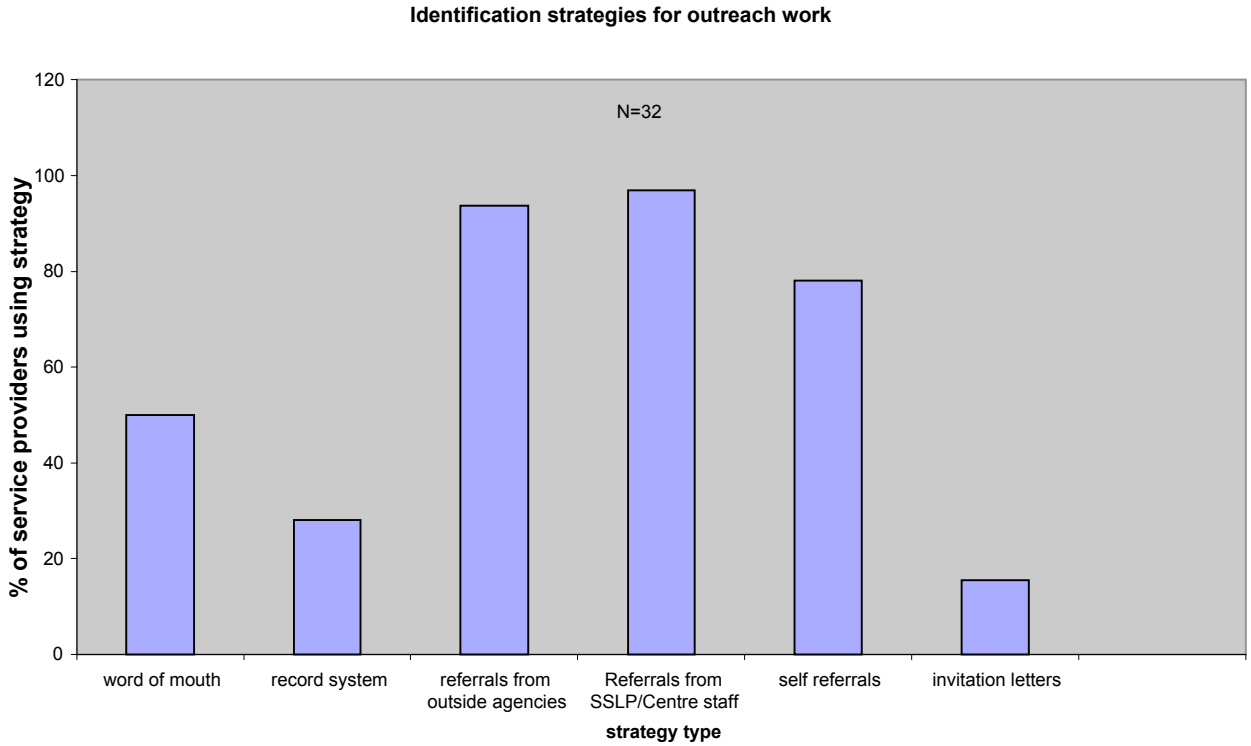
3. Outreach is an important way of initially reaching vulnerable families. Visiting them in their home setting builds up relationships, trust and finally perhaps the confidence for parents to access a service in the centre. A key message is that vulnerable families find 1:1 encounters less threatening than groups.

4.6.25 These findings reflect more detailed evidence presented in the Themed Study, Outreach and Home Visiting in Sure Start Local Programmes (Ball et al. 2006).

4.6.26 How are families identified for outreach work?

Key strategies (summarised in Figure 4.11) for identifying families who would receive outreach visits included *referrals from SSLP staff, referrals from other agencies* and to a lesser extent, *self-referral*. Fifty per cent of the responses indicated that they used w*ord of mouth* to identify users, mostly by information passed between members of their multi-agency teams. Only 30% reported using records to identify potential service users. There was little evidence of good practice in the systematic identification and tracking of individual families/users and their responses to treatments/progression as a result of outreach work.

Figure 4.11: How are families identified for outreach services?

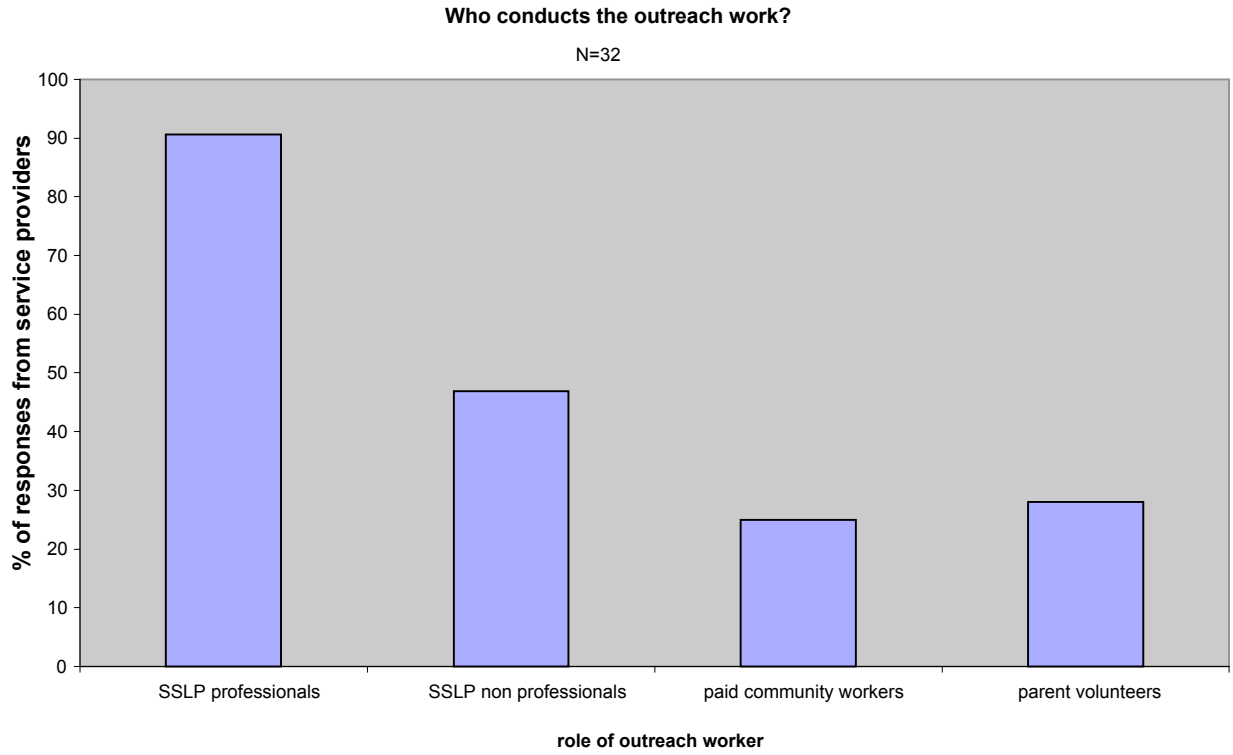


Strategies for identifying users

4.6.27 Who delivers the outreach services?

We then asked about who was responsible for delivering outreach services. Figure 4.12 indicates that whilst much of the outreach work was carried out by *professional SSLP/CC staff*, some was carried out by *non-professional SSLP/CC workers*, and to a lesser extent *parent volunteers* and *paid community workers*.

Figure 4.12: Who delivers outreach services?



4.6.28 We were concerned about the supervision of home based cases for whom such a diversity of professional, para-professional and volunteer personnel might be responsible, perhaps dealing with potentially complex family and health concerns. We asked providers about arrangements for the supervision of casework. All service providers received supervision for outreach work, with three-quarters of those interviewed stating this was on a monthly/6 weekly basis and just under one quarter stating this was weekly/fortnightly. The routine use of supervisions on a monthly basis seemed acceptable to these experienced professionals. However this would need to be supplemented by outreach workers having constant access to a line manager to whom they would refer any difficulties or major problems with their cases.

4.6.29 The qualifications/characteristics of outreach personnel

Analysis of the qualitative data elicited the following views from providers:

1. There is an argument for professionals and para-professionals (such as parent support workers) to work alongside one another in i) engaging the community and ii) delivering the support. However, there is concern to what extent a para-professional is competent, without appropriate training, to deliver treatments for specialised conditions such as postnatal depression.

2. The majority of services have their own mandatory training requirements, often single agency led. Low level joint training seemed to be offered in generic statutory requirements for all children's services, such as child

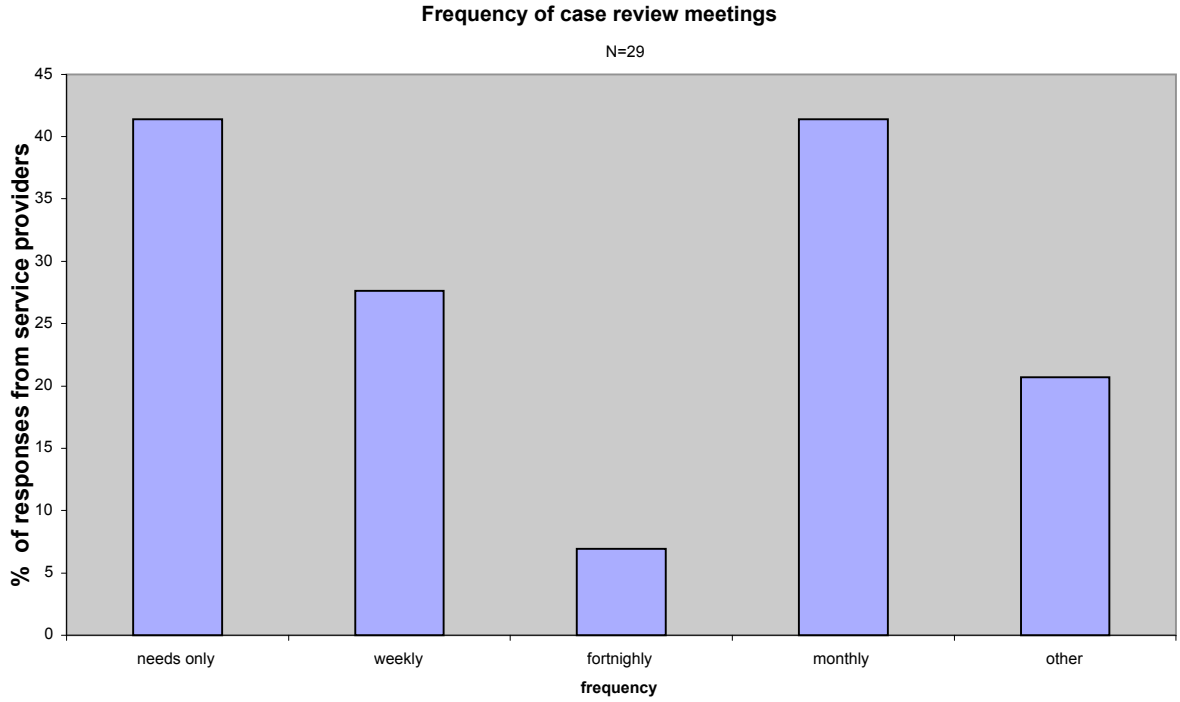
protection, health and safety and equal opportunities. But we still do not have enough specialised training for providers in fields such as drug/alcohol abuse and domestic violence.

3. Grounded knowledge of child development is important for all outreach workers so that they can recognise whether key milestones are being reached by children. Some managers stipulate a minimal requirement to be qualified at National Vocational Qualification Level2/Level3 for personnel who do outreach work and home visiting.
4. Peer support workers or 'buddies' have proven a useful way to engage 'hard to reach' communities.

4.6.30 How often are cases reviewed?

Finally we asked how often outreach/home visit cases were reviewed. Figure 4.13 gives the breakdown of responses. Thirty four out of thirty six service providers interviewed stated that case reviews were conducted on a regular basis. This was most likely to be on a needs only basis and/or a monthly review procedure. Again these experienced service providers seemed to share a consensus view of what were acceptable and manageable supervision systems for outreach case work. These insights may be a useful source for providing guidance for Children's Centres on supervision systems.

Figure 4.13: How often are outreach cases reviewed?



Frequency of outreach case review meetings reported

4.6.31 Maintaining standards whilst devolving services to generic outreach workers

Analysis of qualitative data provided us with further insights to providers' views on maintaining the standard of treatments delivered by outreach teams. These included:

1. The importance of regular supervision (fortnightly or monthly) with their line manager (agency led). Paid community workers also had regular peer support meetings to discuss issues that had arisen in their outreach work. There was less evidence of rigour in training volunteers for home visiting. This is important, since evaluation of other interventions, such as Home Start (Frost et al. 1996) have indicated that volunteers produce poor outcomes.

2. The importance of regular (monthly) case reviews with the appropriate agencies, working towards a Common Assessment Framework type of system. But there must be an effective back up system of line management of case work, so that any difficulties or crises detected by home visitors can be referred immediately to a more experienced, qualified supervisor.

3. Multi-agency teamwork is important, but teams need robust systems and protocols for regular and consistent exchange of information about cases.

4.6.32 Quality Assurance and Service Impact

We questioned providers about *quality assurance* of their services. Thirty three out of thirty six interviewees were aware of measures in place for maintaining standards in their services. Most providers referred to informal and formal in-house evaluation systems for their services. This is important evidence, particularly since the new Ofsted inspection regime depends heavily on regular and robust self-evaluation procedures led by managers. Providers of Play, Early Learning and Childcare services cited regulatory Ofsted inspections as their quality assurance measure. Health–related service providers stated they had standards within their professional roles within the PCT to which they were answerable. Family Support services appeared to rely on their professional traditions favouring in-house observation and appraisal for quality assurance.

4.6.33 Respondents were only able to give anecdotal evidence of *outcome evaluation.* We asked providers what impact their services had on families. Their responses were disappointingly anecdotal. Typical answers were:

1. A parent had been in an abusive relationship and lacked confidence. Volunteering to help at the Parent and Toddler Group built up her self esteem. She has now been helping out in school and is working towards an NVQ level 2 qualification. (Provider responsible for Play/Early Learning services).

2. In some cases it can turn their lives around. (Family Support Worker).

3. Baby massage gives parents confidence in handling their babies. By the third week they often say that their babies' colic and constipation have reduced. It gives them time for 1:1 bonding together. (Health Visitor).

4. More and more children settling into nurseries better, parents learning to play with their children, impact on financial situations of parents, easing storage difficulties for toys at home. Statistics from health authority indicate a decrease in number of accidents at home. (Under 5's Manager).

4.6.34 When we asked them if they had systems in place to measure whether intended outcomes of treatments had been achieved, providers routinely cited service users' satisfaction surveys, attendance figures at sessions and discussion of achievements at team meetings as their evidence base. Only one respondent referenced analysis of monitoring records and routine checking of how many targets they had achieved.

4.6.35 This seems to be an area of practice that must be addressed in setting up systems for monitoring service impact in Children's Centres.

4.7 WHAT WERE THE PERSPECTIVES OF CORE SERVICE USERS

4.7.1 Our intention was to triangulate the views of the providers of services with those who were using them. We asked the three core service providers in each of the twelve Children's Centres to nominate a small group (up to 6) of their service users for a focus group discussion. The schedule used for prompts is shown at Appendix H. Where it was not possible to get the respondents together for a focus group session the prompts were used for one to one interviews. Interviews were face to face or by telephone depending on the respondents' preferences. Shopping vouchers were given to those who agreed to take part. We used whatever strategies worked to access the voices of service users. One hundred and five users responded.

4.7.2 In order to prevent the user perspective being restricted to the 'regulars', we asked providers to nominate users from the three types identified by the Implementation study (Tunstill et al 2005). One type was 'Autonomous', defined as confident enough to access services independently. There were 60 users in this category. A typical comment from an autonomous user was: *Sure Start's fantastic for (my son). He's come on a lot being with other children. Much more outgoing now. We come to all the activities. It will give him good childhood memories. It's a very nice atmosphere here.'* Fieldworkers noted that families identified as autonomous users usually attended several services each week. For example this autonomous user told us that she attended the Bib Club (to promote breastfeeding), moved on to Gym Tots (for her son's physical development), then to Baby Peep (literacy for pre-school children programme). But she also attended Chillout (relaxation for parents), Tot Shop (exchange of baby/toddler clothes) and the Toy Library (resources for play). Overall she used a menu of services typically provided by a Children's Centre promoting the health/well being of parents and children concurrently.

4.7.3 A second type of user was 'Facilitated', defined as needing some support and encouragement to attend services. There were 20 users in this category. For example, a user in this category explained to us how she had been drawn into using services through contact with her midwife: *'She got people together and then we went together to breastfeeding and baby massage. You could ask advice about*

health things instead of having to go to the GP surgery. I'd rather talk to the midwife in an informal group with other women than to the GP. She also went into the hospital with quite a few mums for the delivery. She is always there for advice. She can tell you about giving up smoking, drug use, heroin. Before Sure Start I was alone. I met all my friends here. It stopped me being isolated. Sure Start has kept me sane. When you have a child you don't know what to do. It gets your kids playing with other kids. Coming here has made me more confident.'

4.7.4 The third type of user was Conditional, defined as needing additional, perhaps specialist help to take up services. There were 25 users in this category. A typical conditional user told us: *'When I had my baby I suffered from Post Natal Depression and this was a very difficult time for me because my baby was crying all the time. At first they visited me at home because I was too scared to go out and I didn't feel comfortable with my baby because he cried all the time. The Health Visitor kept coming round and she was very nice to me and encouraged me to go to the centre and assured me she would be there and there were other mums who also had PND, so we were able to support each other.*'

4.7.5 We asked the users what it was about services that worked for them. Their responses were coded under categories specifying *what works for adults* (Category A) and categories specifying *what works for children* (Category C*)*. Table 4.8 shows the percentages of responses by category and user types. In interpreting the data it is important to note that Autonomous users (as we might expect) comprised 57.8% of respondents. They were simply more likely to be around the centres and therefore available. Facilitated and Conditional users comprised 17.5% and 24.7% respectively.

Table 4.5 % of responses about what works for adults and children in services by user type

Category	NUMBER & TYPE OF USERS BY %	A N=60 57.8%	F N=20 17.5%	C N=25 24.7%	Total Users=105 100%
	Service user responses (Adult gains)	number	number	number	% responses
A1	Enables me to meet other parents	26	8	14	13.3
A2	Gets me out of the house	13	7	7	7.5
A3	I benefit from the quality of staff	13	6	7	7.2
A4	Gives me access to education / training	14	5	5	6.6
A5	Gives me access to professional advice	11	3	3	4.7
A6	Gives us access to a comfortable place	11	3	3	4.7
A7	Services within safe walking distance	14	1	0	4.2
A8	Gives me emotional support	3	5	3	3.0
A9	Gives access to multi-agency services	6	2	1	2.5
A10	Timing of services suits me	5	0	4	2.5
A11	Helps me solve practical problems	1	1	5	1.9
A12	Gives us access to a range of cultures	4	0	0	1.1
	Service user responses (Child gains)				
C1	Helps my child to socialise with peers	27	6	11	12.2
C2	Gives my child opportunities to play	21	9	10	11.1
C3	Enhances my child's development	27	6	7	11.1
C4	Offers crèche-respite form each other	6	2	6	3.9
C5	Supports my child's additional needs	5	0	3	2.2
C6	Improves relationship with each other	4	0	1	1.4
	Total responses				101.1

Key Type of users A= Autonomous (confident enough to access services)
F= Facilitated (needing some support and encouragement)
C= Conditional (needing additional, perhaps specialist support)

4.7.6 User responses related to what works for adults in Children's Centre services

Key messages were:

- Users categorised as autonomous tend to take up several services a week.
- Users categorised as facilitated need to be encouraged to use group activities.
- Users categorised as conditional may need sustained home-visiting and 1:1 support.
- Parents valued opportunities to get out of the house and meet other parents with similar concerns in a comfortable and non-judgemental venue.

- They valued the advice, support and professional skills and knowledge of providers.
- Though they valued training and career opportunities, many parents did not want to go back to work until their children were school age.
- They wanted services within safe, walking distance of their homes.
- They wanted services which were affordable and flexible enough to be offered at different times of the day.

4.7.6 Proportionately patterns of responses about what works for them across the three user types are similar. But there is an indication that Autonomous users are more likely to refer to benefits for their children. It is likely that Facilitated or Conditional users are involved in problems of their own and that these dominate their perspectives on what they find useful from the services.

4.7.7 Although providers are naturally concerned with the impact of treatments on users, in contrast **all users of centre based core services rate highly the benefits to them of getting out of the house and meeting other parents**. Typical responses in these categories are: *'It gets me out of the house.' 'It makes a change' ' I like the company.' I have made lots of friends with mums in the same situation as me. It helps to talk about the problems we've got with the kids, like not sleeping and playing me up'.* Respondents referred to the value of getting respite care when they left the children in crèches:' *I like the crèche facility so we can drop the kids off and have an hour or two to ourselves'.* This seems perfectly acceptable when we know that where parents are able to socialise with like-minded parents, they feel less anxious and more relaxed about parenting.

4.7.8 It was important that the centre staff tuned into this need for informal contact between and with parent users of their services. Users detected an inclusive and welcoming atmosphere the minute they first stepped through the door. Parents told us that they liked coming to places that were 'friendly and relaxing' and where *'the staff know your name and your kids'; 'it's the personal touch ...making me feel comfortable'*. Receptionists were key to setting the right tone for the centre.

4.7.9 Users cited the qualities of the staff as being pivotal to their choice of whether to take up services or not. They referenced **three aspects of what they valued in good quality staff: their knowledge and credibility in offering professional advice; their attitudes (for example that they were non-patronising and non-judgemental): and their own experiences of life and ability to empathise with the concerns, beliefs and values of service users**.

4.7.10 Only a few respondents appeared to have registered that multi-agency teams were delivering services and that they found this useful. This may reflect the difficulties Children's Centres have in implementing multi-agency teamwork at service delivery (rather than planning) levels. For many users, not that much had changed. A Health Visitor was still doing the same sort of job. They left their children in crèches and playgroups where 'nursery nurses' or 'teachers' took care of them. They were less sure of the roles of Family Support workers, and rarely

referred to Social Workers. Perhaps it did not matter that parents were unaware of the workings of multi-agency teams, as long as they felt happy about the staff who were working with them.

