



Department
for Education

Evaluation of Children's Centres in England (ECCE)

Strand 3: Delivery of Family Services by Children's Centres

Research Report

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List of Abbreviations

BBEIP	Bright Beginnings Early Intervention
BIS	Department for Business Innovation and Skills
BSFT	Brief Strategic Family Therapy Program
CAB	Citizens Advice Bureau
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CC	Children's Centre
CCLMRS	Children's Centre Leadership and Management Rating Scales
CPD	Continuing Professional Development
CFA	Confirmatory Factor Analysis
CM	Centre Manager
CWDC	Children's Workforce Development Council
DCSF	Department for Children, Schools and Families
DfE	Department for Education
DfES	Department for Education and Skills
DWP	Department of Work and Pensions
EAL	English as an Additional Language
EBP	Evidence-Based Practice
ECAT	Every Child A Talker
ECCE	Evaluation of Children's Centres in England
ECERS-R	Early Childhood Environment Rating Scale - Revised
ECERS-E	Early Childhood Environment Rating Scale - Extension
EFA	Exploratory Factor Analysis
ELLM	Early Literacy and Learning Model
ESOL	English for Speakers of Other Languages
EYFS	Early Years Foundation Stage
EYP	Early Years Professional
FAST	Families and Schools Together
FLLN	Family Literacy, Language and Numeracy
FNP	Family Nurse Partnership
GP	General Practitioner
HENRY	Healthy Exercise Nutrition for the Really Young
HFA	Healthy Families America
HFNY	Healthy Families New York
ICPS	I Can Problem Solve
IDACI	Income Deprivation Affecting Children Index
IMD	Index of Multiple Deprivation
IT/ICT	Information Technology/ Information and Communications Technology
IY	Incredible Years

LEA	Local Education Authority
LLSOA	Lower Level Super Output Areas
MTFC	Multidimensional Treatment Foster Care
NCSL	National College for School Leadership
NCT	National Childbirth Trust (A charity running antenatal classes)
NESS	National Evaluation of Sure Start
NICE	National Institute for Health and Clinical Excellence
NFP	Nurse Family Partnership
NHS	National Health Service
NPQH	National Professional Qualification for Headship
NPQICL	National Professional Qualification in Integrated Centre Leadership
NVQ	National Vocational Qualification
Ofsted	Office for Standards in Education
PAF	Post Office Address File
PAFT	Parents As First Teachers
PAS	Program Administration Scale
PAT	Parents as Teachers
PCIT	Parent Child Interaction Therapy
PEAL	Parents, Early years and Learning Programme
PEEP	Peers Early Education Partnership (now known as Parents Early Education Partnership)
PICL	Parents Involved in their Children's Learning
PVI	Private, Voluntary and Independent
RCT	Randomised Controlled Trail
SALT	Speech and Language Therapy
SEF	Self Evaluation Form
SENCO	Special Educational Needs Co-ordinator
SFP	Strengthening Families Program
SLT	Senior Leadership Team
SMT	Senior Management Team
SSCC	Sure Start Children's Centre
TAC	Team Around the Child
TfC	Together For Children
UK	United Kingdom
US	United States
WFL	Wider Family Learning

Executive Summary

A Policy Perspective (Chapter 1)

Chapter 1 explains the policy background to the development of children's centres. It describes the nature and style of early years provision from the early seventies when many services were provided by the voluntary or private sectors with maintained provision in nursery classes or nursery schools. There was virtually no national policy framework, with provision varying at the behest of local authorities. The chapter describes the developments of the last 40 years and the changes that have resulted to form the current comprehensive model of early education, care, and integrated family support services. It also describes some of the tensions in the core purpose of the current policy: children or parents, employment or family support, and targeted or universal provision in disadvantaged neighbourhoods. These issues underpin the rest of the report which details the current offer of children's centres.