4.7.11 Parents contrasted centres with an ethos **sensitive to their social needs** to those where they had not felt welcome or comfortable. For example, two parents talked to us about their experiences of accessing a new building at the launch of a community cafe: First parent, ' *When we got there we were turned away because there was no room. The second time we went it was the same story. We were told to stand outside in the rain and wait till someone came out so there was room for us to get in. We didn't go back'*. Second parent, who had opted to continue to use satellite services delivered in an old Church Hall, said: *'I managed to get in but they were stressing about not having hot drinks around the children. You couldn't sit and have a drink with the kids like you could in this building. It was don't do this and don't do that. You don't feel at home'.* Another parent told us that she had initially been put off attending group sessions *'because no one introduced me to the others or anything, and I just sat there feeling lonely. In the end I forced myself to go back for the sake of my son. That was very hard for me.'*

4.7.12 We talked to users of a successful Muslim mother and toddler group. It had started as a small one off project in a community centre. The services manager cited in a recent newsletter, *'From this small meeting grew a Mother and Toddler group which in turn was the catalyst for the full range of associated services we provide. From the original 10 mothers who attended that first meeting we now have 124 families registered as users with 166 children attending the centre.'* The play activities included some structured adult led sessions along with some free playtime. The parents were absolutely clear about the reasons for high levels of attendance and use of services: *'it keeps my children occupied. It offers structure and socialisation.'* For adults prayer facilities were available and attention paid to festivals and the constraints of fasting. There was an awareness of what music was acceptable and what not. Opportunities were offered for breast feeding support at home to accommodate sensitivity about feeding in public places. Food was Halal. They had translation and interpretation support when it was needed. In short it built on strong existing services where trust had already been established with users. We had a similar positive response from specialist services for Orthodox Jewish families in the area. Users felt reassured that **their cultural values and beliefs were respected within the buildings and by all those responsible for delivering and using services.** In a world where they felt under threat as cultural groups, it was understandable that this security was very important to users.

4.7.13 Respondents told us that cliques dominated some centres and activities. For example a father told us that in one building delivering early years services he had attended there were *'lots of cliquey types…they won't talk to you when they know you go to Sure Start, turn their noses up at you'*. But in their Children's Centre he believed there was **a mixture of types of people**- *'It's not like that here at all'.* Another respondent in the same group said:*' I sit in the café talking to a teacher and a doctor, they're really nice and we all mix here.'* The staff talked to us about their perspectives of the middle class parents 'swamping' new facilities in this area*: 'They have always been able to seek out good resources for their children and use them. They saw this brand new building and wanted to take advantage of what was on offer.'* One provider told us of her struggle to maintain an inclusive ethos at her

centre. They had *'worked hard to encourage the more affluent parents to be accepting and less judgmental of the more vulnerable families, but I'm doubtful of real progress. The more hard to reach are just not coming through our doors*.' A few parents, all living in areas categorised as Multi-Ethnic in the Local Context Analysis typology, referenced as a positive benefit of activities in the Centre their child and themselves being able to **mix with people from many different cultures and backgrounds**.

4.7.14 Responses across the three types of users referred to **benefits of education and training** for themselves. Responses ranged from one mother reporting that she had joined Basic Skills sessions because her 6-year-old child was bringing homework to her which she found hard to help with, including listening to her reading. She attended sessions during the day whilst her older child was at school, bringing her toddler to the centre crèche. Another was using crèche facilities to enable her to study part time at college as a Beauty Therapist. A third was studying for NVQ childcare qualifications whilst doing voluntary work in the centre and was enabled to do so by the crèche facilities for her baby and toddler offered within the centre. A significant number told us that they did not want to work until their children were of school age. This replicates findings from the NESS Themed Study, *Employability in SSLPs* (Meadows et al. 2004).

4.7.15 **Practicalities for users included whether services were within safe and comfortable walking distance**. One parent reminded us of the battle to get two children under five dressed, in a pushchair, downstairs and out of a flat, across busy roads and to buildings even ten minutes walk away. *'Some days I just can't face it'.* Other parents would not cross territorial lines marked by major roads or railways between one 'community' and another to access services. *'I'd never walk down those streets. Don't feel safe there'*.

4.7.16 A second practicality was whether activities were **flexible enough to be offered at different times of the day**. Parents told us that they had to fit activities around their children's sleep patterns or whether they themselves were *'morning or afternoon type of people'*. But they liked the familiarity of services being delivered by the same staff: ' *I like the drop-ins so I can go when I want and it is the same two people who run it so I know who they are'.* Some more vulnerable parents did not want the pressure of having to attend groups every week. For example, a conditional parent told us: '*When I had my baby I got postnatal depression and didn't want to come out of the house. The health visitor was visiting me. She introduced me to Sally who came every week to see if I was OK. Sally told me about a group she was doing at the library. She said she'd pick me up and take me to it. It was good because it was a drop in and so I didn't have to go every week. I could go when I wanted to without pressure.*'

4.7.17 A third issue was cost. *'I like the toy library because it only costs 50p to use'.*

4.7.18 Users views on what works for children in Children's Centre services

Key messages were:

- Parents believed that their children benefited socially from being able to mix with peers.
- They believed that opportunities for high quality play in safe spaces was important.
- They believed that children benefited in their development from the services and this would help them make a successful start to school.
- Respite care and crèche facilities could offer mutual benefits for parents and their children.
- Parents of children with additional needs or disabilities particularly valued services tailored to their children's needs.

4.7.18 Some responses gave equal weight to the reciprocal benefits of using services for themselves and their children. For example: *'It gets me out of the house and I like being with other mums. It's a different atmosphere from being stuck at home on my own. Here my child can go off and play. At home he always wants me to be with him. This gives me a bit of peace'.* A few respondents linked these **reciprocal gains to promoting better relationships between parent and child**: *'We get on together better when we have some time with other people. If we're at home all day we get on each other's nerves.'* One parent told us that the staff had modelled for her better ways of controlling her child's behaviour: *'I learned a lot from watching what they did with him when he was behaving badly'.*

4.7.19 Parents were most likely to refer to the benefits for their children of being able to **socialise with children of their own age in safe surroundings**. *'He's much less clingy since he's been mixing here with children of his own age. It's the reason I keep coming back to the Dad's group'. 'She can share toys now and runs about with the other kids quite happily'.* Others thought that **access to good quality play equipment and space** was the greatest benefit for their child: *' Look at all the toys. It's great for them to be able to play with all these different things.' 'We don't feel the play park is safe so I like to see them playing in the garden here when I come'.* Autonomous users were more likely to rate the **benefits of children learning through play**, of being able to mix with other children and of **making developmental gains**. A few parents referred to children *'getting ready for school'* but mostly their comments were more general, such as *'she's come on in leaps and bounds.'*

4.7.20 A number of parents were positive about the practical and emotional support they had been given as families with children with additional needs or disabilities. For example the parent of an 18-month-old child with developmental delay was quickly linked with specialist services from Speech and Language and Occupational Therapists:*' Their help has been overwhelming. When children are different, one doesn't know sometimes what is available and beneficial for a child. I'd never have found out about free nappies or sponsorship for a nursery place without the centre staff'.* Other parents had been encouraged to set up small self-help groups in the centre for families of children with disabilities. One parent told us:*' It's such a relief to be with people who understand what it's like to care for a child with disabilities. We can help each other out with tips and useful contacts.'*

4.8 WHAT WERE THE PERSPECTIVES OF NON-USERS

Key messages were:

- Many non users (particularly the most vulnerable) still had a profound distrust of professionals.
- Fathers felt that SSLPs and CCs were 'women's spaces' and felt uncomfortable and excluded.
- Centres were associated with stigmatised services by some non-users.
- Others saw services and centres as dominated by particular cliques.
- Many non-users had informal support systems of their own and did not want to engage with formal services.
- For those with limited language or literacy skills, services were seen as threatening and inaccessible.
- Many non-users argued that they did not want to be patronised by professionals.
- Some SSLPs and Children's Centres were able to overcome these barriers by sensitive and creative approaches to service delivery.

4.8.1 Findings of the Impact Study were that among the disadvantaged families living in SSLP areas, parents/families with greater human capital were better able to take advantage of SSLP services than those with less human capital (i.e. teen parents, lone parents, parents in workless households). This finding replicates those of other evaluations of early interventions (e.g. Early Head Start, Love et al. 2002). We thought it was imperative to access the perspectives of those who were **not** using the Children's Centre services (See Appendix I). Accessing the voices of non-users and 'the hard to reach' was a challenging task for the fieldworkers. They used a range of approaches including:

- locating advocates for minority or vulnerable groups in the community and persuading them to broker meetings.
- accessing lists via centre administrators of families who had been contacted through outreach workers, but not been persuaded to use services.
- contacting families through informal networks via clinics or shops.

4.8.2 Some *non-users* told us that they **did not need services** other than access to traditional pre and postnatal healthcare, citizen's advice for housing and debt concerns and childcare and pre-school for the children. Others told us they simply **wanted to retain their autonomy as parents**. As one respondent told us when SSLP staff offering 'support' approached her, *'I thought it was a bit of a cheek. I've already brought up two kids. I found it like interfering.'* Another young, reluctant user was persuaded to attend a group session but found it *'boring'* and never went back. Another parent said: *'I already have my family around here to help me. I don't need to go to strangers for help.*' Others told us that their lives were too busy or too chaotic to enable them to go to sessions. And others were just apathetic. As one user told us, referring to families in her neighbourhood: '*There's a lot round here who don't give a s…'*

4.8.3 Other parents with extreme problems such as drug or alcohol related abuse, mental health problems, domestic violence or criminal records were **reluctant to be drawn into 'systems'.** They were frightened. They did not want to be on anyone's

list. They had learned not to trust professionals, even those with SSLP logos on their T-shirts. They were unlikely to let para-professionals or volunteers into their homes. A long timescale is needed to break down such barriers and to establish relationships with families with this level of resistance. The original ten year time scale of the Sure Start intervention was realistic in this respect and it is to be hoped that Children's Centres build on goodwill established already.

4.8.4 None of the programmes reported that they were doing well enough in **attracting fathers to their services**. Justifications included: *'We can't mix fathers with the women because of cultural constraints in the Muslim communities'* and *'There's a macho ex miner culture amongst the men round here. They don't want to be in these kinds of places'.* We spoke to several fathers who told us that they felt **uncomfortable and excluded** even if they did come into the centres: *'It's a women's place this'.* The fact that services were predominantly delivered during 'school hours' (i.e. mostly between 10 and 3 o'clock) made fathers feel further alienated from what was perceived as 'women and children times'. However services targeting men had been set up by some centres: a football team meeting on Saturdays, a Father's Inclusion Worker running workshops and sports activities, and a DadsandLads group meeting at the weekends. The lack of male involvement in children's centres, as with the SSLPs, remains an apparently intractable problem.

4.8.5 We report here on accessing the voices of two groups of so-called *hard to reach* families: travellers and asylum seekers.

Exemplar 1: Travellers

A trusted and experienced travellers' worker took the fieldworker to the travellers' site. The site was owned by a former traveller. He had been offered a large amount of money for the land. Because of the legal rights of established families he was unable to sell the land. He was running the site down to make it less attractive for the travellers to stay. There was no hot water and only one domestic sized washing machine on site.

The travellers' worker introduced the fieldworker to the families. She explained that the site housed two types of travellers whom she described as 'English Gypsies' and 'Irish Travellers' with distinct lifestyles and histories. They tended not to mix. Their caravans were set up in different areas of the site. English Gypsies were more affluent, operating small businesses such as landscape gardening or scrap dealing. They were often long established residents (one interviewee had been a resident on the site for 20 years) with large and impressive caravans. The Irish Travellers were described as poor and transient. They lived in smaller, mobile, older vans. Often they did not have the capacity to keep their extended families on the road with them. They tended to be the families subject to the worst stereotyping and prejudice. There were always problems getting their children places in schools. The Travellers' Worker explained: *'They're not on any school waiting lists, and the schools are full, and headteachers are reluctant to help find them places for just a few months.'*

The respondents were four English Gypsy women aged between 20 and 40, three sisters from a family of five, and two Irish Traveller women aged 37 and 40 with 4 and 6 children respectively. One of the Irish Travellers had a baby with additional needs.

They reported that the Toy Library and health visitors came to the site regularly. But they were sceptical about professionals' real commitment to work with traveller families. Their

perception was that service providers drove on to the site in their cars and left as quickly as they could. *'They just tick the box marked 'traveller'...*

They were reluctant to attend services in the Children's Centre, partly because they were a distance away, but also because they felt unsure about their relationship with 'mainstream' communities. They told us that they had never received information about Sure Start activities. This seems to indicate a lack of liaison between child benefit and SSLP systems in this area. But with the encouragement of the Travellers' Worker, two of the English Gypsies had tried out a health and nutrition advice session and Stay and Play activity respectively. They told us that they felt uncomfortable about being asked to leave their children with 'strangers' in the crèche, although they appeared *'friendly and good with kids'.* The Irish Traveller felt particularly anxious about leaving her baby with additional needs: *'It would have to be safe, no small objects lying around...have good security...a clean environment...I would have to be allowed to stay and settle him..I would need to know the staff can deal with him. He needs to be lifted and he's heavy. I don't know if they can cope*.'
They also told us that managing such large families meant that services at set times were not useful for them: *'I wouldn't always be able to get there on time and I don't want someone telling me off for being late... I would go somewhere if you could just turn up when you are ready.'* They said they wanted safe outdoor play spaces for their children to play, but had no idea that the SSLP had extensive play areas.
At the end of the visit the respondents told the fieldworker, *'It's great for you to ask us about all this. No one comes near this site.'*

Exemplar 2: Asylum seekers

There were 25 languages spoken in this SSLP area. One worker, on a short-term contract, spoke Urdu, Hindi and Punjabi, but she was the only person in position who could speak community languages. Translation and interpretation services provided by the City Council cost the SSLP £40 per hour. The new Children's Centre attracted White and African Caribbean more affluent families, but was not seen as welcoming to the Asian or Eastern European asylum seekers and refugees coming into the area.

We contacted the asylum seekers via a Church run neighbourhood centre. Two were Asian Muslim women in their twenties, one an Albanian women and one an African woman from Sierra Leone. They had severe problems. For example one of the women had a debt crisis for which she was receiving practical help, mental health problems for which she was having medical intervention and her two children, both under five, had recently been put on the 'at risk' register. The centre was able to offer some interpreter support.

Three of the women had been brought to the centre by neighbours or through kinship networks: *'A neighbour who spoke my language knew I was needing help and took me to this group'*. The fourth had come because of the Church connection: *'I asked at the church about learning English for me and my daughter because I cannot speak English so we cannot do things.'*

They were confused about what support Sure Start could offer, and how it differed from the welcome group. When asked what would be useful for them they wanted: *'something for single parents like me to help us'; 'access to a library, I don't know how to get there, so I need someone to show me'; 'support to learn English and in the mean time interpreters to help us'; 'nursery places I can afford'*

4.8.6 Two examples of how thoughtful and creative approaches to service design and delivery overcame barriers to access for specific cultural/religious groups and those defined as hard to reach are given below.

4.8.7 Examples of good practice in attracting users from minority or hard to reach groups

Services for those involved with drug abuse

The Nan's group appeared to be unique. It was set up as direct response to a specific need identified in the area; the users who attended the group all care full-time for their grandchildren due to family problems associated with drug addiction. The alternative was placement in the full-time care of social services.
The group evolved from a one-off event organised by a Family Support Worker. After referral by social services, she had worked with the grandparents on a one to one basis offering family support services in their own homes. The worker identified that this group of carers was exposed to extreme levels of stress. She organised a one-off overnight event designed to provide respite and peer support. The trip was such a success that the attendees arranged to meet monthly, in a room at the Children's Centre. This service was needs and user led. It was cited as the only service this group of hard to reach carers used. This was due to the unique and sensitive way it met their needs and addressed barriers to their accessing generic universal services.

Culturally appropriate services

Community characteristics of the Children's Centre (CC) area included a large Jewish Orthodox community and a somewhat smaller though significant Muslim community. The challenge was to provide services that were culturally acceptable to these distinct groups. Two sets of culturally specific values had to be respected by service providers. The SSLP, from which the CC had developed, had responded to the challenge by linking up with the community relevant voluntary organisations already established in the area. From the start the SSLP had worked collaboratively with these voluntary organisations. The organisations were already providing well attended services typical of Sure Start activities, such as ante-natal/postnatal support, mother and toddler groups, adult education classes, health promotion, ESOL classes, and family support in the home. Advertisements publicising the services within local community newsletters were targeted at the Jewish Orthodox and Muslim families with young children.

For example, back in 2002, one Saturday morning, the Programme Manager attended a meeting in the local Muslim community centre set up to engage with local Muslim mothers. From this emerged a small Mother and Toddler group - the beginning of what became a range of services targeting Muslim families within the community.

User interviews conducted separately in both Muslim and Jewish Orthodox mother and toddler groups indicated these services were well used. The mothers felt very comfortable in their settings. They valued the opportunity to network with other mothers from similar cultural backgrounds.

4.8.8 An extract from a local evaluation report for this centre reinforces the point: *"Religious Muslim women and Orthodox Jewish women are unlikely to stay and socialise because of the cultural differences and particularly for Muslim women who are veiled. Because there are men involved they have to keep their veil up, and for*

Orthodox Jewish women there is the issue of non-kosher food. Issues about breast-feeding publicly which would be quite acceptable even encouraged in the secular community, but for religious women be distressing."

4.9 KEY THEMES EMERGING FROM STAGE 3

4.9.1 What services were delivered by the Children's Centres in the last year?

Staff at the 12 proficient and effective Children's Centres reported to us that services were being constantly adjusted as they transformed themselves from Sure Start Local Programmes to Children's Centre status. Providers told us that some of their services had been disrupted by changes in staffing or budget constraints. Nevertheless, building on the capital inherited from their proficiency as SSLPs, they were committed to deliver a balanced set of services in the core areas of Health, Early Learning, Play and Childcare and Family Support. They were also aware of the need to maintain their standards in service delivery whilst responding to a succession of national and local policy changes in the field of children's services.

4.9.2 What were the views of providers of core services on what works?

Key Messages on the rationale for services

Providers reported:

- that principles underpinning the **rationale for introducing** services were *needs based* and *demand led*, with health workers putting slightly more emphasis on the importance of an *evidence base,* and family support workers referring to *intuition* and slightly more likely to reference *statutory requirements* (probably in relation to child protection).
- a similar pattern of citing user *needs* in justifying whether services were **centre based, outreach or both,** but with Early Learning, Play and Childcare service providers less inclined to cite a *needs base*, Family Support workers more likely to reference *statutory requirements*, and all respondents likely to reference *resources* as the driver behind decisions about locating services. Resources meant staff and spaces, and by implication the budgets to sustain them.
- that decisions about the **format of services** (that is whether they were workshops or 1:1 session, or centre or home based services) were *resource* driven (particularly for health workers) but with *needs based* and *demand led* also cited as important drivers. *Research evidence* was less likely (not at all by family support workers) to be reported as important in informing decisions about the format or content of services. Family support workers referenced *intuition* for informing their decisions about service formats.
- that the **choice of service deliverer** was based on their *qualifications*, was especially important for health providers, with family support workers indicating that *matching* staff (in terms of gender, culture, life experiences and attitudes) to users was of equal importance. *Job requirements* and the *availability of staff* were cited as important drivers in the choice of service deliverer.
- **factors underpinning proficiency of services** referred to included:
    1. for vision: clarity of purpose, shared values based on evidence and understanding of community characteristics.

2. for service planning: non-stigmatised services and multi-agency teamwork in service delivery.
3. for service delivery: balance between formal and informal group sessions, sensitivity to constraints/preferences of users, building on strengths of inherited services, flexibility, tailoring services to individual family/groups.
4. for service location: centrally located and visible venues with satellite buildings to ensure pram-pushing distance access for all users, transportation and childcare for vulnerable users.
5. for sustaining services: empowering users to set up self-help groups.

Key messages on service use

4.9.3 **Providers** reported that:

- **Main users** were *all families*, with a range of *specialist targets* such as vulnerable families, teenage parents, grandparent and childminder carers, travellers, refugees and asylum seekers.
- **Reasons for non-use** included user *lack of confidence/motivation* as the prime factor, with *unsuitable service times*, *cultural/religious/linguistic barriers*, *services not meeting local needs* and *access*.
- **Users were contacted** for universal services mainly through *word of mouth*, with *general publicity* through local networks and community venues, and *targeted invitations (by telephone, letter or door knocking).*
- Providers **identified users** who might benefit from particular services through *referrals from Centre staff and outside agencies*, *self-referrals, word of mouth* and *invitation letters* sent to families.
- **Attendance** was maintained by follow up *telephone calls, letters or house-calls* and by providing *incentives* and *early recruitment* and *ongoing signposting* to services.
- Key factors in **service take up** are *quality of staff (including both personal and professional attributes), regularity of service, availability of childcare, format of service, venue and timing*. Factors related to the user perspective - for example *users input into planning* or the nature of *service clientele* were cited as less important.

- The range of **factors contributing to increasing reach** included:

(1) reaching out to fathers and working parents,
(2) providing practical help and emotional support to enable take up of services,
(3) signposting of services by all agencies,
(4) employment of post holder specifically to promote reach,
(5) use of peer support/buddying,
(6) texting teenage parents,
(7) providing incentives,
(8) reducing barriers created by language and literacy difficulties,
(9) targeting publicity carefully to specialist groups.

Key messages on outreach:

4.9.4 **Providers** reported that:

• Outreach was **pivotal to proficiency** in service delivery, but needed to be **balanced with and pursuing similar aims to group activities in centres.**

• Users were **identified for outreach activities** through *referrals from outside agencies and centre staff, self referrals* but most effectively by *word of mouth* between members of the multi-agency team. There was little evidence of effective use of *monitoring record keeping systems* to identify potential users.

• Outreach was mostly **delivered** by *centre staff* with some support from *para-professionals, paid community workers* and *parent volunteers.*

• Concern was expressed by some professionals about the challenges of *sustaining high quality services whilst devolving outreach activities to* **less well qualified workers and/or volunteers.**

• **Supervision** of all case workers delivering outreach services, usually on a *monthly or six weekly* basis, was seen as essential.

• But robust arrangements also had to be in place for **cases to be reviewed** f*requently* or when necessary on a *needs basis*.

• A range of factors cited as underpinning **proficiency in outreach** included**:**

(1)1:1 works for vulnerable users.

(2) home visits establish trust.

(3) outreach can achieve many purposes concurrently.

(4) qualifications (knowledge base and attitudes) and personal characteristics (friendliness and empathy) of outreach workers are critical to its success.

(5) training and regular supervision are essential for all charged with delivering outreach work.

(6) robust protocols and systems are needed for the exchange of information between agencies delivering outreach and centre based services.

Key messages: the perspectives of users on what works for adults?

4.9.5 The emphasis of service users on *what makes services work* for them *as adults* were their social and emotional gains. Getting out of the house and being in regular contact with other like-minded parents of young children made a difference to them in the demanding role of parenting. They also valued the quality of SSLP staff and their ability to help with practical problems (such as debts, housing, disputes with neighbours and family members) and their professional expertise (advising them about their own health, child development, opportunities for training and employment). The practical aspects of provision they rated as important were: a safe and comfortable place to be with their children and meet up with their peer group networks, venues within safe walking distance of their homes, one-stop shops offering access to multi-agency teams and services at flexible times.

Key messages: the perspectives of users on what works for their children

4.9.6 The emphasis on what works for their children was also on the social benefits of services in helping their children to socialise with peers. They rated opportunities for their children to play in a safe place with high quality play equipment, including access to safe outdoor play. They also rated the benefits of services for enhancing their child's development in getting them ready for pre-school and transition to school. They reported that respite care in crèches benefited both parents and children and improved their relationships. In general services were seen as taking the pressure off them as parents and making them feel more positive about parenting. Parents of children with disabilities or additional needs were particularly aware of the support they were offered and were worried about what would happen when their children made the transition to school.

Key messages: the perspectives of non-users?

4.9.7 Non users of services reported as barriers to their use of services:

- Fathers' perceptions that centres were a women's place.
- Working parents complaining that few services were offered outside school hours.
- Black and Minority Ethnic groups reported language and cultural barriers.
- Non users felt that cliques, from whom they felt alienated, dominated centre-based group services.
- Non-users were wary of associations with the stigma of a service as for families in need.
- Parents reported a lack of confidence in meeting strangers and entering new spaces.
- Parents reported an unwillingness to be patronised by professionals.
- No-users reported a concern about discussing intimate problems in public spaces.
- Non-users claimed they already had an adequate network of family/friendship for support.

4.10 Discussion

4.10.1 We argued earlier in the report that it is inappropriate to investigate proficiency in the delivery of services in intervention programmes without considering holistic aspects of the programme. Of course it is possible that one-off proficient services are delivered within programmes that are not functioning well overall. Such proficient one-off services are likely to be delivered where there is a history of inherited good practice in a local area. The service ploughs on with consistency despite contextual constraints or deficits in managerial and structural systems. Alternatively proficient one-off services may be linked with an inspirational service provider who has acted as a 'hero innovator', acting independently of others within health, education or family support services. In this stage of the Programme Variability Study we focused our attention on twelve SSLPs which had become Children's Centres where we had evidence of both all round *proficiency* in their implementation (as measured by high scores on the Programme Variability Rating Scale) and of *effectiveness* in parent and child outcomes (as measured by Impact item scores). We were therefore confident that evidence of services offered in a range of twelve Children's Centre contexts would be useful in exploring what works in the practicalities of service delivery.

4.10.2 In triangulating the views of core service providers with those of users of these services our findings suggest that there is much agreement between the two stakeholders on what works. Providers listened to the views of local people in the initial stages of planning and setting up services. They made efforts to locate the services in a range of buildings within pram pushing distance of local communities, or to offer home-based versions of treatments for those who were identified as likely to benefit. Users were appreciative of these efforts to tune services to their needs. Users were also positive about the qualifications and attitudes of most providers. Above all users appreciated the social and emotional aspects of support for their parenting, as well as help with practical problems such as child health, debt counselling, safety in the home and stress relief. Many regular users were benefiting from access to several different services during the week. Parents rated highly the value of the social and emotional support given by SSLP provision. They reported that the services made them feel better about parenting. This links with the findings at Stage One where we reported enhanced parenting outcomes: higher levels of maternal acceptance and less household chaos.

4.10.3 However, providers were less certain about the format of services. There were examples of teams of multi-agency providers attempting radically different formats - such as informal drop-ins, playbuses, surgeries/clinics offering instant appointments over extended periods of the day. Service users were able to articulate clearly the benefits to them and their families of such flexible and responsive services. But many of these experiments foundered without the backing of committed managers. Sometimes they foundered because providers were unable to commit to the extra hours required to staff such flexible services. In other cases it appeared that it was more comfortable for professionals to revert to traditional formats - health clinics at set times, play opportunities with little flexibility for working parents, parenting programmes which were at one extreme over prescriptive or at another unfocused in aims. Centres were most successful when staff as a team continually monitored the costs, take-up and impact of services and refined formats to changing community needs and preferences, whilst retaining a strong sense of

the underpinning aims and objectives of the services. In some cases this simply meant building on the strengths of already well established and trusted services inherited in the area.

4.10.4 Reach figures remained a disappointment to many SSLPs, and it was in triangulating the views of non-users with those of service providers that we found some dissonance. In some cases providers recognised the barriers identified by non-users of their services. For example, providers recognised that building up parental confidence was important, that they needed to be sensitive to cultural/religious/gender preferences, that language barriers were a deterrent to some potential users, and that the pragmatics of the timing, location, flexibility and format of services for working parents and fathers needed to be addressed. Non-users clearly spelled out to us the reasons why they were not using the services. It is clear that providers need to explore practical strategies to address these barriers if reach figures for services from Children's Centres in so-called disadvantaged areas are to be higher than those of former SSLPs.

CHAPTER 5. IMPLICATIONS FOR CHILDREN'S CENTRES

5.1 The findings of the Programme Variability Study have important implications for those charged with delivering integrated services for young children and their families from Children's Centres. They should inform the content of training programmes for those working with children within the workforce reform for children's services initiative. These include the core skills and knowledge for Early Years Professionals, the training of teachers to work with under fives, preparation of professionals and para-professionals to implement the Extended School agenda and the Masters qualification for those charged with managing Children's Centres. Findings of the report may also inform the design of self-evaluation protocols for Children's Centres.

5.2 What can we learn from variations in Sure Start Local Programmes?

5.2.1 The Sure Start intervention was designed to promote broadly based community changes. A pivotal requirement was that the content and processes of each programme were to be negotiated with local communities, often outside the remit of local authority structures. Thus there were many variations in the way SSLPs designed, delivered and monitored the usage of their services. However this very variety provides us with evidence of what works, in what contexts, for what kinds of communities, at what point in the development of local children's services.

5.2.2 The only commonality to the 500+ programmes was the guidelines drawn up annually by the DfES. These guidelines were based on evidence of 'what works'. The literature reviewed in the first chapter gave a brief overview of seminal research findings on the impact of early interventions. Faced with the challenge of designing an instrument and protocols to investigate variations in the effectiveness of SSLPs, it was the guidelines, themselves underpinned by research evidence, which we used as our conceptual framework for the Programme Variability Rating Scale, shown at Appendix A. The scale was applied to the 150 SSLPs in the longitudinal Impact study. Its efficacy was confirmed by the analysis of the Programme Variability Rating Scale process scores against the products of the child and parenting measures for the Impact study. Some relationships emerged from the analysis between distinct items on the scale and particular impact measures, as outlined in Chapter 3 at 3.1.6. Significant effects pointed to the importance of:

- empowering staff, parents and children,
- a welcoming and inclusive ethos to all venues for services,
- and effective strategies for the early identification and targeting of treatments for those children, parents and families who would benefit.

5.2.3 But for the purposes of informing policy and practice for Children's Centres the key finding was that programmes scored high, medium or low across the 18 dimensions. In other words the holistic approach to programme implementation and service delivery integral to the design of the SSLPs was justified. Overall the ratings of programme proficiency across the 18 dimensions in the rating scale were predictive of worse or better than expected child and parent outcomes. The implication is that the DfES guidelines were appropriate for the aims and objectives

of the SSLP intervention, and recognition of this positive achievement should be given.

5.2.4 Confirming the efficacy of the instrument gave us confidence to use it as the basis for further research. But the instrument was also an important product in its own right. It was underpinned by the specific criteria for running a SSLP, but it could be adapted to measure the proficiency of the processes of managing and implementing services from Children's Centres. Current Ofsted protocols emphasise the centrality of good self-evaluation and the scales could be adapted for use as a basis for self-evaluation for Children's Centre managers and staff.

Implications for Children' s Centres from Stage One Findings

- Children's Centres need to implement the original Sure Start vision in its entirety. The most proficient and effective Children's Centres will perform well across all 18 measures of proficiency and effectiveness.

- The dimensions of proficiency include:
    - holistic aspects such as establishing a welcoming, friendly and professional ethos and empowering parents and providers of services.
    - ensuring that strategic, systemic processes are firmly in place such as governance that is representative of key stakeholders and functions well.
    - clear operational systems for identifying users, monitoring service use and identifying service impact at both group and individual levels.

- For families with very young children services which address the needs of both parents and children concurrently are likely to be successful.

- Children's Centre managers need to pay attention to training multi-agency teams to work together in new ways.

- Children's Centre Managers need to take care to build on the strengths of inherited services that have a proven track record of good quality and measurable impact.

5.3 What can we learn from the differences between high, medium and low levels of programme proficiency?

5.3.1 The first stage of the Programme Variability study gave us insights into the broad-brush evidence of what distinguished more or less proficient SSLPs. At the second stage we used case studies of 16 programmes across four quartiles of proficiency, and with better or worse than expected child and parent outcomes, to explore the nuances of what worked or did not work in different contexts and for different kinds of communities. As in the analysis of the data for 150 SSLPs at Stage 1, our findings confirmed that SSLPs were operating proficiently in all dimensions or not in any. Their performances across the 18 dimensions of the Programme Variability Rating Scale were inter-related. This indicates that Children's

Centres should maintain a holistic approach to delivering good quality services for children.

5.3.2 The blurring of roles and responsibilities within multi-agency teamwork proved challenging for all professionals involved in the radical approach to service delivery inherent in the SSLP model and now central to government policy in children's services. Health workers found it particularly difficult to embrace change. Evidence from Stage One indicated that health-led SSLPs were achieving better outcomes, probably because they had access to data-bases which enabled them to target potential users and establish relationships with parents even at the pre-natal stage. With this information they were able to set up services and deliver treatments promptly. But at Stages Two and Three there was evidence of difficulties for health workers in adjusting to new ways of working. Examples are at 3.2.27 where we recorded ambivalence amongst health workers in the section discussing multi-agency teamwork, at 3.2.29 where they were unhappy about shared space, and at 3.2.22 where Primary Care Trusts refused to share data with SSLP programmes. It is a statutory requirement for health authorities to work in liaison with Children's Centres to address the health and well being of pre-school aged children and their parents. Such professional anxieties will need to be addressed and confronted in the content of training both at initial single agency and on-going cross-disciplinary training for all staff intending to work in Children's Centres, but perhaps particularly with staff from the health sector.

5.3.3. Implications for Children's Centres from Stage Two

- Children's Centres need to plan their programmes with reference to a wide range of performance indicators.

- They need regular and systematic self-evaluation strategies to monitor the proficiency and effectiveness of their programmes and services. Evidence of more or less proficiency in the SSLPs histories of implementing complex menus of services for families with young children will be useful material upon which to draw in planning for their own practice, identifying challenges which have been overcome and avoiding less productive practices.

5.3.4. In particular they need to:

- Actively ensure that there are robust structures for governance and leadership.
- Establish and demonstrate an ethos which is welcoming and inclusive, with friendly and knowledgeable staff.
- focus staff on their capacity to empower providers and users of services, even when this requires staff to step outside their comfort zones.

5.3.5 Features of proficiency that were linked to effectiveness include:

- Audit local needs in order to tune services, with a clear focus on and sensitivity to local community priorities.
- Identify and target as early as possible parents and/or children with specialist needs with specialist treatments

- Allocate and train appropriate providers to deliver services, with a clear understanding of how to deploy to best effect the relative skills and knowledge of generalist and specialist workers in teams
- Train and manage service providers for the complexity of multi-agency teamwork
- Equip managers/leaders with the skills of project management, budgets, human resources management and IT systems (or the expertise to buy such skills in)
- Commit to sustaining service use and increasing reach figures, including persistent attempts to access the 'hard to reach'.

5.4 What made services in Children's Centres work? The perspectives of providers, users and non-users

5.4.1 The first round of Children's Centres are in areas designated as deprived, and therefore many centres will be building on the experience of SSLPs they inherit in their areas. In the third stage of the Programme Variability Study we turned up the microscope on services. A key aim was to provide examples of good practice to inform the roll out of Children's Centres, particularly in areas of social exclusion.

5.5 Service Use

5.5.1 Our first objective was to find out what services delivered by Children's Centres able to build on SSLPs that were proficient (good scores on the Programme Variability Rating Scale) and effective (with better than expected Impact child and parent outcomes). We mapped services that had been delivered in the core areas of Health, Early Learning, Play and Childcare and Family Support. A second objective was to investigate the perspectives of providers on what worked in the delivery of services, including what informed decisions about centre based group activities and outreach/home-based activities. We talked at length to experienced core service providers in the Children's Centres. A third objective was to triangulate the perspectives of service providers with those using these same services. We asked providers to facilitate access to a focus group of types of users- some confident in using the service and others who had been coaxed into attending. Our findings have important implications for training and supporting the providers of proficient services delivered from Children's Centres.

5.5.2 As with many professional groups, the rhetoric of the providers' discourse was informed by ideologies - in this case the cogent vision of the original Sure Start intervention set out in the guidelines. Providers of core services claimed, for example, that key decisions about service implementation - whether it was centre based or outreach/home based and the format of the programme - were based on auditing user needs and responding flexibly to demand from the local community. Family support workers made reference to 'intuition' informing their decisions about services, while health workers were more likely to reference the importance of an evidence base. However, it was clear that resources inevitably underpinned their decision-making, particularly for example the availability of appropriate staff. Providers were also clear that the qualifications, how well they matched the job description and the personal qualities of staff were all critical to achieving good quality services and to whether users kept attending them. These findings have

important implications for the way Children's Centre staff are recruited, appointed and trained.

5.5.3 When we analysed the perspectives of users of the services on what works for them we gained insights into their priorities. As we might have anticipated, their views on what works had a different emphasis from those of service providers. As parents of young children, their main aim was to get through another day! What they wanted above all was companionship, both for themselves and their young children. For confident parents, their priorities were to get out of the house. They wanted an accessible and comfortable space where they could take a break with others who were able to empathise with the challenges of parenting. For some parents attending group sessions in centres was a step too far. For them outreach and home visiting remains the best option. They may be encouraged later to join group sessions. There is evidence that where parents feel supported by social networks, they are more likely to feel positive about parenting, and in the long term this helps their children. Children's Centres need to continue to offer informal spaces and places for parents of young children to network with each other.

5.5.4 Parents appreciated access to specialist professional advice about their own and their children's health, well being and development. They welcomed the emotional support of access to knowledgeable and sympathetic professionals who were able to reassure them about any anxieties they had about rearing young children. They also rated practical support in addressing real problems (such as debts, housing, benefits and domestic crises). Children's Centres need to plan for this wide range of services in putting together teams, or to ensure that all generalist staff are trained in how to help parents access specialist expertise at point of need in partnership with local agencies, charities and private providers.

5.6 Increasing reach

5.6.1 One of the disappointing findings across all three stages of the Programme Variability Study was the poor reach figures of many SSLPs. The remit of the intervention was to engage with the families of all new-borns and children 0-3 in the SSLP area. In reality if SSLPs achieved 25% reach on a monthly basis (as reported to the Sure Start Unit by administrators) we rated them as satisfactory. A proficient SSLP was demonstrating regular, consistent and growing reach figures of 100% for all new-borns and 26-50% for families with children under 3. In proficient programmes and centres we found that providers were continually striving to improve their reach figures. In proficient SSLPs strategies for improving reach were both generic and targeted. So for example, publicity for universal services would be displayed in local clinics, post offices and GP surgeries. But they also individualised publicity. For example they made telephone and house calls and letters of invitation geared specifically to individual family needs. These strategies were particularly important for targeting specialist treatments such as those delivered by Speech and Language Therapists, mental health workers and for monitoring children identified as at risk. Children's Centre staff will need to build on the good practices of proficient SSLPs in identifying universal users and targeting those with specialist needs.

5.6.2 It is sometimes easy for centres to build up groups of regular users, rather than planning retention and exit strategies for users linked to regular monitoring of the impact of treatments. Such groups can be perceived by potential users as cliques and can deter newcomers from attending services. Children's Centre staff need to avoid the trap of relying on core groups of users, often families that are using a range of services on a weekly basis, without also constantly striving to attract and retain new users.

5.6.3 When we asked service providers about factors influencing reach, they were inclined to attribute poor attendance to the characteristics of users (for example their lack of confidence and low motivation levels and cultural and religious barriers) rather than to the characteristics of their services. Providers commended as strategies to improve the take up of services, offering crèche facilities and ensuring that the quality of staff was high. The quality of staff was about both their qualifications (often specialist to the treatments) and their qualities (their ability to empathise with local communities and their own work or life experiences).

5.6.4 SSLPs and Children's Centres appeared to be offering services predominantly during 'school hours'. When we interrogated the data from non-users, they identified unsuitable timing of services as a significant barrier to their attendance. Services routinely delivered between 9.30 a.m. and 3 p.m. automatically excluded many 'mainstream' working parents, particularly fathers. The delivery of services during school hours seemed to be driven by custom and practice, and for the convenience of the providers, rather than by tuning into the realities of parenting and working in the current economic context of modern family lives. Thinking out of the traditional box in planning for the staffing, location and timing of services are important challenges for Children's Centres to address.

5.6.5 The most demanding aspect of reach was to attract and sustain the users defined as 'hard to reach: teenage parents, families where substance abuse dominated their lives, those involved in criminal activities, homes overshadowed by domestic violence, asylum seeker and refugee families. There were impressive examples of service providers who had found ways of working with hard to reach constituencies. Children's Centre staff will learn much from these examples, and from similar strengths demonstrated by the voluntary sector and specialist agencies in their local partnerships.

5.6.6 Finally we tackled the challenging task of accessing the perspectives of non-users of services. It is the first time the voices of the so-called 'hard to reach' non-users have been heard in NESS reports. Our experiences of trying to track them down mirrored the frustrations of the SSLP and centre staff in attracting them to use services.

5.6.7 The evidence was that there were too many families remaining outside the loop of the interventions and services offered. Their messages about why they were not using services were clear. Fathers' perceptions of the services and venues were that they were 'for women'. Working parents, even when on shifts, found the 'school hours' timing of services difficult. Some non-users simply did not want to be involved in activities that in their view replicated support systems they already had through neighbours, friends and family networks. Some were hostile to

professionals 'interfering' in their lives. Some thought the services were stigmatised as for 'needy' families, and some that they were for cliques of 'better off' families. Those with limited use of English were daunted by lack of interpreter support. Some families' cultural and religious beliefs made them feel uncomfortable about attending universal services requiring them to mix with local groups and communities, and preferred specialist provision.

5.6.8 Implications for Children's Centres from Stage 3:

- Children's Centre managers and practitioners can learn from models of proficient services inherited from Sure Start Local Programmes.

- Service uptake is dependent on tuning into local community needs and preferences.

- Information about universal services needs to be embedded routinely in health visitor and midwife protocols for home visiting all newborns and advertised for parents of children under school age in local GP surgeries, post offices, community centres and shops.

- Specialist services need to be targeted at point of need and monitored for impact by paper or electronic based systems for multi-agency team members to exchange information on a regular basis.

- There needs to be cohesion between principles and practice in centre-based and outreach services.

- Reach figures, particularly for the so-called hard to reach, were disappointing in many SSLPs.

- Children's Centres need to address barriers to non-use. Some barriers are specific to certain groups - for example fathers or working parents - or based on the attitudes of staff to changing their own traditional ways of working – or practicalities such as location, timing and format of centre and satellite building based services.

5.6.9 These insights into the complexities of involving a wider range of users in their services present significant challenges to those charged with delivering services from Children's Centres in former SSLP areas. However, as the exemplary material in this report demonstrates, we have much to learn from the positive experiences of proficient SSLPs to inform those willing to take on the challenges.

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Appendix A: Programme Variability Study Rating Scales

The scales were based on the DfES Guidelines to which the SSLPs were all working, the conceptual framework common to all SSLPs. The Guidelines were based on research evidence of what was likely to be effective in early intervention programmes in so-called disadvantaged areas. Each of the 18 dimensions in the scales include 7 level statements of proficiency and potential effectiveness. Important principles in operating the rating scales were that raters were working to common templates of evidence from all 150 SSLPs rated, that inter-rater reliability was high, and that raters were blind to the Impact outcomes for the programmes they rated.

Programme Variability Study
Rating Scales

Rate each item after following the guidance notes carefully

1	2	3	4	5	6	7
Inadequate		**Minimal**	**Satisfactory**	**Good**		**Excellent**

1. SSLP has a well-articulated vision that is relevant to the community. (Please include the vision statement if you can find it)

1. No evidence of vision in documentation, interviewees cannot state vision
2. Token statement and no evidence of sign-up and responsiveness to local communities
3. Muddled statement of vision, one that is not widely known/shared
4. Written statement, known by staff and users, that expresses some sense of local need
5. Further evidence of either parents or workers being signed up to the vision
6. Increased level of sign-up and responsiveness to local communities
7. Statements from staff/parents/others that express the vision and shared commitment to it.