Setting the Scene (Chapter 2)

The Evaluation of Children's Centres in England (ECCE) is a six year study commissioned by the UK Department for Education. The study is undertaken by a consortium of three partners; NatCen Social Research, the University of Oxford, and Frontier Economics.

Children's centres are intended to be one of the main vehicles for ensuring that integrated and good quality family services are located in accessible places and are welcoming to all. They aim to support young children and their families, particularly the most disadvantaged, to reduce inequalities in child development and promote school readiness. ECCE aims to provide an in-depth understanding of children's centre services, including their effectiveness in relation to different management and delivery approaches and the cost of delivering different types of services. The key elements of the evaluation are outlined below.

- Strand 1: Survey of children's centre leaders
- Strand 2: Survey of families using children's centres
- Strand 3: Investigation of children's centres' service delivery, multi-agency working, leadership and management, evidence-based practice, and reach
- Strand 4: Impact analysis
- Strand 5: Cost Benefit Analysis

Reports have been produced in relation to Strand 1, Strand 2 and Strand 5. This is the first report from Strand 3, documenting evidence gathered during 2012. A summary now follows.

Strand 3 describes the range of activities and services that centres deliver, centre partnership working methods, leadership and management, evidence-based practice, and centre reach. Describing implementation in 2012 is important for understanding which particular aspects of implementation are associated with positive outcomes. Strand 3 findings are also important in their own right because they tell us which families are being reached in the context of their neighbourhood, and they identify the risks of current partnerships and organisations so the risks can be managed better. Strand 4 will describe the impact of children's centre provision on families and children.

Strand 3 children's centres constituted the same sample of 128 which had taken part in other elements of the evaluation (Strands 1 and 2); these were all Phase 1 and 2 children's centres that were intended to be located in the most disadvantaged areas. The first wave of Strand 3 fieldwork was carried out over two days in each centre.

Service Delivery, Multi-agency Working and Integration (Chapter 3)

This chapter starts with three questions. First, which child and family services were the Strand 3 centres offering? Second, who did the centres work with as partners, and how were they developing multi-agency approaches? And third, what was the extent of shared vision and practice between the centres and their partners?

Which child and family services were children's centres offering in 2012?

- Children's centres presented a very large number and range of services – childcare and early education, health, social care, adult education, community engagement, and benefits and employment advice. These services were delivered by centres' own staff as well as by staff from partner agencies, and in the evenings, weekends and during the day.
- The 'top five' services (mentioned by over 90% of the centres) were stay and play, evidence-based parenting programmes, early learning and childcare, developing and supporting volunteers, and breastfeeding support.

How did the services studied in 2012 (Strand 3) compare with those reported in 2011 (Strand 1)?

- The range of services across 2011 and 2012 was broadly similar. However, in 2012 there was a shift towards services which had a more targeted and focused approach. For example, there was an increase in evidence-based parenting programmes and decreases in informal peer support for parents as well as stay and play for school aged children.

What was the picture of multi-agency working and integration?

- Centre managers placed particular importance on four aspects of service delivery and ethos, in marked contrast to earlier views about the importance of services being delivered in one place ('co-location'):
 - Being able to talk informally to staff like health visitors, midwives, or social workers,
 - Having workers willing to ring up other professionals or services if parents need information or a referral to another service,
 - Workers visiting families at home,
 - The physical accessibility of the centre, for example to wheelchair users.
- There were mixed and often unrealistic expectations by staff as to what centres could provide. Different professional cultures created tensions especially about the balance between open access and targeted services, and between adult-focused support and child development activities.
- A moderate to high level of *shared vision* with partners was identified, particularly when providing services to a centre's target groups.
- The most common multi-agency working practice at management level concerned referral procedures (e.g. the Common Assessment Framework [CAF]) and informal ways of keeping in touch (e.g. 'brown bag' lunches).
- Almost three quarters of the centre managers thought that service delivery had been affected during 2011-2012 by direct funding cuts or indirect restrictions (e.g. a freeze on recruitment). Eight in ten centres anticipated further reductions, particularly in user take-up, during 2012-2013. In a time of substantial cuts across the board in public services, children's centre staff were determined to focus services on those for the most disadvantaged families. There was fear, however, that cutting more open access services such as Baby Massage might eliminate an 'attractive hook' for families who are difficult to engage.
- The original model of children's centres, as discrete 'stand-alone' units for the delivery of services, was already changing to a more distributed model of service delivery.