Sources:
- Compare to central Sure Start Unit vision
- Delivery plan
- Publicity material
- Sure Start website
- Interviews
- Case studies

2. SSLP Partnership Board includes a balanced representation of local organisations, local education authority, social services, local NHS, voluntary and community organisations, and local parents.

1. No evidence of balance in board membership/references to board
2. Board has two or more significant gaps
3. Board with one significant gap (only one voluntary agency, no parents, no health)
4. Board includes balanced representation of a manageable size
5. As 4) plus training for parents to participate/contribute to board decision-making
6. As 5) plus evidence of an effort made to reflect the make-up of the local community (ethnicity, gender, etc.) within the board
7. As 6) plus explicit statements of value of board (i.e. 'great board'!) and evidence of senior representation from agencies

Sources:
- Delivery plan
- National Survey
- Interviews
- Board minutes

3. The Partnership is functional

1. Conflict or tensions exist; the partnership is in disarray; concerns are expressed about the partnership; vested interests disrupt partnership; breakdown in relationship between Programme Manager and partnership

2. Domination of partnership by one party
3. Lurches along; intermittent conflict; partnership functions at low level (e.g. erratic poor attendance, lack of commitment) and possible domination by one partner
4. Evidence that tensions and vested interests are acknowledged but reconciled; building on existing strengths
5. Internal management is functioning well
6. Some evidence of relationship between partners beyond what is for the benefit of the SSLP
7. Partnership actively supports PM, cooperates internally; reconciles vested interests; pulls in other partnerships; is an active advocate outside the board (e.g. does Health programme willingly, share stats, exchange favours with other partners i.e. not charging rent for premises)

Sources:

- Delivery plans/ any updates - evidence of previous local authority integrated service
- National Survey
- Annual Reports
- Minutes of meetings
- Organisational charts
- Interviews

4. SSLP has an intention to empower users and service providers.

1. No sense that users are involved at all in service planning or delivery; over professionalisation of staffing (e.g. over-dominance of highly qualified professionals such as clinical psychologists, S&L therapists)
2. Token mention of parents but services dominated by professionals
3. Parents involved in some voluntary work; users on the board
4. Shows evidence of moving towards blurring the distinction between staff and users and working towards balance of voluntary and paid staff; community volunteers do outreach & home visiting; community volunteers provide support for families; training also offered to volunteers
5. Has a balance of voluntary and paid staff; clearly defined exit strategies for users; built in features to develop local peoples' involvement; services include self-help groups, or other services run by users
6. Has whole programme away days; staff development; SSLP includes services for additional community groups (e.g. grandparents, prisoners, teenagers); there is community development training for staff
7. Shows evidence that staff are part of a learning community (e.g. there are opportunities for change in staff roles and responsibilities, access to professional development); evidence of mutual respect for contributions of all parties

Sources:

- National Survey
- Annual reports
- Publicity and other literature produced by SSLP
- Case studies

5. Communication systems reflect and respect the characteristics and languages of the host communities

1. Visibility of programme in the area is low; no acknowledgement of diversity or characteristics of the community
2. Poor attempt to make programme visible
3. Publicity in the main (dominant) languages of the community (or acknowledges why this may not be possible)
4. Publicity that reflects and respects the characteristics of the community (e.g. pictures with people from cultural backgrounds of the communities); the public face of the SSLP reflects and respects the characteristics of the community; visible public face (e.g. shop on the high street, centrally placed site, recognisable face)
5. Significant profile in area; evidence that both targeted (e.g. brochure for families with special needs children) and generic (e.g. posters on activities) communications are designed to reach the wider community
6. Creative ways of meeting language needs; evidence that the community is routinely involved in the development of the signage for buildings and/or publicity material rather than in token decisions (e.g. colour of carpets/walls)
7. Evidence of considering the needs of those who cannot read or have other needs; sensitivity to differentiating materials and signage for frequently excluded groups (e.g. travellers, asylum seekers, blind, those with learning difficulties); high profile in general community – innovative methods of reaching wide audience (e.g. ad in local cinema, signs on buses/fire engine, articles in local paper)

Sources:

- Interviews – provide information on local context, visibility

- National Survey
- Local context analysis – provide information on local context
- Delivery plan – does it discuss context of community and make plans for it?
- Publicity and Building signage

6. SSLP has effective leadership/management.

1. There is no evidence of leadership
2. Evidence of inappropriate/frequent changes in leadership that are disturbing the performance of SSLP; little thought given to spread of responsibility within the Senior Management Team. PM reported as unsatisfactory, partnership does not get on with PM, partnership members in conflict
3. Evidence of weaknesses in leadership/senior management team (including partnership)
4. Lines of management/accountability are clearly defined in documentation (organigram, annual report, etc) evidence of satisfactory leadership that has been sustained
5. Spread of responsibility amongst stable SMT; there is strong leadership (knowledge of field and how to manage people) that is sustainable
6. Frequent references from staff, local authority officers, and users to the high quality of leadership (PM and SMT); evidence of strategies to address conflicts
7. Inspirational leadership shared across Senior Management Team; leadership capable of promoting shared vision throughout workforce

Sources:
- National Survey
- Interviews
- Delivery plan
- Organisational charts
- Annual reports

7. Multi-agency team work is established in the SSLP

1. No evidence of multi-agency teamwork
2. Imbalance in core and peripheral team structures across agencies; lack of commitment to integrate agencies in service delivery; no shared staff training
3. Balance in core and peripheral team structures in agencies/service delivery systems
4. Multi-agency teamwork is well established; evidence of some shared staff training
5. Evidence of joint strategic planning across agencies (e.g. get together to do joint planning); multi-agency teamwork is commended; regular joint training
6. Co-location (in same building), even if only certain times of the week, where possible
7. Multi-agency teamwork extends beyond boundaries of SSLP

Sources:
- National Survey
- Interviews
- Delivery Plans
- Case studies
- Organisational charts
- Annual reports
- Themed studies

8. There are clear pathways for users to follow in accessing specialist services.

1. No systematic arrangement for users to access services; ad hoc arrangements for users to reach specialist services
2. Unacceptable/erratic time delays in getting specialist support to children/families at points of need
3. Key worker system to ensure users can access help at point of need
4. Flexible systems for accessing specialist services (e.g. drop-in, self referral)
5. Key worker system with responsibility for coordinating assessment, diagnosis and self- or staff-referrals; working to common assessment/record keeping tool
6. Sensitivity to need for non-stigmatised systems for accessing specialist services and sharing confidential information
7. Guaranteed response time; proven systems for routinely sharing specialist knowledge among all workers; all SSLP workers have an understanding of appropriateness of referring users beyond generic to specialist help (where and how)

Sources:
- National Survey

- Publicity material
- Interviews
- Themed and Case studies
- Annual reports
- Evaluations

9. Staff turnover is low

1. Chaotic and erratic staffing and/or turnover in staff
2. Interviewees report that staff turnover is high because of difficulties within the SSLP
3. Reported problematic vacancies in staffing
4. Has acceptable levels of turnover for the area (e.g. some geographical and discipline areas may have issues related to local skill shortages, maternity leaves)
5. Staff stability
6. Evidence of strategies for recruiting and retaining staff (e.g. targeted training for individual staff development)
7. Evidence of high levels of job satisfaction amongst wide range of SSLP staff and volunteers

Sources:
- National Survey – Section 1.1, questions 2-4
- Interviews
- Annual reports
- Evaluations
- Case studies and themed studies

10. SSLP takes account of and acts upon evaluation findings.

1. Doesn't do evaluation
2. Limited use of evaluation budget; confuses monitoring with evaluation
3. Has commissioned regular evaluations but not responded to them; has an in-house evaluation system of some sort; evidence of using evaluation budget for evaluation at an expected or reasonable level; appear to understand the difference between monitoring and evaluation
4. Evidence of responding in short term to evaluation findings
5. Either staff or parents participate in evaluation process,
6. Uses evaluation data over time to feed into long term strategic planning
7. Well developed understanding of long-term evaluation processes and their application to service improvement

Sources:
- Evaluation reports
- Interview NESS support staff
- Annual report budget lines
- National Survey

11. SSLP has strategies for identifying users.

1. No system in place to identify users
2. Ad hoc systems only
3. Some strategies for identifying new users; staff report on potential new users
4. Centralised database and/or:
    a. attempts at information exchange about user needs with other agencies;
    b. attempts to locate and support children with disabilities or special educational needs
5. Systemising of record keeping; referral of users and their needs; actions around information exchange about special needs
6. Evidence of systematic and routine exchanges of information between professionals about potential users: new babies, families moving into the area, etc; links with housing
7. Regular systematic contact with all families in neighbourhood by SSLP staff in order to identify new users as well as user needs; has achieved balance between need to monitor and support users

Sources:
- National Survey
- EYO & Chair interviews
- Case studies
- Publicity
- Delivery plan

12. SSLP is showing a realistic and improving reach of children in the area.

1. Under 10%
2. 10-15%
3. 16-24%
4. Regular, consistent, and increasing reach that is around the average SSLP reach of 25%
5. 100% reach of new babies + regular consistent, and increasing reach of 26-50%
6. as 5) plus reach of 51-79%
7. as 6) plus reach of 80%+

Source:
- Reach figures

13. SSLP is aware of reach and has strategies to improve/sustain use of services over time.

1. No evidence of strategy to identify users including hard-to-reach groups; no acknowledgement of reach being an issue
2. Some acknowledgement of concern about improving reach; no evidence of action
3. Evidence of minimal strategies to maintain and improve reach (e.g. only have health visitors to reach users); regular monitoring of use
4. Identified workers for most key issues; systems to identify the take-up of services
5. Membership card system routinely interrogated for patterns of use; identified workers for all relevant key issues; monitors time between service request and response
6. Creative registration process systems for increasing/retaining membership use that involve parents and children
7. Innovative approaches to sustaining family take-up of services and reaching-out to new constituencies

Sources:
- National Survey,
- EYO & Chair interviews
- Case studies
- Publicity
- Delivery plan
- Annual report

14. Service delivery reflects the guidance requirements for the provision of core services in support, health, and play & childcare

1. Absence of any services in any one of the core service areas
2. Evidence of sustaining inherited levels of service without reshaping them to vision
3. Evidence of response to core requirements and efforts to redress imbalances in services
4. As 3) plus tailoring services to specific needs of the community
5. Increasing signs of flexibility in tailoring services to meet local needs
6. Resourcefulness and imaginative approaches to modifying and extending services
7. As 6 plus including services in the area that enhance SSLP provision in an innovative way (e.g. co-opting local Area Based Initiative to enable extension of SSLP services beyond pre-defined)

Sources:
- National Survey

15. SSLP service delivery reflects intention to target children, parents & families and the community

1. Absence of any services covering any one of the target groups
2. Evidence of sustaining inherited levels of services without reshaping them to target any one of the target groups
3. Evidence of adjusting focus of services to target the target groups
4. As 3) plus evidence of tailoring services to specific needs of groups
5. Increasing signs of flexibility in tailoring services to target groups
6. Resourceful and imaginative approaches to modifying and extending services to a special target group (e.g. robust special needs set ups)
7. As 6) plus more than one specialised target group

Source:
- National Survey (see answer key)

16. SSLP shows innovative features.

1. Replicating traditional service delivery models
2. Some indication of trying to reshape delivery models
3. Creative features within standard services

4. At least one innovative service
5. More than one innovative service
6. Range of innovative features in more than one service
7. A range of innovative features including surprising services; innovation evident in both nature of service and delivery mechanisms

Sources:
- EYO and Chair interviews
- National Survey
- Publicity
- Delivery plan
- Annual report
- Case studies

17. Services accommodate the needs and preferences of a wide range of users.

1. Any evidence of difficulty in access
2. Operates school hours only and reduces services during holidays
3. Open working hours in range of accessible venues
4. Evidence of attempting to extend accessibility and availability (e.g. phone, delivering services in the evening)
5. Strategic mix of venues (e.g. using libraries, shops, leisure facilities), variety of access points (e.g. mobile units) and flexible times
6. Providers and users involved in identifying varieties of preferences and needs which have been accommodated including weekends, evenings, school holidays
7. Contact available 24 hours. 365 days a year

Sources:
- National Survey
- Publicity
- EYO and Chair interviews
- Case studies

18. Overall, the SSLP has a welcoming and inclusive ethos.

1. Minimal materials
2. Bureaucratic language; over-reliance on commercially produced standard leaflets
3. Publicity appears to be friendly and welcoming (e.g. languages and more pictures vs. words)
4. Shows evidence of awareness of need to be welcoming
5. Evidence of moving welcome beyond boundaries of building into community beyond
6. Level of sensitivity – evidence of targeting materials for particular groups; sensitivity to how different groups are portrayed (e.g. men and babies); high levels of cultural sensitivity
7. Attention paid to welcoming wide range of users within the community using innovative features; refers to the local community for advice about ethos and materials

Sources:
- Overall sense from all the material that you've covered
- Case studies (esp. buildings)
- Publicity

APPENDIX B: Implementing the Programme Variability Rating Scale at Stage 1

In the Figure B.1 below, the rating system and an indication of the guidance notes for completion of the templates for two of the eighteen dimensions, numbers 2 (Composition of the Partnership) and 4 (Empowerment of Parents and Staff), are given as illustration. The complete version of this instrument is at Appendix A. Further details of the guidance notes for researchers are given in the Appendices of *Variation in Sure Start Local Programme Effectiveness: Early Preliminary Findings* (NESS Research Team 2005b).

Dimension 2: Composition of the Partnership

2. SSLP Partnership Board includes a balanced representation of local organisations, local education authority, social services, local NHS, voluntary and community organisations, and local parents.

Guidance: This question relates to the relative distribution of representatives on the Partnership Board, and their level of seniority within their organisations (if this information is available). It also looks at efforts made to reflect the make-up of the local community within the board, as well as whether arrangements are made to make parent involvement possible (e.g., training, crèche, etc.).
Please make sure to write down the number of representatives from each area (health, education, etc.).

Level Statements
1) No evidence of balance in board membership/references to board
2) Board has two or more significant gaps
3) Board with one significant gap (only one voluntary agency, no parents, no health)
4) Board includes balanced representation
5) As 4) plus training for parents to participate/contribute to board decision-making
6) As 5) plus evidence of an effort made to reflect the make-up of the local community (ethnicity, gender, etc.) within the board
7) As 6) plus explicit statements of value of board (i.e. 'great board'!) and evidence of senior representation from agencies

Extracts from the Programme Variability Rating Scale Level Statements and Guidance Notes

Dimension 4: Empowerment of users and providers of services

4. SSLP has an intention to empower users and service providers.

Guidance: This question focuses on efforts made by the SSLP to involve users in the running of the SSLP, and provide opportunities for development to service providers. Things that may be noteworthy are the balance between volunteers and paid staff; are parents involved in decision making, are there exit strategies for users, services run by users, away days, staff development opportunities (including community development training, evidence of mutual respect, etc.

Note that you would find evidence of community development training in the National Survey, section 3.5, under "other".

1) No sense that users are involved at all in service planning or delivery; over-professionalisation of staffing (e.g. over-dominance of highly qualified professionals such as clinical psychologists, speech and language therapists)
2) Token mention of parents but services dominated by professionals
3) Parents involved in some voluntary work; users on Board
4) Shows evidence of moving towards blurring the distinction between staff and users and working towards balance of voluntary and paid staff; community volunteers provide support for families; training also offered to volunteers
5) Has a balance of voluntary and paid staff; clearly defined exit strategies for users; built in features to develop local peoples' involvement; services include self-help groups or other services run by users
6) Has whole programme away days; staff development; SSLP includes services for additional community groups (e.g. grandparents, prisoners, teenagers); there is community development training for staff
7) Shows evidence that members of staff are part of a learning community (e.g. there are opportunities for change in staff roles and responsibilities, access to professional development); evidence of mutual respect for contributions of all parties.

Each higher level of rating on the 7-point scale indicates an advance in both proficiency and sophistication of implementation, therefore the scales are cumulative. Figure B.2 shows the evidence on empowerment for a programme that was rated 7on this domain (the highest score).

Evidence for high PVRS rating for an SSLP on the dimension of intention to empower users and service providers

	Dimension 4: Empowerment of staff and users
Source	**Evidence**
SS website	"Families with young children are actively engaged in planning and developing"
SS website	"Within a range of culturally sensitive services parents are given opportunities and encouragement to further develop their skills and confidence"
SS website	"….a range of workshops and training programmes for parents and early years staff to raise awareness of language development and communication"
Delivery Plan (p.15)	"Parent representation at all levels will be a key feature of Sure Start…Participating parents will receive appropriate training and support and the process will be empowering and inclusive."
Delivery Plan (p.17)	"It is particularly important that we tap the energies, imaginations and talents of the most excluded groups, of which there are many in….."
Delivery Plan (p17)	"We must commit resources to training and developing the skills and capacities of local parents so that they can have a meaningful role in directing local services for families with young children."
Delivery Plan (p.19)	Will train staff in all local services in community participation
Delivery Plan(p 8)	Provide induction and equal opportunity training for all new partners
Evaluation Update (NESS)	Has formal and informal training sessions for parents only and sharing staff and volunteers
Evaluation Update (NESS)	Group of ten parents trained to do evaluation and 10 year follow-up of planning and development exercise
NS 2 (p 3)	4 FTE volunteers doing outreach and home visiting (do general programme contact, 2 support families, 1 play, learning and childcare)
NS2 (p.7)	Equipment loan scheme run by parent

NS2 (p. 32)	Have parent forum
NS 2. (p33)	Has childcare, confidence building activities and training opportunities to allow parents to attend partnership meetings
NS 2 (p 42)	Has training for staff and volunteers, most done separately except induction, Health and Safety and Play and Learning techniques
NS 2 (p43)	Parents involved in all aspects of staff recruitment

Another programme was rated at 3 (minimal) on the rating scale, based on the evidence given below in Figure B.3:

Evidence for minimal rating for an SSLP on the dimension of intention to empower users and service providers

	Dimension 4: Empowerment of staff and users
Source	**Evidence**
Publicity	Encourages dads and grandads with fathers' baby massage group and special page in newsletter
NS2	Outreach delivered by Sure Start staff and Home-Start volunteers
NS2	Provides career, education and training advice for parents
NS2	Child care provision, confidence building training and pre-meeting debrief for parents on board. Parent involvement worker recruits members to parent forum, which elects reps to board
NS2	Training for staff not available for parents
Newsletter	Have a volunteer day

Another dimension (11) addressed the identification of users. Here the statement was *"SSLP has strategies for identifying users",* and in this case a good SSLP (rating 5) would be one that *"identifies all potential and new users and has systems in place to identify special needs users".* Lower rated programmes would have no strategies at all, or ad hoc systems only. Higher rated programmes would have a centralised database and systematised record keeping, routine exchanges of information between professionals about new and potential users, and regular systematic contact between SSLP staff and all families in order to identify new users as well as user needs.

Examples of ratings on this dimension are shown at Figures B.4 and B.5. In the first example given, an SSLP which rated highly (6) on this dimension had the following entries on the template:

Evidence for a good rating for an SSLP on the dimension of identifying users

	Dimension 11: strategies for identifying users
Source	**Evidence**
NS3	SSLP uses centralised database for discovering where families live, when new babies are born and when new families move into the area. Plus multi-disciplinary team adds data directly onto SSLP database
NS3	SSLP would expect to be informed if any children with disabilities or special needs moved to the area
NS3	SSLP would expect to be notified of a child moving into the area registered with Social Services or on CP register
NS3	Parents/carers with special needs are identified through outreach/home

	visiting
NS3	8 out of 12 group issues identified as being significant in the area have a member of the outreach team allocated specific responsibility
EYO interview	Good strategies in place, lots of parent involvement and community action in identifying people who need the services

In contrast, Figure B.5 shows template entries for identifying users for an SSLP which rated minimal (3) on this dimension.

Evidence for a minimal rating for an SSLP on the dimension of identifying users

	Dimension 11. SSLP has strategies for identifying users
Source	**Evidence**
NS	SSLP discovers where new families live via information from Health Visitors Discovers when new babies are born via midwifery team
NS	Health visitors inform SSLP when new children move into the area with disabilities or SEN Health visitors monitor whether children under 4 are receiving routine health checks
NS	Systems for making contact with children not attending health checks: Health visitors send re-appointment cards and visit families to make follow-up appointments
EYO	Feels that the geography of the area (small communities) means that mainstream services are not integrated, information is not shared and this needs improvement
PDO	System of identification and registration of users needs tightening up

Reliability of the Programme Variability Rating Scale Procedures

Initially application of the rating procedure was carried out by four of the research team. Using the evidence accumulated for 42 SSLPs, these programmes were scored by all four assessors. Following this initial rating a refinement of the rating guidelines took place taking into account the lessons learned. All assessors were operating 'blind' to the Impact Study child and parent results.

Subsequently the remaining 108 programmes were rated by two of the four original assessors. The inter-assessor reliability for these two assessors was computed across all 18 dimensions. Reliability was good with levels of agreement within 1 point being from 77% to 98% with a mean of 87%. The Kappa statistic ranged from 0.55 to 0.97 with a mean of 0.77. The Spearman's rho statistic ranged from 0.74 to 0.99 with a mean of 0.83.

Details of the inter-correlation of the 18 ratings can be found in *Variation in Sure Start Local Programme Effectiveness: Early Preliminary Findings* (NESS Research Team 2005b: p14)

Appendix C: Stage 1 Framework for 4-way classification of services as family, parent, child or community focused

This framework was used to explore the number and type of services offered by 150 SSLPs. Family focused services targeted the whole family, individual parent focused services targeted support to parents, child focused targeted children alone, and community focused related to services with a wider remit such as GP surgeries or leisure facilities.

Framework for 4-way classification of services as family, parent, child or community focussed

Type of service	**Coding**	**Type of service**	**Coding**	**Type of service**	**Coding**
SUPPORT –RELATED SERVICES		***SUPPORT –RELATED SERVICES***		***HEALTH – RELATED SERVICES***	
Family centres run by a voluntary agency	***FAMILY***	Credit unions	***COMMUNITY***	GP Surgeries	***COMMUNITY***
Family centres run by a statutory agency	***FAMILY***	Swap shop for children's clothes, school uniforms, etc	***FAMILY***	Health visiting services	***FAMILY***
Home visiting schemes/ outreach work (e.g. Home-Start or Newpin)	***FAMILY***	Grandparents' group	***FAMILY***	Community midwife services	***FAMILY***
Welfare rights advice centres	***COMMUNITY***	Fathers' group	***PARENTS***	Community health workers	***COMMUNITY***
Housing advice centres/ agencies	***COMMUNITY***	Parenting programmes	***FAMILY***	Health promotion services related to smoking cessation	***PARENTS***
Money advice centres/ agencies	***COMMUNITY***	Support centres/ agencies for teenage parents	***PARENTS***	Health promotion services related to healthy eating/ nutritional advice	***FAMILY***

Relationship counselling schemes	***FAMILY***	Telephone help line(s)	***PARENTS***	Breastfeeding promotion services/ advice/ support	***CHILD***
Leisure activities for parents (e.g. swimming, art classes)	***PARENTS***	Drop-in sessions with separate crèche / playgroup	***PARENTS***	Child health clinics	***CHILD***
Type of service	**Coding**	**Type of service**	**Coding**	**Type of service**	**Coding**
HEALTH – RELATED SERVICES		*HEALTH – RELATED SERVICES*		*HEALTH – RELATED SERVICES*	
Family planning services, including emergency contraception	***FAMILY***	Special provision for disabled children	***CHILD***	Self-help groups	***COMMUNITY***
Counselling services	***FAMILY***	A register or database of disabled children in the area	***CHILD***	Home safety equipment loan scheme	***FAMILY***
Pharmacy/ Chemist shops	***COMMUNITY***	Specific post-natal depression services	***PARENTS***	Alternative health practitioners	***COMMUNITY***
Specialist services for children with particular needs (e.g. speech & language therapy)	***CHILD***	Ante natal clinics	***PARENTS***	*PLAY AND CHILDCARE –RELATED SERVICES*	
Specialist services for parents with particular needs (e.g. speech & language therapy, psychological services, physiotherapy)	***PARENTS***	Well women clinics	***PARENTS***	Nursery schools	***CHILD***
Child development centre/	***CHILD***	Outpatient clinic-	***COMMUNITY***	Primary schools	***COMMUNITY***

team		psychiatric			
Portage services	***CHILD***	Outpatient clinic – other	***COMMUNITY***	Nursery classes	***CHILD***
Type of service	**Coding**	**Type of service**	**Coding**	**Type of service**	**Coding**
PLAY AND CHILDCARE –RELATED SERVICES		***PLAY AND CHILDCARE –RELATED SERVICES***		***PLAY AND CHILDCARE –RELATED SERVICES***	
Secondary schools	***COMMUNITY***	Services for children with physical development difficulties	***CHILD***	Swimming pools	***COMMUNITY***
Childminders	***CHILD***	Services for children with socio-emotional difficulties	***CHILD***	Tumble tots group	***CHILD***
Childminding network	***COMMUNITY***	Parent & Toddler groups	***FAMILY***	Other relevant services (please specify)	
Day nurseries	***CHILD***	Outside/ outdoor play areas	***CHILD***		
Full time day care sessions/ or centres	***CHILD***	Crèche sessions	***FAMILY***		
Pre-school play groups	***CHILD***	Soft play areas	***CHILD***		
Summer play schemes	***COMMUNITY***	Training for childminders	***COMMUNITY***		
After school clubs	***COMMUNITY***	Adventure playgrounds	***COMMUNITY***		
Breakfast clubs	***COMMUNITY***	Scrapstores	***COMMUNITY***		

Libraries	***COMMUNITY***	Bookstart schemes	***CHILD***		
Toy libraries	***FAMILY***	Reading schemes *other* than Bookstart	***CHILD***		
Child speech & language development services	***CHILD***	Junior sports schemes (including gymnastics)	***CHILD***		

APPENDIX D: EXTRACTS FROM EXEMPLARY SCHEDULE FOR STAGE 2 FIELDWORK

In this appendix we present examples of the proformas and protocols used by all field workers to collect, collate and manage data. The conceptual framework of the instruments maintain the focus on the inter-related dimensions of programme proficiency delineated in the Programme Variability Rating Scales used at Stage 1.

Schedule for Phase Two PV Fieldwork
PM (Programme Manager)

1. SSLP has a well-articulated vision that is relevant to the community. (Please include the vision statement if you can find it)

1) No evidence of vision in documentation, interviewees cannot state vision
2) Token statement and no evidence of sign-up and responsiveness to local communities
3) Muddled statement of vision, one that is not widely known/shared
4) Written statement, known by staff and users, that expresses some sense of local need
5) Further evidence of parents or workers being signed up to the vision
6) Increased level of sign-up and responsiveness to local communities
7) Statements from staff/parents/others which express the vision and their shared commitment to it.

1. *Check Phase 1 file for vision statement. Compare with any changes given or on programme documents and seek explanations.*

What is the file version of the vision of the programme?

If relevant ask why vision has changed?

Notes

2/3/4 How committed do you feel to the vision?
How well does the vision reflect local communities' priorities? Any omissions? Why?

Notes

5/6/7.*Check for visibility of vision statements on regular documentation/website/public displays etc for users and staff.*
How was the vision written? How often is it referred to by staff and users?
How strongly do respondents express their commitment to the vision?
How do you think it is translated into their practices?

Notes

2. The Partnership is functional

1. Conflict or tensions exist; the partnership is in disarray; concerns are expressed about the partnership; vested interests disrupt partnership; breakdown in relationship between PM and partnership
2. Domination of partnership by one party
3. Lurches along; intermittent conflict; partnership functions at low level (e.g. erratic poor attendance, lack of commitment) and possible domination by one partner
4. Evidence that tensions and vested interests are acknowledged but reconciled; building on existing strengths
5. Internal management is functioning well
6. Some evidence of relationship between partners beyond what is for the benefit of the SSLP
7. Partnership actively supports PM, cooperates internally; reconciles vested interests; pulls in other partnerships; is an active advocate for SS outside the board (e.g. does Health programme willingly, share stats, exchange favours with other partners i.e. not charging rent for premises)

1/7 ***Try to arrange observation of a Board meeting, and before visiting the SSLP ask for minutes of as many previous meetings as possible. From minutes make notes on:-***

- *Comprehensiveness? Clear account of meetings?*
- *Systems for actions and checking on completion of tasks?*
- *Attendance patterns - explanations?*
- *Seniority of attendees*
- *Domination by one party?*
- *Users as active contributors to meetings?*

Any other clues about functioning of partnership.

Check in PV files for Chair/EYO/PDO interviews for comments on partnership functioning? Is the same Chair in post? Note where the Chair is from (parent/employee of partner agency/great and good)? Impact on partnership?

Notes

Establish whether there are any agencies that are thought to have created problems for joined up working.

How do you get on with the Board?

Notes - probe for explanations/impact on programme

If the Partnership has dedicated administrative/executive support ask the following questions (or continue with manager).

- Who was in original Partnership and who is now in the Partnership and what happened in between to account for any changes?
- Are there small local voluntary organisations as well as national charities represented?
- How many Chairs have there been/why did they change/ what is the system for choosing Chair?
- Do Partnership members deploy the resources of their agency on behalf of SSLP rather than only using the SSLP as a source of resources for the agency?

Notes

3. SSLP has an intention to empower users and service providers.

1. No sense that users are involved at all in service planning or delivery; over professionalisation of staffing (e.g. over-dominance of highly qualified professionals such as clinical psychologists, S&L therapists)
2. Token mention of parents but services dominated by professionals
3. Parents involved in some voluntary work; users on the board
4. Shows evidence of moving towards blurring the distinction between staff and users and working towards balance of voluntary and paid staff; community volunteers do outreach & home visiting; community volunteers provide support for families; training also offered to volunteers
5. Has a balance of voluntary and paid staff; clearly defined exit strategies for users; built in features to develop local peoples' involvement; services include self-help groups, or other services run by users
6. Has whole programme away days; staff development; SSLP includes services for additional community groups (e.g. grandparents, prisoners, teenagers); there is community development training for staff
7. Shows evidence that staff are part of a learning community (e.g. there are opportunities for change in staff roles and responsibilities, access to professional development); evidence of mutual respect for contributions of all parties

1. Are users involved in service planning?
2. Are users involved in service delivery?

Probe who and how? Impact on services? Staff and user comments? Tensions? Resolutions?

3. Do you think the programme relies on highly qualified professionals in the way the programme operates?

Comments

4. Are users on the board?

*Check minutes of board meetings for evidence of their active participation

Probe how/any dilemmas?

5. Is there a balance of voluntary and paid staff?

Note what volunteers do? Turnover?

- *Outreach/home visiting*
- *Family support*
- *Health*
- *Early learning, play and childcare*
- *Other*

Probe for consequences for volunteers/paid staff/quality of services?

6. Are there exit strategies for service users?

Probe what strategies are in place for preventing the same families using services/ensuring regular throughput of users/setting up opportunities/alternatives for those moving on from services?

7. Are there whole programme away days/staff development?

Probe what/purpose/who attends? Benefits? Drawbacks?

8. Is there community development training for staff and/or parents?

Probe what/why/how/who? Comments?

9. Are there opportunities for staff and volunteers to learn about each other's professional roles and responsibilities?

Probes: Shadowing, regular meetings, joint professional development, exchange of information

10. Are there opportunities for staff to learn about parents' roles and responsibilities?

Details/comments
Reflect in your journal on why high scores on this item seemed to be linked to better than expected parental outcomes?

4. Communication systems reflect and respect the characteristics and languages of the host communities

1) Visibility of programme in the area is low; no acknowledgement of diversity or characteristics of the community
2) Poor attempt to make programme visible
3) Publicity in the main (dominant) languages of the community (or acknowledges why this may not be possible)
4) Publicity that reflects and respects the characteristics of the community (e.g. pictures with people from cultural backgrounds of the communities); the public face of the SSLP reflects and respects the characteristics of the community; visible public face (e.g. shop on the high street, centrally placed site, recognisable face)
5) Significant profile in area; evidence that both targeted (e.g. brochure for families with special needs children) and generic (e.g. posters on activities) communications are designed to reach the wider community
6) Creative ways of meeting language needs; evidence that the community is routinely involved in the development of the signage for buildings and/or publicity material rather than in token decisions (e.g. colour of carpets/walls)
7) Evidence of considering the needs of those who cannot read or have other needs; sensitivity to differentiating materials and signage for frequently excluded groups (e.g. travellers, asylum seekers, blind, those with learning difficulties); high profile in general community – innovative methods of reaching wide audience (e.g. ad in local cinema, signs on buses/fire engine, articles in local paper)

1/2/3/4 *Check publicity material, posters, visibility of buildings and take photos (nb check for permission) Collect examples, photos and reflect on what impact they might have on staff, users, the communities in the area?*

Do you think your publicity/visual images/signage acknowledge diversity/community characteristics?

Do the programme services target specific groups such as parents with children with additional needs/women only services as well as generic groups?

Give examples - ask about strengths and weaknesses in reaching groups/accommodating community needs and preferences. Ask to see a current list of services on offer? How much might be outreach? How much is targeted and how much universal services? What do they see as benefits and drawbacks.

Do there seem to be innovative methods for reaching a wide spectrum within the SSLP community?

Make a note of examples - any evidence of impact.

5. SSLP has effective leadership/management

1) There is no evidence of leadership
2) Evidence of inappropriate/frequent changes in leadership that are disturbing the performance of SSLP; little thought given to spread of responsibility within the Senior Management Team
3) Evidence of weaknesses in leadership/senior management team (including partnership) - PM reported as unsatisfactory, partnership does not get on with PM, partnership members in conflict
4) Lines of management/accountability are clearly defined in documentation (organigram, annual report, etc); evidence of satisfactory leadership that has been sustained
5) Spread of responsibility amongst stable SMT; there is strong leadership (knowledge of field and how to manage people) that is sustainable
6) Frequent references from staff, local authority officers, and users to the high quality of leadership (PM and SMT); evidence of strategies to address conflicts
7) Inspirational leadership shared across Senior Management Team; leadership capable of promoting shared vision throughout workforce

1, 2 and 3. *Return to PV files to establish from NS and interviews how many PM's there have been and whether there have been any issues around leadership. Make notes on evidence of current PM's leadership style*

If they have had changes to PMs ask of PM and a couple of staff within programme hierarchy:

Can you talk me through changes in PM and the impact this has had on SSLP? How are things now?

Notes

Who do you see as having leadership in the programme?

Where do team members perceive their line management to be?

Probe for any issues arising from clarity or conflict in line management/leadership within SS and partnership systems

4. Do you have a management team working alongside the PM? Who are they/what do they do? Do they work well together? How do they work with the Sure Start board?

Again probe for evidence of clarity/confusion/conflict/consensus and impact on effectiveness

5. If the PM was not around (perhaps off sick) how would the programme operate? Is there a spread of responsibility within the programme to ensure sustainability of leadership?

Probe for examples/key issues

6. Do you consider that the programme is managed well? What are key features of the leadership here? If not how could leadership and management be done differently?

Notes on key features of effective or ineffective leadership and management

7. Would you describe leadership here as inspirational? Can you give some examples of ways this is done? What is the impact on programme functioning? Staff? Users?

Notes

6. Multi-agency teamwork is established in the SSLP

1) No evidence of multi-agency teamwork
2) Imbalance in core and peripheral team structures across agencies; lack of commitment to integrate agencies in service delivery; no shared staff training
3) Balance in core and peripheral team structures in agencies/service delivery systems
4) Multi-agency teamwork is well established; evidence of some shared staff training
5) Evidence of joint strategic planning across agencies (e.g. get together to do joint planning); multi-agency teamwork is commended; regular joint training
6) Co-location (in same building), even if only certain times of the week, where possible
7) Multi-agency teamwork extends beyond boundaries of SSLP

1, 2, 3. Confirm staff figures from Phase 1 file and check out against current list of employees. Who seems to be core (i.e. permanent full time staff) and who peripheral to the programme staffing/service delivery? What are explanations? Check with staff about implications for their commitment, status and working practices.
Is there evidence of shared staff training across the agencies contributing to SS staff?

Notes

Give examples. How often? Who is involved? Where does it take place? Is it mandatory? Are there social events for the team or perhaps team building events? Implications for effective practice? Dilemmas?

5. Do staff from different agencies get together to do joint planning? Does this cause any problems with their other work?

Give examples. How often? Who is involved? About which specific services? Are volunteers involved? What are seen to be the benefits and drawbacks?

Was there any multi-agency work going on in the area before Sure Start?

Probes: How did it work? Who was involved? Have the parties involved accepted the Sure Start ethos or have there been any resentments? How are these dealt with?

6. Where are staff based? How does location affect their working practices?

Who is where when and why? Impact on practice?

8. Is there multi-agency teamwork working outside SSLP boundaries, who are they what are they doing.

How does this work? Can you give an example? Benefits to both parties? Dilemmas?

In your journal make some overall assessments of the benefits and drawbacks of multi-agency work in this SSLP for achieving parent and child outcomes.

7. There are clear pathways for users to follow in accessing specialist services.

1) ***No systematic arrangement for users to access services; ad hoc arrangements for users to reach specialist services***
2) Unacceptable/erratic time delays in getting specialist support to children/families at points of need
3) Key worker system to ensure users can access help at point of need
4) Flexible systems for accessing specialist services (e.g. drop-in, self referral)
5) Key worker system with responsibility for coordinating assessment, diagnosis and self- or staff-referrals; working to common assessment/record keeping tool
6) Sensitivity to need for non-stigmatised systems for accessing specialist services and sharing confidential information
7) Guaranteed response time; proven systems for routinely sharing specialist knowledge among all workers; all SSLP workers have an understanding of appropriateness of referring users beyond generic to specialist help (where and how)

1. Are there systems in place to allow users to access specialist services?

Probe: What are they? *How effective are they?* *Systems for Self- referral?* *Access to agencies internal and external to SSLP?*

2. Are requests for specialist services monitored to ensure they are acted on?

If no, why not?	*If yes, what data is collected?* *Probe: which service accessed?* *Appointments made and kept?* *Time delays?*

2. Approximately how long would it take for a request for a specialist service to be acknowledged and acted on?

Probe reasons? Implications for e.g. children with language delay, parent with drug related problem?

3. What type of specialist support is available?

Probe: special needs *Teenage parents* *PND* *Asylum seekers* *Travellers families*

English as a second language

4. How is specialist support provided?

Probe: Key workers
Drop – ins
Group support
Translation/ interpretation
Home visits

5. Are there systems for other agencies not directly involved in Sure Start to refer users to specialist services?

Probe Internal/ External to SSLP? Impact on those in need?

How are issues of confidentiality dealt with? Is there a common assessment/record keeping tool? How is information exchanged about users of specialist services across agencies? How is sensitive information dealt with?

Probe: Sharing of information
"Need to Know" basis/confidentiality/sensitivity
Discrete access to services/ groups
Assessment and record keeping systems
Collect any examples of documentation and cases of sensitive treatment.

Is any training given to generic workers on identifying users who would benefit from specialist services? Is it effective?

If no, why not?
If yes, what type? Record any examples of training given and results on quality of services/quick response to an identified need.

8. Staff turnover is low

1) Chaotic and erratic staffing and/or turnover in staff
2) Interviewees report that staff turnover is high because of difficulties within the SSLP
3) Reported problematic vacancies in staffing
4) Has acceptable levels of turnover for the area (e.g. some geographical and discipline areas may have issues related to local skill shortages, maternity leaves)
5) Staff stability
6) Evidence of strategies for recruiting and retaining staff (e.g. targeted training for individual staff development)
7) Evidence of high levels of job satisfaction amongst wide range of SSLP staff and volunteers

1 - 7 Do you have any general comments regarding the recruitment and retention of staff in your SSLP?

Comments

4 How many other Sure Start programmes exist within your area? How does this impact on staffing?

4 Are there any particular aspects of your service delivery that are easier or more difficult to recruit staff for. If so, why? What have you done about it?

Comments

4. Could you briefly describe your local labour market conditions (e.g. skill levels and other employment opportunities)? Do these factors affect staff recruitment?

Comments

3 - 4 have any situations arisen in the past that have led to the dismissal of staff? If so, could you please discuss*?*

Probes: Performance, punctuality, attendance, working arrangements, conflict) Give some examples.

3 - 5 Have staff left your programme for voluntary reasons? If so, what reasons did they give for leaving?
3 - 5. Thinking back over your time working at your present programme, what would you say have been the three biggest challenges for a) The recruitment of staff b) The retention of staff? What effect has this had on the quality of

Comments

services you offered?

Probes: Left for another job, maternity leave, left for child/home/ other care reasons, sickness, left to enter further or higher education, moved away, job dissatisfaction, conflict).*Give some examples.*

5. How many staff work on temporary contracts (3 months 6 months) or short-term contracts?

Probe: affect on retention/job satisfaction?

6 - 7 What childcare provision or other family friendly policies do you provide for your staff? How many of your staff use Sure Start related childcare?

Comments

6. What proportion of your staff work a) full time b) part-time (probe actual working hours). Do you have any flexible working schemes? Do any of your staff job share?

Comments

6 - 7 Can you give any examples of staff working in your programme that have been promoted (within your programme)? Would you say there are clear promotional ladders/targeted training? What are the levels of qualification of your staff?

If possible ask for a list of all staff with qualifications.

Would you say overall staff moral is presently high or low?
Is this true of volunteers too?
Has this changed over the life-course of your programme?
Has this impacted on user gains/achievements?

Ask for specific examples of benefits and drawbacks at different stages of the programme.

9. SLP takes account of and acts upon evaluation findings.

1) Doesn't do evaluation
2) Limited use of evaluation budget; confuses monitoring with evaluation
3) Has commissioned regular evaluations but not responded to them; has an in-house evaluation system of some sort; evidence of using evaluation budget for evaluation at an expected or reasonable level; appear to understand the difference between monitoring and evaluation
4) Evidence of responding in short term to evaluation findings
5) Either staff or parents participate in evaluation process,
6) Uses evaluation data over time to feed into long term strategic planning
7) Well developed understanding of long-term evaluation processes and their application to service improvement

1/2/3 Before visit:
1. Review SSLP's evaluation reports available in NESS or on Website
3. Check Evidence Table in PV files for information, if local NESS Evaluation Support Officer was not consulted- get their opinion.
2. Check SSLP accounts for evidence of expenditure on Evaluation.
Make appointment to visit person responsible for commissioning, and if in-house, conducting Evaluations.

Programme Manager
(if no in-house evaluator) 3.How do you commission Evaluation?
(Depending on Accounts) 3. How do you set the budget for Evaluation?

Prompt:why/overspent/underspent?

Prompt: choice of contractor/topic

Notes

6/7How do you use evaluation data to feed into long term strategic planning and improve services?.....*Examples?*

10. SSLP has strategies for identifying users.

1) No system in place to identify users
2) Ad hoc systems only
3) Some strategies for identifying new users; SS staff report on potential new users
4) Centralised database and/or:
    a. attempts at information exchange about user needs with other agencies;
    b. attempts to locate and support children with disabilities or special educational needs
5) Systemising of record keeping; referral of users and their needs; actions around information exchange about special needs
6) Evidence of systematic and routine exchanges of information between professionals about potential users: new babies, families moving into the area, etc; links with housing
7) Regular systematic contact with all families in neighbourhood by SSLP staff in order to identify new users as well as user needs; has achieved balance between need to monitor and support users

1/2/3 Are there systems in place to identify users?

Families with children 0-3	*New babies*	*New families in area*
•	•	•
•	•	•
•	•	•

4 Is there a centralised database?

Further detail e.g.
Where did it come from?
How did it come into being?
How useful is it? Does it work!
Who updates it?
If not probe reasons and consequences

Is there a system to locate and support children with disabilities and SLN?

Prompt: Describe it and say who is involved and how effective it is for the benefit of parents and children

2. Can you describe the systems that identify users and their needs and that trigger action?

Ask them to talk through a particular user experience and show the system and how it benefited the user?

Who has access to this system?
How often is it accessed and updated?

3. Is information shared and exchanged with professionals outside SSLP?

What information is shared and who is involved in this information exchange? e.g. Housing, social services, education? Benefits? Examples?

How and why was this involvement established?

Prompts: *Inherited history of information exchange?* *Clear strategy devised by SSLP?* *Other?* *Effectiveness?*

Try to get them to give you a positive example and a negative example of information exchange in relation to benefits for children, parents, families?

7. How confident are you that you are identifying, monitoring and supporting ALL families in your neighbourhood?

How do you maintain a balance between monitoring and supporting your users? Can you give us some positive examples?

Reflect in your research journal why high scores on this item appeared to be linked

Examples

with children's scores on non-verbal attainments!

11. SSLP is showing a realistic and improving reach of children in the area.

1) Under 10%
2) 10-15%
3) 16-24%
4) Regular, consistent, and increasing reach that is around the average SSLP reach of 25%
5) 100% reach of new babies + regular consistent, and increasing reach of 26-50%
6) as 5) plus reach of 51-79%
7) as 6) plus reach of 80%+

1 – 7.What are the patterns of reach in your SSLP for children in the area? How have these changed over time? Why have they changed?

What are the patterns of reach for new babies? Again any changes? Why?

What systems does your SSLP use to record reach? Why do you use these?

How confident are you that these systems accurately reflect reality?

If less than total confidence in system to record reach, for which groups are you dubious about reach figures?

Record any insights into reach figures

Reflect in your research journal on the implications of reach figures and processes on potential outcomes for children and parents in the SSLP?

12. SSLP is aware of reach and has strategies to improve and sustain use of services over time.

1) No evidence of strategy to identify users including hard-to-reach groups; no acknowledgement of reach being an issue
2) Some acknowledgement of concern about improving reach; no evidence of action
3) Evidence of minimal strategies to maintain and improve reach (e.g. only have health visitors to reach users); regular monitoring of use
4) Identified workers for most key issues; systems to identify the take-up of services
5) Membership card system routinely interrogated for patterns of use; identified workers for all relevant key issues; monitors time between service request and response
6) Creative registration process systems for increasing and retaining membership use that involve parents and children
7) Innovative approaches to sustaining individual family take-up of services and reaching-out to new constituencies

2. What are your concerns about improving reach?

Prompts e.g. 'hard to reach': travellers, asylum seekers, etc *multiple use of services by same users*

3. How have you addressed these concerns?

In which ways? Why? Effects?

Is there a system for regular monitoring of service use by individual user? Children/parents?

Describe. What have they learned from this?

Is there a system for regular monitoring of take up of services in general?
e.g. take-up of nutrition clinics, child care places, etc

Describe. What have they learned from this?

4. Do you have identified workers with particular responsibility for specific services?

Which? Why? Effects?

Do you have identified workers with particular responsibility for key issues?

Which issues? Why? *Prompts: e.g. Parental well-being (mental health, lone parents, drug and alcohol abuse)* *Child well-being (S&L, child protection)* *Community benefits (safety, environment, leisure, well being*)

5. Do you have membership systems?

Describe *Why do you have it?* *How do you use it?* *How does it work?* *How useful is it?*

Ask for an example and file it

How do you monitor time between service request and response?

6. Can you describe your registration process?

Description. An example? Strengths and weaknesses?

How is it useful for increasing and retaining use of services?

Example of impact?

7. Do you have innovative approaches?
    a. To sustain individual family take-up of services?

What? Why? How?

    b. Reaching out to new constituencies?

What? Why? How?

Nb Tackle 14 and 15 together

13. Service delivery reflects the guidance requirements for the provision of core services in support, health, and play & childcare

1) ***Absence of any services in any one of the core service areas***
2) ***Evidence of sustaining inherited levels of service without reshaping them to SS***
3) ***Evidence of responding to core requirements and efforts made to redress imbalances in inherited services***
4) As 3) plus tailoring services to specific needs of the community
5) Increasing signs of flexibility in tailoring services to meet local SS needs
6) Resourcefulness and imaginative approaches to modifying and extending services beyond core requirements
7) As 6plus including services in the area that enhance SSLP provision in an innovative way (e.g. co-opting local Area Based Initiative to enable extension of SSLP services beyond pre-defined)

14. SSLP service delivery reflects SS intention to target children, parents & families and the community

1) Absence of any services covering any one of the target groups
2) Evidence of sustaining inherited levels of services without reshaping them to target any one of the target groups
3) Evidence of adjusting focus of services to target the target groups
4) As 3)plus evidence of tailoring services to specific needs of groups
5) Increasing signs of flexibility in tailoring services to target groups
6) Resourceful and imaginative approaches to modifying and extending services to a special target group (e.g. robust special needs set ups)
7) As 6) plus more than one specialised target group

1*&2. Look at PV files for evidence of what services are offered. Follow up with some general questions about services to staff, manager and parents.*

(if possible service co-ordinator)
What services did you inherit that have been of particular value?
What services have you changed and why?
What have you left unchanged and why?
What new services have you introduced and why?
In what way are services different from what was offered in this area in the past?
What has the effect been for staff and service users?
What kinds of services do you believe are still needed in your SSLP community?
What has the SSLP done/plans to do to meet those needs?
How have you balanced the provision for children, parents and families?
Has any constituency been less well served? Why? What are the consequences?

How have you balanced the needs of the range of specialist group users in the area?
Has any group been over represented in resources? Why?
Has any group been under represented? Why?
What messages has this given to the communities?
What impact may imbalances have had on attainments/benefits from services?

How have you sustained the quality of services whilst innovating?

Can you give us some evidence of this?

Responses

(E.g. Ofsted reports, local authority inspections systems, awards, self evaluation systems)

5. Can you give us some examples of how you have tailored services to meet local SS community needs?
    5. Do you have any particularly imaginative examples for us?
    6. Do you have any examples of going way beyond SS guidelines in enhancing or innovating services?

Responses

Prompts: what, why and how? How has this made a real difference to children/parents/families/the communities here? Do you have any evidence?

In your research journal reflect overall on what you have discovered about the 'doses' (quantity and types) of services offered to children, parents and families. What effects may these have had?

Notes

Also reflect on the quality of services offered and the likely impact on gains?
What is your overall hunch about who has most benefited from services in this programme? Why?

Notes

15. SSLP shows innovative features.

1) Replicating traditional service delivery models
2) Some indication of trying to reshape delivery models
3) Creative features within standard services
4) At least one innovative service
5) More than one innovative service
6) Range of innovative features in more than one service
7) A range of innovative features including surprising services; innovation evident in both nature of service and delivery mechanisms

Are there any of your services which you think are particularly innovative? Why did you decide to offer these? How do you believe they have had an impact on users?

Details of examples and benefits

Do staff and volunteers meet to discuss the services your programme offers and how they could be made more innovative? Can you give us an example of an innovation that did not work? What did you learn from this?

Example and reasons

16. Services accommodate the needs and preferences of a wide range of users.

1) Any evidence of difficulty in access
2) Operates school hours only and reduces services during holidays
3) Open working hours in range of accessible venues
4) Evidence of attempting to extend accessibility and availability (e.g. phone, delivering services in the evening)
5) Strategic mix of venues (e.g. using libraries, shops, leisure facilities), variety of access points (e.g. mobile units) and flexible times
6) Providers and users involved in identifying varieties of preferences and needs which have been accommodated including weekends, evenings, school holidays
7) Contact available 24 hours. 365 days a year

It is likely that evidence about this dimension will be accumulated as you keep visiting the programme, but these prompts may help you to focus on particular observations and enquiries as you go along.

1. *Any evidence of difficulty of access? This means physical access and contact with the project by 'phone or personally. How far are programme sites from where people live? How often are they open? Are they visible and easily identifiable? Are they visible and easily identifiable to people who might not speak English? Might not read? Might have a disability? (Hearing, sight, physical limitations, wheelchair). Have one or several small children?*

Notes

This kind of information is usually collected by observation and visits to sites. At each, try to test the approaches, entrances and room layouts as though you yourself have a disability or several children to look after. Obviously it would be nice, if there is a disabled parent-user, to talk to them about the programme, but it's not likely that you will find one easily, so you may have to find some of this information vicariously. For general understanding of whether sites and service delivery is convenient for all in the area, parent users will be a good source, but staff too will usually tell you the weaknesses in the delivery systems.

2. Have any activities been discontinued? (Ask Programme Manager) Have attempts been made to adapt poorly attended services? Has the SSLP conducted a user survey as part of the evaluation or separately from it? Have the results fed into the SSLP delivery?

17. Overall, the SSLP has a welcoming and inclusive ethos.

1) Minimal materials
2) Bureaucratic language; over-reliance on commercially produced standard leaflets
3) Publicity appears to be friendly and welcoming (e.g. languages and more pictures vs. words)
4) Shows evidence of awareness of need to be welcoming
5) Evidence of moving welcome beyond boundaries of building into community beyond
6) Level of sensitivity – evidence of targeting materials for particular groups; sensitivity to how different groups are portrayed (e.g. men and babies); high levels of cultural sensitivity
7) Attention paid to welcoming wide range of users within the community using innovative features; refers to the local community for advice about ethos and materials

This should be completed after other domains, as the ethos of the SSLP will become apparent during the course of other work with them. It may be that your impressions are modified the more time you spend in the settings. The key strategy is observation and personal experience.

1/2/3/6 Assess publicity available in NESS. Is it encouraging, friendly and welcoming, culturally sensitive?

Elaborate - collect some examples if we don't have any on file. Analyse them for likely impact on users.

Is the Programme flexible in responding to queries?

You might phone up to request literature as if a member of the public

Response?

Make a note of some examples of new families/users arriving in the settings? What happens?

Examples

Visit the SSLP without first arranging an appointment and observe how you are greeted.
Are reception staff welcoming, helpful?
Do the outer fencing and gates provide a good balance between security, safety and welcome?

Describe what it feels like to enter the building(s)

Is it accessible to families with disabilities/buggies?
Is the reception area welcoming or a barrier to the SSLP?
Are appropriate languages on signs?
Does the place seem welcoming for children i.e. Toys/activities/suitable furniture?
Is there a well used Community Café?
Other?

Short descriptions of observations

Once inside (and probably accompanied), observe:
Are people mixing, or are there individuals left out of groups. If so, are staff doing anything about it?
Is there enough space for the activities?
Is it easy for people to find their way around (including those with little English or disabilities)?
Does it feel welcoming and inclusive?

Short descriptions

While in the area conduct informal vox pops with carers with small children at school gates, shops, parks etc. Try to approach as wide a range of people as possible.
Do they use the SSLP?

YES …What do they think of it? / NO … Why not?

In your research journal give an overall view of whether you think this programme is likely to have impact on (1) the kinds of gains we are looking for in children and their parents in the Impact study and (2) other aspects of child, parent, carer, family and community functioning in the area that may not necessarily have been 'measured' by NESS.

Notes

Appendix E

At the second stage of the project we did 16 case studies of SSLPs representing a range of proficiency as measured by the 18 dimensions of the Programme Variability Rating Scale. The 16 SSLPs were ranked in four quartiles of proficiency, with Quartile 4 as the most and Quartile 1 as the least proficient programmes. The 16 SSLPs were in different demographic and geographical contexts and represented a range of approaches to implementing the Sure Start vision.

The 18 dimensions of proficiency were grouped into three broad domains: holistic aspects of implementation, the how of processes underpinning services and the what of services.

In this appendix we have summarised the evidence of proficiency demonstrated by the 16 case study programmes by Programme Variability Rating Scale dimensions, grouped into the three broad domains.

1. HOLISTIC ASPECTS OF IMPLEMENTATION

Dimension 1: Evidence of effectiveness in the SSLP vision

Quartile 4

- Founded on firm understanding of needs of local communities, with clear commitment from providers and users (B)
- Displayed both in documentation and around buildings (E)
- Modified over time to meet local and national agendas, but core principles retained and shared (C)
- Parents involved at early stages of formulation (A)
- Known by range of stake-holders with commitment to making it happen (D)

Quartile 3

- Close to government vision - a showcase SSLP (I)
- Vaguely known, but less clarity about how vision will be achieved (F)
- Radical, leaving little scope for those not aligned with it e.g. health (G)
- Generic Local Authority vision, underpinned by imperative to reflect principles of cultural diversity (H)

Quartile 2

- Fragmented across sites and stakeholders (L)
- Broad SSLP aims; all things to all people (J)
- Expressed differently by different stakeholders (K)

Quartile 1

- Expressed in concrete (e.g. new buildings, services) rather than aspirational terms (M)
- Driven by original hero innovators, but lost as they left the SSLP (N)
- Static, token vision (P)
- Original vision lost in changes of managers (O)

Dimension 4: Evidence of effectiveness in empowerment

Quartile 4

- High levels of focused training for staff and volunteers; street committees ensure local communities are represented; commitment to training and employing local people; family friendly employment (B)
- Parents and staff have generous support for training; monthly whole staff meetings; some sense of glass ceiling for volunteers/parents in organisation (E)
- Parents' views genuinely accessed and responded to; encouraged to take over groups; staff encouraged to undertake relevant continuous professional development; family friendly employment; formal volunteer strategy being promoted (C)
- Parents and staff empowered by good quality, targeted training; part time volunteer co-ordinator; confident parent chair will take on local politicians (A)
- Staff trusted to do jobs without micro-management; clear strategy to train and employ local people as volunteers then employees; some parents felt constant pressure to be 'better' parents could be oppressive (D)

Quartile 3

- Staff training for career enhancement; local parents encouraged to train/find employment; parent representation features more 'articulate, middle class'; clear distinction in operations between volunteer and paid staff (I)
- Users are empowered but in a somewhat maternalistic way (F)
- Radical approach to empowering local people to train, work within the SSLP, set up own businesses; history of empowerment of local communities through political action (G)
- Employment/training opportunities seen as preserve of more advantaged parents; sprinkling of volunteers; ethnic mix of community reflected in staffing (H)

Quartile 2

- Volunteers encouraged, offered training, but role seems restricted to servicing professionals; 50% of staff live locally; away days exclude some professionals and their purpose seems opaque (L)
- High value of parent link meetings, parental choice grants, encouraging parents to train for outreach work; staff encouraged to access training on ad hoc rather than principled basis (J)
- Strong community development worker, but general apathy amongst parents (beyond a core group) about involvement in SSLP; staff seem disempowered by changes of insider managers and by interference from Local Authority outsider systems. (K)

Quartile 1

- Parent Action Group seems well established; some volunteers have progressed to paid work; lack of clarity about complementary roles of volunteer and professional staff; away days good for bonding, but not focused on strategic planning; some professionals talk is not respectful of local communities (M)
- High priority given to getting parents into paid employment, but focus on meeting funding targets; volunteering token and not taken seriously; no sense of providers and users working together to forge SSLP identity (N)
- Training opportunities for parents limited to 'elite' group; poor staff training (P)
- Parent forum meetings encouraged but little impact on activities; handful of volunteers; individuals encouraged to pursue training, rather than for team functioning; clear distinction between staff and volunteers with concerns about hierarchies linked with ethnicity (O)

Dimension 5: Evidence of effectiveness in Communications

Quartile 4

- Sensitively structured with clarity about meeting needs of Indian Subcontinent and other community languages and low literacy levels. Communicating with asylum seekers and travellers still needs attention. Building visible and centrally sited on 'community' campus (B)
- Routinely effective, though lacking sensitivity to minority groups; parents 'consulted' but sometimes overruled on decisions about buildings; new building seem under-used, but 19 satellite buildings may disperse activities which are used, but not highly visible? (E)
- Attention paid to tuning leaflets and posters to low literacy levels; images reflect diversity; particular attention to traveller community; SSLP building centrally sited on shopping parade and known to all (C)
- Braille and taped versions of leaflets; some translated into (very small) minority languages; Local Authority pragmatism meant central building was sited on failed secondary school building (A)
- SSLP publicised widely in local shops, metro stations, schools, clinics etc.; publicity eye-catching, accessible, in tune with local communities' characteristics; images of diversity in buildings; translation services available; building in main shopping centre with range of accessible satellite sites (D)

Quartile 3

- Communications strongly reflect ethnically diverse communities and main leaflets are in three languages; main building visible and accessible with range of satellite venues (I)
- SSLP well known and highly visible in area; service providers' leaflets are accessible and imaginative but SSLP administrative staff produce unimaginative publicity with standard clip art (F)
- All communications are exemplary in reflecting local communities and languages, but signage to the main building, next to a primary school, is poor (G)
- Signage, posters etc. reflect diversity of local communities; key documents in 4 languages; low literacy levels mean much translation is oral; Urdu signage inside and outside 3 main buildings. Buildings are sited next to a Primary School and health centre, an upgraded Council building on a residential estate and a converted community centre next to a mosque (H)

Quartile 2

- Leaflets, posters appear to be franchised to satellite providers of services; main building on peripheral estate and feels more territory of professionals than users with 'bunker' mentality (e.g. careless of needs of youth users of community centre next door); shop in main shopping centre publicising the SSLP about to be closed (L)
- Translation facilities available for leaflets, publicity; building centrally located but poorly signed (J)
- Attempts to ensure that publicity reflects local diversity of communities erratic and SSLP buildings not well signposted (K)

Quartile 1

- Low key approach to communication with little evidence of tuning into asylum seekers or small number of Asian families; parents involved in token decisions about buildings (e.g. wall colours) but not principles -location and purpose of buildings not clear (M)
- Word of mouth publicity favoured (and therefore same networks regularly used which may exclude many potential users); buildings not well known or signed in area; addressing diversity interpreted (by manager) as having images of ethnic minorities and black British on displays (N)
- User information leaflets and website out of date; visibility of buildings poor with limited signage; users complain of poor communications (P)
- Erratic awareness amongst providers of need to reflect local communities in communications; token attempts in visual imagery to reflect diversity (e.g. clipart); health literature available in several languages but needs of two dominant languages in area (Somali and Bengali) poorly

addressed elsewhere in services; buildings poorly located and badly signed; some publicity incomplete and other out of date (O)

Dimension 18: Evidence of effectiveness in ethos

Quartile 4

- Ethos strongly based on empowerment of users and providers; characterised by high levels of professionalism from manager(s), local knowledge and a welcoming feel to venues for services (B)
- Staff are generally welcoming, though health visitor/midwife agenda dominates ethos in setting the atmosphere of buildings (E)
- Consistent evidence of respectful and appropriate relationships between providers and users of services; careful attention to welcoming and inclusive ethos; range of well signposted and accessible buildings (C)
- Unappealing physical siting and appearance of buildings with poor signage; but once across thresholds welcoming ethos from all staff (A)
- Consistently warm and welcoming ethos across wide range of buildings; attempts to involve whole families (young people, grandparents etc.) through large-scale fun days some with serious aims (e.g. health promotion, clearing up locality) others for leisure (visits to seaside, adventure playgrounds) (D)

Quartile 3

- Consistency in welcoming ethos across buildings; exemplary response to diversity, carefully planning culture specific activities alongside whole community events (I)
- Welcoming to majority white population, but those from small minorities would need confidence to enter into the SSLP networks which seemed mono cultural (F)
- Good track record of welcoming ethos; now conflict as new political realities undermine original vision; community café in foyer now closed (G)
- Continued efforts to remodel buildings to make them attractive; but some appear the territory of particular community groups, perhaps alienating other potential users (H)

Quartile 2

- Some buildings complex to access and dominated by more advantaged user groups; once buildings entered staff are friendly and appear to know users well (L)
- Attempts to be welcoming mitigated by shared function of buildings; receptionist signposts users to SSLP facilities, but no community café; staff not distinguishable (no logos or name badges) and little signage across venues (J)
- Ethos not welcoming because of staff uncertainties about roles and responsibilities; dispersed services with poor signage to venues (K)

Quartile 1

- Aims to provide open access non-stigmatised services to all, but lacks welcoming ethos in reality (M)
- Buildings come across as 'efficient' and institutionalised ('like social services') rather than welcoming; community café now used for staff purposes (too messy?); some users report buildings as 'too posh' (N)
- Bedevilled by inappropriate position of new build (now CC) sited near the most affluent primary school in area, alienating many potential users; community involvement seems minimal (P)
- No welcoming area or receptionist at main building; no community café or informal meeting place for users; little signage to buildings; security measures off putting; staff not visible by logo or badge (O)

2. 'HOW' PROCESSES UNDERPINNING THE PROFICIENT IMPLEMENTATION OF SERVICES

Dimension 2: Evidence of Effectiveness in Board representation

Quartile 4

- The Board includes a balance of agencies and partners with senior level representation. The community has been consulted and involved well at strategic level. Parents are supported well on the board with pre and post meetings and with relevant training. Some of these are long serving parents and there may be a need for new investors in the future as a Children's Centre. (B)
- The Partnership structure seems unusual - an Executive (management) Board, and a Partnership Board meeting quarterly with a Parent Forum for financial decision making (but which was allegedly dominated by the Programme Manager). Health systems seem to dominate at senior management/partnership levels, with education very much in the background, but a parent chair was confident that groups with vested interests were not allowed to dominate meetings. Some suggestion that parents encouraged to be partnership representatives had been there for a while and were not representative of the local communities (E)
- The Board has wide-ranging and senior level representation from the maintained and voluntary sector. Parents are trained to support their contributing to Board, (though their attendance looks erratic?) and the template suggests male parents were on the Board. (C)
- Partnership membership seems sound with arrangements for parents to be trained for genuine participation in decision making, but within Local Authority dominated agenda for funding.(A)
- The Board is divided into two to be of a manageable size and comprises a wide range of senior representatives from the statutory, voluntary and local community sectors, and well-trained parents. (D)

Quartile 3

- Board includes membership of key agencies and is manageable size. Parents well represented on Board and trained for decision making (I)
- The Partnership is dominated by a National Charity through the Programme Manager. Effectiveness is limited by lack of engagement by Social Services, Primary CareTrust, Education and local regeneration projects. (F)
- The Board appeared to have a balanced representation with a wide range of stakeholders, a representation of the ethnic mix of the area and training for parents, but again disrupted by current conflicts. (G)
- Partnerships strongly structured by city Borough Council infrastructures (council and political) inherited in area .Ethnicity characteristics reflected in parents on Board by careful structuring; Parents tend to be passive as board members; Lack of explicit training to support parent's effective contributions to Board (H)

Quartile 2

- The large Board appears to be well balanced in representation (though the Primary CareTrust does not seem to be involved) and minutes indicate good attendance. Parent representation is token and parents receive no training in contributions to the Board. There are a range of vested interests represented on the Board and some goodwill has been stretched over the period of the SSLP e.g.

Ba. Family Support service is now dislocated from the SSLP. The Local Authority has not been well represented on the Board, but this is likely to have been a deliberate policy from the SSLP in order to retain its independence from local political and strong Local Authority interference. (L)

- Intention to keep Board balanced with 7, 7, 7 split. Notable absentees are Social Services although Programme Manager attempted to address this. No senior representative from Primary CareTrust and little representation from voluntary sector. Good representation from parents in terms of numbers and community although parental contributions to decision making somewhat engineered by Programme Manager. InformationTechnology support given to parent representatives in addition to induction process. (J)

- Board has balance of statutory, voluntary and parent members. Attendance at meetings fairly consistent. Diverse representation of parents. But no parent training for Board (K)

Quartile 1

- Board membership looks OK on paper, but indications are that a clique has hold of decision making, and that parental representation is limited to a few long standing members. Parents are not offered training in how to contribute to board decision making. Briefings before meetings may be about ensuring consensus rather than explaining implications of strategy/operational decisions to be discussed? (M)

- Board dominated by (apparently highly regarded) Primary CareTrust in city- Chair has been from nursing from start of programme- an effective chair. Parent representation token - handpicked articulate (middle class) parents or those employed (encultured) as parent representatives on board. Not offered training for board contributions. (N)

- Board includes 'hand picked ' parents with low levels of representation from statutory agencies (P)

- Initial problems to get balanced representation. Notable absentees were Primary CareTrust and Social Services, but this now seems addressed. Stable and competent Chair. Low representation from parents. Those parents involved not representative of ethnicity of communities, or fathers or families at risk. No Board training for parents. Now more senior representation from agencies as fight corners for Children's Centre resources.(O)

Dimension 3: Evidence of effectiveness in Board function

Quartile 4

- Reported conflicts within the Board have been resolved for the greater good of the community. Social services, early years and health appear to be centrally involved at all levels, with strong Local Authority back up. (B)

- There was a general consensus that the Board functioned well, with good attendance levels at quarterly meetings, including representation from other Area Based Initiatives within the SSLP area. But one respondent felt that jargon at the Board excluded some people from feeling comfortable/involved (E)

- The SSLP Board systems appear to have been well managed by a competent Chair and programme manager who works hard to keep membership involved and informed. Documentation analysis indicates a wide range of senior partners in the partnership, with commitment to the functioning of the SSLP, in early stages of the intervention. Networking is reported with a range of related initiatives in the area beyond the SSLP remit (but to the benefit of the partnership in general). However erratic attendance and less senior representation has crept in as the children's services agenda has changed expectations and relationships across agencies, and now vested interests and pragmatism appear to dictate who attends the partnership meetings and when. (C)

- Despite recent conflict over transition to Children's Centre partnership has functioned effectively over the SSLP period, with a range of committees to ensure community participation. (A)

- The Boards appear to have functioned well over time- with the manager showing astute ability to use local political and community networks as well as professional networks to achieve results. Careful attention is paid to ensure that all Board members, including parents and new comers, are made to feel welcome, comfortable and at ease (including providing lunch, pleasant environment for meetings etc.) (D)

Quartile 3

- Signs of resentment amongst EY staff at being 'taken over' by Sure Start initiative and a sense of them threatening the quality of some of their services. Positive affirmation about Board from interviews. No domination by one party. Good attendance at meetings (except perhaps by local churches*)*. Partnership has always supported the programme manager. There is co-operation within the partnership. There is manageable tension. Effective chairing of Board. Off the record comments about how on occasion the Board's decision can be overridden/disregarded by the Local Authority. Inherited 'boundary' disputes from Early Years and SSLP systems may impact on decision making (I)

- It is a friendly, well run Board that makes decisions about service provision and finances for the SSLP, but does not have the level and breadth of membership to act strategically for the community.(F)

- The functioning of the Board appeared to be effective, gaining the support of many vested interests in the communities by streetwise tactics, but again is now threatened by Local Authority systems.(G)

- Attendance depends on content of the agenda- implication of vested interests rather than general good of SSLP influencing members? Meetings held at times, with crèche support, helpful to families; English used as language of communication at meetings (though interpretation done voluntarily by parents) (H)

Quartile 2

- The Board appears to have functioned competently and been supportive of the two managers. There is some indication that attendance of partners (particularly the voluntary sector and Church) is motivated by their financial interest in Sure Start funding opportunities -described as 'milking the system' (L)

- The Programme Manager has strained relationships with the Borough - evident in Board meeting. Borough dominates discussions but weak on strategic decisions related to move to Children's Centre (nb. previous history of dominating decision about evaluation focus). Programme Manager battles against outside interference. Programme Manager actively seeks parents' views but Borough appears to treat them in token way. (J)

- Board functions at satisfactory level superficially. Clear action points at meetings that are followed up and good parental input. But there is a lack of communication to staff about what happens at meetings, and clear evidence of conflicts that are not reconciled. A negative feature is the programme manager being line managed by lead body. Apparent dominance by National Children's Homes charity and paucity of information exchange between agencies. (K)

Quartile 1

- There are reports of strong views being expressed at Partnership meetings, but conflicts appear to be resolved. Get an impression of passive inertia. Chairing is pragmatic rather than principled? (M)
- Professionals (often high status) dominate decision making. Divisive blame culture between services, particularly as SSLP is transformed into Children's Centre status. Dominance by professionals with selected parents trained into paid employment for the programme. (N)
- Partnership lurches along with low level functioning (P)
- Minutes and attendance indicate Board functions satisfactorily with perhaps Early Education dominant. Some tensions between Primary Care Trust and SSLP exacerbated by inconsistency in management and constant gov initiatives. Parents needs addressed but in a low key way (O)

Dimension 6: Evidence of effectiveness in leadership/management

Quartile 4

- Staff comments on management/leadership are mostly positive, just one negative comment about the family support co-ordinator. The current Programme Manager is very committed to the job and is hands on. The previous Programme Manager is also still working in the city and retains her links with them. There are clear lines of accountability for operational management and appraisals/supervisions.(B)
- The leadership of the long- standing manager is commended by several respondents, but there is some evidence that her managerial skills may be limited. There appear to be conflicts of personality at Senior Management Team level, which seem not to have been addressed openly. (E)
- The programme manager has been in post since the inception of the SSLP and is a strong leader, commended by stakeholders as demonstrating consistency in approach/vision/ competence. She is supported by a stable and effective senior management team with clear lines of accountability within and without the SSLP team. Health involvement at managerial level may now be threatened by the Children's Centre agenda funding/cash constraints in the Primary Care Trust, in favour of diverting the funding to pay for grass roots health workers operating from the Children's Centre. (C)
- Long standing, well- admired manager with praise from a wide range of stake holders. Good infrastructure of Senior Management Team and devolved lines of responsibilities for management. (A)
- Leadership and management by a duo of competent powerful women with complementary professional skills and knowledge base. Effective organisational systems for service delivery with clear lines of accountability and supervision. Support from Local Authority provides robust infrastructure (D).

Quartile 3

- Good programme managers/leaders from the beginning, strong management skills and knowledge/experience base of current manager. Organigram indicates shared Senior Management Team responsibilities that are sustainable (I)
- Management dominated by procedures set in place by a National Charity, the Accountable Body, which has established practices in children's services. The programme is managed efficiently and the present Programme Manager is ideal in this time of change, in that she is not possessive

about SSLP resources and is managing the transition to a Children's Centre in the most inclusive and effective way. She is an able manager of the small core team and, with the aid of her finance officer, is getting the most services for the most people out of the available budget. Service providers are mostly well managed by their providing organisations. Overall the leadership and management have been effective.(F)

- Leadership has been inspirational and sustained by 2 managers (both employed by Local Council) and management systems show clear lines of accountability and supervision, but some junior staff are disenchanted with their managers and 'false' promises (created by suspended funding?).(G)

- Despite 3 changes of manager, City Borough Council infrastructure has maintained consistency in management. Some concern over supervision and accountability for social services staff. (H)

Quartile 2

- History of two managers with wildly contrasting styles, but overall satisfactory. Newly appointed manager has little experience (sent from other sector of city to build bridges) and is on management course. Previous head and deputy left together. Senior management team just been established to aid organisational processes, but not offered training for new roles and responsibilities. Overt conflict between current manager and long standing finance administrative officer. Two staff members express serious concern about inadequacies of protocols and practices - describe them as unsafe.(L)

- Strong leadership with current manager in post for 5 years. Clear and well documented management structure. Programme manager currently in dispute with lead body with effect on decision making. Programme Manager about to leave with no replacement. Period of uncertainty. (J)

- Three managers with subsequent weaknesses in leadership. Lines of accountability and supervision unclear.(K)

Quartile 1

- Structural arrangements for management seem robust, but several references to poor management skills of current, long standing manager, though praise for her deputy. Weekly meeting of Senior Management Team, but indications that communications between each sector not consistent? (M)

- Disruptive changes in managers - for Programme manager post Local Authority assigned changes in roles, temporary posts, maternity leaves, part time manager. Manager of childcare required to leave.(N)

- History of poor management - original manager suspended for incompetence. Current head and deputy appear at odds (P)

- History of poor leadership with 5 programme managers and associated dysfunctional Senior Management Team. Current Programme Manager spoken of highly, but interim manager only with limited responsibility for core staff only. Parents seem confused about decision making and SSLP management. (O)

Dimension 7: Evidence of effectiveness in multi-agency working

Quartile 4

- Really good multi-agency work with all mainstream agencies and lots of local faith based organisations and local schools etc. Regular meetings and training for different agencies to learn about each other and share approaches to activities for users. New build offers co-location and enhanced opportunities to work closely.(B)

- Multi agency team work seems to be commended with regular mechanisms for meeting (where the workers are not co-located) and to exchange information - there appears to be strong borough wide support for Multi-Agency Teamwork. (E)

- Staff from across different agencies appear to actively promote joined up thinking and doing (e.g. schools liaise actively with the SSLP, a range of professionals work together in group activities, other workers are sent to the programme to see how Multi-agency team work should be done). The co-location of wide range of staff in the new building seems key to their effective collaboration. However health workers (and the Primary Care Trust in general) have been more ambivalent about Multi-Agency Teamwork (e.g. defending the territory of their Healthy Living Centre), with some reluctance to share information (will only give postcodes of new births), though individual health visitors do appear to have worked alongside SSLP staff comfortably (C)

- Have built on inherited strengths of previous projects in area using inter agency co-operation. Drew on strengths of city Early Years Development and Childcare Partnership. Joint training and monthly meetings of all professional groups involved in SSLP. Teams tend to be co-located because of large unit situated in Secondary school headquarters. (A)

- Multi-agency teamwork seems pragmatic and practical in orientation rather than just a good idea. Fortnightly inter -agency meetings tackle referrals and action to be taken. Care has been taken not to alienate long established voluntary sector or community based initiatives, but to support them wherever possible with SS funds and resources. (D)

Quartile 3

- Multi agency team meeting weekly. Co-location of workers from different agencies - open plan office ensures informal exchanges of information about users. Good number of referrals from other agencies. A parent perceived that agencies worked together, offered flexibility. Despite rhetoric of multi agency team work, and its overall success, there is evidence of a gulf between early years (education) and SS staff (I)

- Within the area, there is a culture of interagency work, which has been expanded and nurtured by SSLP. Lack of engagement by Primary Care Trust though continues to provide Health Visitors, who were to be the first contact with the SSLP, though there is a high quality midwife in the area. (F)

- Despite current difficulties, multi-agency team work seemed to be developing well, helped by co-location in the new building.(G)

- Co-location of staff and Borough Council commitment means multi-agency teamwork does happen. Networks include voluntary and private agencies, police and housing. Some indications of tensions over funding streams with social services and health mainstream (H)

Quartile 2

- Local authority have promoted multi-agency services through training. Evidence here of shared training with partnership (franchised) providers of some services. Problems keeping health on board. Monthly joint strategic planning meetings between agencies have fizzled out. Agencies

appear to be working within boundaries in parallel rather than demonstrating multi-agency teamwork in service delivery.(L)

- Multi-agency team work established and developing. Ad hoc examples of joint service planning and delivery across disciplines. Externally, a mental health charity, MENCAP, deliver respite services which Speech and Language Therapist (SALT) attends. Limited links with statutory agencies. No Social Services or Housing representation on Board. Difficulties with lead body. Shared notes between health and SALT worker recently initiated where previously Health concerns about confidentiality of information prohibited the sharing of records. Notes not routinely shared with outreach workers. Teams tend to work 'alongside' rather than with each other. Co-location facilitates this (J).

- Interagency work at rudimentary level with bunker mentality still rife (particularly with health agencies) (K)

Quartile 1

- Some movement towards Multi-agency team work, for example have volunteered to pilot the government common assessment framework (CAF), but started from a low base line of inter agency co-operation in the city structures. Links seem to be at day to day rather than strategic thinking levels.(M)

- Despite the shared buildings, services offered in boundaried parallel ways rather than in multi-agency teams. Strategic planning at financial streams rather than visionary levels; uneasy relationships underlie meetings. An initiative based on Single Regeneration Budget history in area caused resentment when new services/resources came into the area.(N)

- Low level co-operation by Health. Daycare staff critical of teacher involvement. Homestart co-ordinator reportedly kept 'at arm's length'. (P)

- Evidence of planning jointly for multi-agency teamwork in delivery of services (e.g. joint workshops, guest speakers) limited. But good practice demonstrated in the 'Cause for Concern' meetings where professionals come together to discuss and implement care plans for the most in need. Communications and information sharing between agencies rudimentary, not helped by staff seconded from Primary Care Trust and SSLP working in separate buildings. No collective inter agency monitoring or evaluation of service impact (O)

Dimension 8: Evidence of effectiveness in pathways to specialist services

Quartile 4

- There are clear pathways to specialist services. Good links to mainstream for speech and language, physiotherapist and dietician and lots of training taking place so those unqualified can spread the work. All staff have access to family files and sharing of information appears to be happening when it should. However they are hindered by lack of InformationTechnology skills in translating high quality paper records into data bases/electronic filing systems for analysis/interrogation.(B)

- Arrangements for users to access specialist services are opaque, but seem to work by serendipity rather than careful design - this could be down to people who have worked together for a long time, sharing information informally and regularly (E)

- There is a key worker system and each family has a common case file /management file- used to keep track on all the services they use. All staff are trained to identify specialist needs, child protection concerns, and to whom concerns should be referred. There are referral forms for both internal and external referrals to agencies. Referrals are acted upon within 3 days. There was a

record of all referrals over a 6-month period with sources clearly identified. Family support workers no longer required to refer to agencies via General Practitioners, but can contact them direct (C)

- Key worker system, warm line phone facilities and systems set up by regularity of home visiting, and diagnostic approach to family needs ensures users can access services at point of need.(A)

- The researcher commends the system for identifying users as the best she has seen. There is close attention to all front line workers being trained in first level identification of special needs, and key worker systems for families to pull together expertise and services for their needs. The referral forms correspond to mainstream systems to facilitate movement between SSLP and mainstream opportunities for families to access. Close monitoring of take up and access to specialist services.(D)

Quartile 3

- Systematic referral system. Response time quick - within 1 week contact and 2 week appointment made. Weekly multi-agency discussion of cases. All staff aware of specialist services offered, especially with regard to Special Educational Needs. (I)

- On the whole, users do access specialist services, but this is a function of a good family link service and multi-agency teamwork rather than formal systems which are in place, but not well used in the way they might be to target and monitor the progress of individuals and their families.(F)

- Pathways to access specialist services show effective key worker system, backed up by training of all generic workers, common record keeping systems, guaranteed referral times, regular meetings to exchange information about use, and high levels of sensitivity to cultural and confidential issues.(G)

- Referral systems seem appropriate and timely. Family support workers monitor take up and sustaining of service use by families. Culturally sensitive alternative to Edinburgh scale for Post Natal Depression diagnosis and treatment designed and used. (H)

Quartile 2

- Key worker and family files systems seem well established, but some suggestion child protection protocols not secure. Data base set up and monitors service use, but not perhaps creatively used for strategic planning. Information exchange across agencies appears rudimentary, but trialling Common Assessment Framework for city, so may improve. (L)

- For specialist services families have access to Speech and Language therapists, Health visitors, Play and Education officer and additional outreach support for key communities. Provision for special needs seems limited to respite care on Sundays. There is a formal and informal referral system - includes ability to self refer with quick turnaround. There is not a key worker system. Care plans do not appear to be collaboratively instigated or followed up. (J)

- Haphazard referral systems for specialist help, though Special Educational Needs and Speech and Language Therapy provision seemed good. Little attempt to systematically monitor usage of specialist services (except by individual workers) (K)

Quartile 1

- There is a key worker system, family files and proper attention given to confidentiality. Home visitor are trained to detect Special Educational Needs, but general vagueness about how pathways to specialist services are functioning? Reported problems with access to Primary Care Trust database.(M)

- Health visitors and midwives dominate arrangements for users to access services in first instance; but keep files (and now working spaces) detached from others.(N)
- Ad hoc systems for users to access specialist services - no key worker system (P)
- Families have access to specialists e.g. Speech and Language Therapy, Food and Nutrition, but they seem to operate autonomously. Few targeted services e.g. poor Special Educational Needs provision. No key worker system. Each service running own data base and monitoring systems, Turnaround seems fast for support.(O)

Dimension 9: Evidence of effectiveness in staff turnover

Quartile 4

- Staff turnover has been low and staff stable but morale becoming a problem re uncertainties around budgets, staffing for emergent Children's Centre. Some suggestion that family friendly policies for staff (lots of flexible hours and part timers) may disadvantage continuity for users. (B)
- Staffing is stable, family friendly policies appear to work; overall morale of staff is high with some patchy bits (and related stress induced illness?). (E)
- Staff morale seems high with regular opportunities for socialising and opportunities for training evident. The senior management team stable, but there is a high turnover of staff and recruitment problems because of locality (difficult to get to, 'bad' reputation), maternity leaves (predominantly young female staff with young children), local skill shortages (e.g. midwife, nutrition, health visitor posts) and the disincentive of short contracts. (C)
- Staff overall seem satisfied with work and relatively stable with changes due to local/national shortages of key trained professionals. (A)
- Staffing is stable and morale appears to be high. Attention is paid to reshaping job descriptions or specialist inputs where proven not to fit with SS ways of working. Family friendly working practices appear to be in place. (D)

Quartile 3

- Low staff turnover. Creative staff development ideas (e.g. Bookstart scheme) Good morale. Flexible working scheme. Staff made to feel valued. Early Years management system (described as hierarchical) does not fit with SS systems of staffing. (I)
- The proximity to attractive areas of full employment has made the recruitment and retention of professionals difficult. Locally recruited and trained Early Years staff hitherto stable and effective, are now unsettled by impending change. (F)
- Staffing has been characterised by high levels of investment in local staff drawn from communities, and until recently staff morale seemed high. The training on the job policy raised inevitable concerns about maintaining high standards.(G)
- Diversity of staffing evident in 2 or the 3 main sites for services. Retention and recruitment of staff supported by family friendly policies. Skills shortages in childcare .Valuable staff poached across SSLPs in town (H)

Quartile 2

- Low staff turnover with family friendly work policies, some disaffected staff but mostly morale high. Training for staff and volunteers seems freely available and well resourced and delivered. (L)
- The programme has benefited in the past from stable staffing. But the midwife role has been problematic with vacant post for 6 months, impacting on ante-natal services. The efficiency of the feedback process between Core Management Team and Individual Teams has been questioned. The current mood is one of uncertainty and negativity towards the direction the Lead Body is taking in the transition to Children's Centres.(J)
- High turnover of staff at all levels. No coherent staff development opportunities. No staff team building or training days evident (K)

Quartile 1

- Staff turnover reported as high because of problems with SSLP management and poaching from other SSLPs in city. Lack of appropriately qualified staff reported. Poor Human Resources systems from City Council. Staff morale seems low. Lots of temp and part time contracts. (M)
- Settled, stable staffing (N)
- Loss of staff during troubled phase. Little evidence of equitable use of training fund to support staff development (P)
- Staffing problems throughout life of SSLP. Periods of low staff morale reported. Core management staff now stable, but current manager on interim post (whilst Children's Centre agenda is resolved) (O)

Dimension 10: Evidence of effectiveness in evaluation

Quartile 4

- Evaluations (both at local and national levels) have been a source of irritation to the SSLP staff, but they have in house monitoring and self evaluation of services.(B)
- Evaluation seems to be done routinely and competently at service levels, but there seems less confidence in the funded overall evaluation (Local University) insights into more holistic aspects of SSLP effectiveness (E)
- Evaluation is both for operational purposes e.g. fine tuning or changing services in response to user feedback and for strategic decisions e.g. how to move towards targets (example of focusing on health in post natal groups) or how to maximise service use (e.g. changing service delivery times and target users). They have a competent information and evaluation officer. They liaise strategically with other initiatives to tackle evaluation needs (e.g. Single Regeneration Budget and Health Action Zone to do a joint household survey). NB. half the designated evaluation budget not spent last year - but is this because in house officer salary costed differently? (C)
- Regular, good quality evaluation reports with in-house and external evaluation procedures - focus therefore clear - and signs that strategic decisions made in relation to evidence/analysis. (A)
- Service evaluations routinely done - involves parents and providers. Local University involved in exploring range of issues in participatory evaluation model.(D)

Quartile 3

- Recognition of the importance of evaluation in providing an evidence base for effective services,

especially in the light of budget cuts. Good mix of external and internal evaluation with high calibre research from external sources. . Dissemination of evaluation findings to all stakeholders facilitates their usefulness. Evaluation findings are used for service development over short and long term strategic planning. User views are important to the programme, though lack of evidence as to what extent parents involved in internal evaluation except as respondents to regular surveys. (I)

- Until this transition period, the full evaluation budget has been used to ensure that services give value for money and what parents want. Both staff and parents are involved in the process. All current evaluations are of individual services rather than the SSLP as a whole. Evaluating and changing services in terms of immediate operational indicators such as cost per user, rather than the value of the service to the area as a whole or feeding insights into strategic planning. (F)

- Evaluation has been under funded, under valued and under used. (G)

- Evaluation centralised by City Borough Council, contracted to a National Charity, but tailored to foci for each SSLP. User satisfaction surveys feed into short-term adjustment of services (e.g. crèches gave way to more Stay and Play services). Reported poor dissemination of evaluation findings with cover up of negative implications. (H)

Quartile 2

- Both in house and externally funded evaluations (Higher Education) seem well funded and feed into short-term developments (e.g. involving fathers), but a sub group deals with evaluation and generally staff not connected to findings? (L)

- Evaluations have been routinely commissioned. Programme Manager takes the lead in deciding focus and takes to Board for final decision. One piece stopped by Local Authority senior managers despite SSLP decision being passed. Ad hoc examples of responding to short term service evaluations. (J)

- Evaluation commissioned but not used. Low level functioning in this dimension (K)

Quartile 1

- Local University consortia do evaluations + in house monitoring of user satisfaction with services. The latter do seem to result in tweaking of services. Focus of evaluation from consortia seems to be determined by manager and reports not widely disseminated to grass roots staff. (M)

- External funded local evaluation seems to have 'worked'; but internal project based evaluation laissez faire and not useful. (N)

- Low level in house evaluation of services- late sending them to National Evaluation of Sure Start Local Support module. Outsourced MORI to audit needs, but not aware of how best to use data - 'expensive mistake'.(P)

- Initial audit outsourced in 2001 but not responded to. No formal evaluation commissioned. Evaluation recently back on agenda. (O)

THE 'WHAT' OF SERVICE DESIGN AND DELIVERY

Evidence provided in dimensions 12-15 was numerical and is not included in this appendix. The implications of findings in these dimensions related to service content are reported in the main body of the text in Chapters 3 and 4.

Dimension 11: Evidence of effectiveness in identifying users

Quartile 4

- Good centralised database/health systems for identifying newborns/users and lots of follow up outreach/family support workers. All children visited at 6-8 weeks, 9 months and 12 months - and information used to target specialist services to families. (B)
- The identification of users appears to rely mostly on health visitor or midwife input. There is no central database (allegedly because of confidentiality issues? A health driver?), but all new users are given a reference number at registration to help monitor their use of services. (E)
- In order to identify potential users, they have their own database, which appears to be systematically updated and interrogated. They have established systems for dealing with confidential information and exchange with other agencies and use local networks strategically to locate new users. However they are constrained by Primary Care Trust refusing information about new birth addresses, and a general lack of co-operation from Primary Care Trust about access to their database (justified in terms of Data Protection Act). Consequently they have to rely on the good will of midwives for information (given informally) and need more outreach workers from the SSLP team. (C)
- Systematic procedure of health visitor visiting all newborns, referred immediately to parent link team who follow up with visit to assess family needs. Membership form and usable soft ware for monitoring attendance at services help to track use over time. Do not have centralised database. Primary Care Trust releases information about live births but not addresses. (A)
- Impressive comprehensive, multi-agency database updated by health co-ordinator. Reported close liaison with other agencies e.g. drug and alcohol abuse specialists from mainstream or voluntary agencies - though some staff are not Information Technology competent enough to be effective contributors to or users of the database. (D)

Quartile 3

- For identifying users Red book system seems effective. Health visitors make first contact with families with new babies and routinely get consent forms signed for Sure Start workers to contact them (system efficiency sustained by weekly meeting at clinic). Good referral system from other agencies. Have a database but no evidence that Primary Care Trust share their database. (I)
- Although information on every birth is available to the SSLP; the database is not being used to its full capability to ensure that families access the services they need. Overall reach seems good enough. (F)
- Their strategies for identifying users look very impressive - shared database, good links with other agencies, key worker and health visitor input, common membership/registration details. (G)
- Good centralised database drawing mainly on health records, audited and replaced regularly. Transient population and frequent family name changes complicate the tracking of families. (H)

Quartile 2

- Central role of health visitors for referrals - newborns on centralised database. Information on 3-year-olds from nurseries and pre-schools, but not formalised systems. Family files checked regularly by key worker, especially for accessing specialist services. (L)

- Outreach and health workers take lead in identifying users. Mainstream systems such as RICHES (a health system) database, and range of referral systems. Links with hospital to identify pregnant women. Limited links with Social Services and Housing. SSLP has potential to track individual usage but is not used to do so. Active networking of Outreach manager via baby clinic identifies potential new users. (J)

- No systematic way of identifying users (K)

Quartile 1

- In principle Health Visitors are main source of identifying users, but administration of data seems poor with previous officer leaving through stress and reported problems gaining information from health service about children in area. (M)

- Have effective database to monitor take up and use of SSLP services, but have to pay Primary Care Trust for initial data on births. Social services and education seem marginalised in information sharing. (N)

- Initial contacts with families with babies via clinics and General Practitioners. Denied access to Primary Care Trust database. Little evidence of targeting users for specialist services systematically. (P)

- Ad hoc strategies to identify users, limited in use. Information exchange on referrals and users largely by word of mouth, constrained by traditional agency boundaries. A centralised database (O)

APPENDIX F. Coding of Service Categories at Stage 3 (List compiled from evidence of services from the Implementation Study and Stage 1&2 of Programme Variability Stu

SUPPORT – RELATED SERVICES	HEALTH – RELATED SERVICES	PLAY AND CHILDCARE – RELATED SERVICES
1 Welfare rights advice centres or sessions	**15** GP Surgeries	**33** Nursery schools
2 Housing advice centres/ agencies or sessions	**16** New Birth Home Visit (In addition to mainstream) & Health visiting	**34** Nursery classes
3 Money advice centres/ agencies or sessions	**17** Smoking cessation programme	**35** Childminders
4 Relationship counselling schemes	**18** Healthy eating/ nutritional advice services	**36** Day nurseries
5 Leisure activities for parents (e.g. swimming, art classes)	**19** Counselling services	**37** Full time day care sessions/ or centres
6 Drop-in sessions with separate crèche / playgroup	**ANTE-NATAL SERVICES**	**38** Pre-school services/facilities
7 Fathers' group	**20** Family planning services, including emergency contraception	**39** play schemes
8 Parenting programmes	**21** Services specifically for pregnant teenagers	**40** After school clubs
9 Support services for teenage parents	**22** Community midwife services	**41** Breakfast clubs
10 Home visiting service	**23** Ante natal clinics	**42** Crèche sessions
11 Home safety services	**POST-NATAL SERVICES**	**43** Toy libraries
12 Equipment loan scheme(s) *other than safety equipment*	**24** Specific post-natal depression services	**44** Literacy services: e.g. Libraries or Bookstart
13 **Employment related services**	**25** Well women clinics	**45** Speech and Language services; e.g. Chat-away
14 ESOL classes	**26** Breastfeeding promotion services/ advice/ support	**46** Childminding network
Other Services (please specify)	**27** Child health clinics	**47** Parent & Toddler groups
	28 Specialist speech and language therapy for child/parent	**48** Outdoor/indoor play areas
	29 Specialist services for children with developmental/ behavioural problems	**49** Training for childminders
	30 Portage services	**50** Junior sports schemes (including gymnastics) e.g. Tumble tots group
	31Special provision for disabled children	
	32Psychiatric/ mental health services	

APPENDIX G: STAGE 3 INTERVIEWS SCHEDULES FOR CORE SERVICE PROVIDERS

Telephone Interview Schedule

Programme Number_____

Introduction

I am ringing from the National Evaluation of Sure Start where we are currently conducting some research on services offered within Sure Start programmes/Children's Centres. Your programme/centre recently completed a questionnaire on services that have been available over the last 12 months. We would now like to follow up on this and find out a bit more about the service (s) you are involved in.

The interview will briefly address the following areas:

- Service Implementation
- Community reach
- Multi-agency delivery
- Outreach
- Retention and exit strategies
- Evaluation and
- Good practice

This should take no longer than 20 minutes to complete.

Consent

I agree to take part in a telephone interview. I understand that the information provided in the interview will be held in confidence and if material is present or published, neither I nor my Sure Start programme will be identified by name.

To be ticked by interviewer ☐

Thank you for participating in this study

Background

1. Firstly, just a few background questions on the service itself. We are particularly interested in your service _____*(Name of service).***

2. Could you just confirm the target group for this service

_____

(Write target group or universal).

3. And what are the service's key aims?

_____
_____
_____
_____
_____
_____
_____

Service Implementation

Talk me through the birth of this new service.

1. What led to it's emergence?

Needs Based	Intuition	Research Based	Requirement Led	Demand	Resource Led	Other

(Tick as mentioned)

_____

_____

_____

_____

_____

_____*(Additional Notes)*

2. What drove the decisions on whether the service was to be?

(Use the table below to complete each part)

a) Universal or Targeted
b) Centre Based or Outreach
c) Delivery Format i.e. drop-in; courses/workshops etc
d) Choice of Service Venue

	Needs Based	Intuition	Research Based	Requirement Led	Demand	Resource Led	Other
a							
b							
c							
d							

(Tick as mentioned)

_____

_____

_____

_____

(Additional Notes)

e) **Choice of Delivery Person**

Appropriately Qualified	Availability	Job Requirement	Matched Target Group	Demand	Other

(Tick as mentioned)

_____

_____

_____

(Additional Notes)

3. Who was involved in the planning process?

Other SS / Centre agencies	Other Non SS /Centre agencies	Users	Wider Community	Partnership Board	Other

(Tick as mentioned)

_____

_____

_____

(Additional Notes)

Community Reach

We would now like to focus on service reach.

4. a) Who would you say are your main users?
b) Why do you think this is the case?

_____
_____
_____
_____

5. a) Which types of families would you say are currently not accessing the service?

_____
_____
_____
_____

b) Why do you think this is the case?

Services are not culturally/religiously appropriate	*(Tick as mentioned)*
Services are run from inappropriate buildings/physical access is difficult e.g. stairs	
Language barriers	
Services are not relevant/do not meet needs of local families	
Parents need support to access services (parents with emotional/special needs)	
Poor/inappropriate promotion of services	
Families cannot afford to use services	
Services are run in areas that are difficult to access i.e. by foot/public transport	
Services are run at unsuitable times	
Parents lack confidence/motivation (ring which applies)	
Other _____(please specify)	

_____
_____
_____

(Additional Notes)

6. How do potential users gain knowledge about the service?

Advertising in local/community newspaper	*(Tick as mentioned)*
Signs/posters/leaflets at local community sites e.g. leisure centres, schools etc	
Website	
Door to door delivery of flyers	
Signs/posters/leaflets at Sure Start services/Children's Centres	
Word of mouth	
Direct telephoning	
Invitation letters to family (either sent to home or hand delivered)	
Other _____(please specify)	

_____
_____
_____
_____

(Additional Notes)

7. How do <u>you</u> identify people who might benefit from your service(s)?

Word of mouth
Programme/Centre Record system
Referrals from outside agencies
Referrals from SSLP staff
Self referrals
Invitation letters to family (either sent to home or hand delivered)
Other _____(please specify)

(Tick as mentioned)

_____
_____
_____
_____
(Additional Notes)

8. a) Once families attend the service, are there strategies are in place to ensure continued attendance?

Yes ☐ No ☐

b) *(If yes)* **What are they?**
(If no, go on to Q9)

Key worker system	Follow-up telephone calls	Letters sent	House calls	Incentives provided	Other (please specify)

(Tick as mentioned)

_____
_____
_____
_____
(Additional Notes)

If <u>identified</u> as <u>targeted service</u> ask <u>questions 9 and 10</u>

If <u>not identified</u> as <u>targeted service</u>, <u>go to question 11</u>

9. To what extent do you feel you are reaching your target group
(If not most, prompt for why they think this is the case)?

Most	Some	Few	None

(Tick 1 only)

_____
_____
_____
_____
(Additional Notes)

10. What strategies do you have in place for encouraging your target group to attend?

_____
_____

_____
_____
_____

For all

11. On a scale of 1-4 with 1 being not at all important and 4 being very important, how important do you view the following in terms of uptake of service?

Regularity with which service is delivered	
Service facilitator skills/experience	
Similarity of service facilitator to service user e.g. gender/culture/age	
Service venue	
Timing of services	
Provision of child care	
Service clientele	
Service user input in planning/delivery	
Service format i.e. 1:1; group etc	
Other _____(please specify)	

(Go through each item and write down score of 1-4)

_____
_____
_____
_____

(Additional Notes)

12. What factors might improve access and uptake of services?

Produce more/better written materials	
More structured group sessions	
Involve a wider range of professionals	
Better publicity	
Increased targeting for vulnerable groups	
Involve parent volunteers	
More individualised support	
Provide wider range of services	
Conduct regular user consultations	
Provision of child care	
Other _____(please specify)	

(Tick as mentioned)

_____
_____
_____
_____

(Additional Notes)

Outreach

Let us move on to talk about outreach work.

13. Could you give me examples of outreach work conducted within your support area (i.e. family support/play and education/ health)?

_____
_____
_____
_____
_____

14. How are families identified for outreach work?

Word of mouth
Record system
Referrals from outside agencies
Referrals from SSLP/Centre staff
Self referrals
Invitation letters to family (either sent to home or hand delivered)
Other _____(please specify)

(Tick as mentioned)

_____
_____
_____
_____

(Additional Notes)

15. Who conducts the outreach work within your support area?

SS /Centre Professionals	Other Non SS/Centre Professionals	Paid Community Workers	Parent Volunteers	Other

(Tick as mentioned)

16. What training do the outreach workers receive?

_____
_____
_____
_____

17. What kind of supervision do the outreach workers receive?
(Probe for i) who supervises, ii) how often, iii) general content of supervision)

_____
_____
_____
_____

18. a) Do the outreach workers conduct case reviews with other programme/centre staff?

Yes ☐ **No** ☐

b) *(If yes)* **How often?**
(If no, go to question 19).

Needs Only Basis	Weekly in-house meetings	Fortnightly in-house meetings	Monthly in-house meetings	Other

(Tick as mentioned)

_____
_____
_____
_____

(Additional Notes)

19. What additional support services/organisations do outreach workers have access to?

Citizen's Advice Bureau
Home-Start
Social Services
Local Child Care Providers
Employment agencies e.g. REED; JOBCENTRE
Women's Aid/Refuge (or similar domestic violence organisations)
Substance Abuse Organisations
Shelter (or similar housing organisations)
Relate (or similar relationship counselling organisations)
Refugee/Asylum Seeker Organisations
Gingerbread (or similar single parent organisations)
MENCAP/SCOPE (or similar organisations working with families and disabilities)
Other _____(please specify)

(Tick as mentioned)

_____
_____
_____

(Additional Notes)

20. a) To what extent would you say there has been a multi-agency collective in the delivery of *family support services/health/play and child care*? *(as appropriate)*

Very Much	Quite a bit	Somewhat	None

Tick 1 only

(If none, go to Q21)

Signposting families to each other's services
Joint service planning
Joint service delivery
Informal referrals
Formal referrals
Joint instigation of care plans
Other _____(please specify)

(Tick as mentioned)

Retention/Exit Strategies

This next section asks about any retention and/or exit strategies in place.

21. a) Within your support area (i.e. family support/play and education/ health) *do you have planned exit strategies in place for when a particular course/programme comes to an end?*

Yes No N☐ ——☐——☐_*(if NA, why?)*__

b) **(If yes***) What are they?*
(Use the table below to complete 21b and 22b)
(If no, go to Q22)

22. a) Do you have strategies in place to encourage families to move on from a particular service?

Yes No NA☐ ——☐——☐_**(***if NA, why)*__

b) **(If yes***) What are they?*
(Use the table below to complete 21b and 22b)
(If no, go to Q23)

	Signposting to other services	Certificate of Attendance	Volunteering Opportunities	Key worker System	Other (please specify)
21b) Exit					
22b) Moving On					

(Tick as mentioned)

_____
_____
_____
_____
(Additional Notes)

23a). For either case, are follow-up strategies employed?

Yes No N☐ ☐ ☐

24b). **(If yes)** ***Is this for all users or targeted users?***
(If no, go to Q25)

All ☐geted ☐

_____
_____
_____
_____
(Additional Notes)

Outcome Evaluation

We are coming to the end of our interview. Thank you for your time. These last two sessions focus on evaluation and good practice. So, let us firstly focus on evaluation.

25) What impact do you believe your service has had on families?
(Probe for specific examples)

_____
_____
_____
_____
_____
_____
_____

26a) Do you have systems in place to measure whether intended outcomes have been achieved?

Yes ☐ **No** ☐

26b)*(If yes)* **What are they?**
(Probe for i) format, ii) how regularly they are conducted and iii) *who gets involved*

(If no, go to Q27)

_____
_____
_____
_____
_____

27a) Do you have any quality assurance measures in place?

Yes ☐ **No** ☐

27b) *(If yes)* **What are they?**
(Probe for i) format, ii) how regularly they are conducted and iii) *who gets involved and complete table below)*

(If no, go to Q28)

i) FORMAT	Local Authority Inspections	Formal In-House Evaluations	Self-Evaluation by Service Provider	Externally Commissioned Evaluations	Other (please specify)	CIRCLE
ii) REGULARITY	Quarterly	6 monthly	Yearly	Adhoc	Other (please specify)	*CIRCLE*
iii) INVOLVEMENT	Users	Partnership	Designated staff	Service Provider	Other (please specify)	*CIRCLE*

_____
_____
_____
(Additional Notes)

27c) If a problem arises, how is this handled?

_____
_____
_____
_____

Good Practice

Just to finish off, we are interested in hearing your thoughts on what makes good practice with regards to service delivery.

29) What do you think is the most effective way of delivering _____

(substitute for selected service e.g. parenting programme; smoking cessation etc)

Structured Group Sessions	*(Tick as mentioned)*
Provision of Written Information	
Home-Based 1:1 Intervention	
Drop-In	
Telephone Helpline	
Other _____(please specify)	
Combination_____(please specify)	

_____
_____
_____

(Additional Notes)

30) What key facilitator skills do you feel are important for delivering this service?

Parental Experience	*(Tick as mentioned)*
Professional Qualifications	
Community Awareness	
Additional Language Skills i.e. other than English	
Other _____(please specify)	
Combination_____(please specify)	

_____
_____

(Additional Notes)

31) What would you say are the good practice features of your particular service?

Engaging the community	*(Tick as mentioned)*
Interagency collaboration in service planning and/or service delivery	
User involvement in service planning and/or service delivery	
Facilitator(s) is well trained	
Service draws on other examples of good practice	
Service has a theoretical base	
Service is easily replicated	
Service is flexible, offering tailored intervention where necessary	
Other_____(please specify)	

_____
_____

(Additional Notes)

APPENDIX H: STAGE 3 PROMPTS FOR FOCUS GROUPS OF SERVICE USERS

Focus Group – Service Users.

Circle prompts

What service did you access at Sure Start?

How frequently do you attend?

Prompts for open discussion.

What do you like/ dislike about them?

- What is important about this service?

Regularity with which service delivered
Service facilitator skills
Service venue
Timing of Services
Provision of child care
Service clientele
Service user input in planning
Service user input in delivery

- Examples of good practice

- Examples of “good” and “bad” staff

Who is there when you attend a service?

- Awareness of multi agency work? Staff from different agencies in attendance?

What drew you to start using these services?

- How did you find out about the service/ Sure Start?

Advertising in local/community newspaper
Signs/posters/leaflets at local community sites e.g. centres and/or schools
Website
Door to door delivery of flyers
Posters and/or flyers at Sure Start services
Word of mouth
Direct telephoning
Other _____(please specify)

How have you and your family benefited from these services?

Has anyone asked you what you would have liked?

- Any Involvement/ Consultation in service planning?

What else would you have wanted?

APPENDIX I: STAGE 3 PROMPTS FOR INFORMAL INTERVIEWS WITH SERVICE NON-USERS AND HARD TO REACH

Focus groups – non users

Circle Questions.

Do you use any local groups or services, including nurseries and crèches, which help you, your child or your whole family? If so, can you tell me a bit about them, including how you found out about them?

- Content
- Frequency of use

Prompts for open discussion

Those who do use services, what do you like/ dislike about them?

- Staff
- Venue
- Support

Those who don't, why not?

- Perceived difficulties in accessing services

Services are not culturally/religiously appropriate
Parents lack confidence
Parents lack motivation
Services are run from inappropriate buildings/physical access is difficult e.g. stairs
Language barriers/lack of confidence in spoken English
Services are not relevant/do not meet needs of local families
Parents need support to access services (parents with emotional/special needs)
Poor/inappropriate promotion of services ----------
Families cannot afford to use services
Services are located in areas that are difficult to access by public transport
Services are run in areas that are not in pram pushing distance
Services are run at unsuitable times
Lack of flexibility on home visits

Has anyone ever asked you what you would like, in terms of services and support?

What would make you give up your time to come to a service/ group?

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