An in-depth perspective to multi-agency working and integration focused on the following themes:

- 'Reach': the catchment areas of centres were on the whole highly disadvantaged, with a mix of structural or neighbourhood problems (e.g. high unemployment, poor housing) and individual difficulties (e.g. poor health, low self-esteem).
- Engaging families: most centres were 'open access' while also taking referrals, and used different ways to publicise their services (e.g. by organising 'fun events' in the community). However, many centres also spoke of long-standing difficulties in getting access to birth data from the health

authorities; this seemed to be a local policy decision that could be addressed, since the problems in gaining access to health data were not encountered in all centres.

- Shared vision and partnership: centres differentiated between partners who worked with a universal approach (schools, JobCentre Plus, health) and those with a more targeted focus (social care). Health was seen as especially close in terms of shared vision. Tensions, however, were common. Differences in professional backgrounds and cultures were noted, as were different line managements and funding, targets, and eligibility levels for services. Nonetheless, it was widely recognised that multi-agency collaboration required the building of trust, which took time.
- In conclusion, centres were continuing to offer a surprising variety of services in 2012 despite cuts, with a high level of shared vision and practice, and commitment to multi-agency working.

Leadership and Management (Chapter 4)

Effective leadership has been shown as important for pupil outcomes within schools. The Children's Centre Leadership and Management Rating Scale (CCLMRS)¹ and a leadership questionnaire for children's centre managers and key staff were developed to measure key features of leadership and management.

Describing leadership and management within children's centres:

- The CCLMRS scale was used to measure five domains of quality: 1) *Vision and Mission*, 2) *Staff Recruitment and Employment*, 3) *Staff Training and Qualifications*, 4) *Service Delivery*, and 5) *Centre Organisation and Management*.
- The highest scoring domain of quality when using the CCLMRS was *Staff Training and Qualifications*, which scored in the 'good' range. Three further domains of quality scored within the 'adequate nearing good' range (the *Vision and Mission*, *Staff Recruitment and Employment*, and *Service Delivery* items).
- The quality of a centre's *Organisation and Management* was the lowest aspect of leadership, scoring in the 'adequate' range. This is likely a consequence of the reconfiguration of centres and tightening of centre's funds, together possibly prompting staff redeployment and increased staff turnover. Centres scoring lower on *Centre Organisation and Management* were more likely to have had withdrawal of resources and reductions to services within the 2011/2012 financial year.

¹ These leadership instruments were developed from a small grant from the National College for School Leadership (NCSL) in 2010.

- The leadership item rated overall lowest was *staff meetings and consultation*. This item was rated as '*inadequate*'. This may reflect the move towards clustering and the consequent difficulty of bringing staff together.

Measuring leadership via questionnaire:

- Most managers reported that they encouraged their staff to share best practice and work together across services and boundaries, and they facilitated staff to work collaboratively.
- Aspects of leadership most positively reported upon included the *vision and purpose* within centres and the maintenance of more mandatory elements, in particular *safety and safeguarding*.
- Both managers and key staff noted difficulties when it came to *incorporating others within the management structure* of a children's centre. *Bringing staff together from different agencies and different professions* was often raised as challenging.

Comparing views of managers with those of key staff:

- Managers and staff had some different perspectives from one another when it came to assessing the leadership and management of children's centres. The lowest level of agreement between managers and staff was found for *Continuing Professional Development (CPD)* and the extent to which children's centres *worked with partner agencies*. In both cases the staff responded less favourably than the manager.

Relating leadership and management to the characteristics of managers and children's centres:

- Age of managers (older was better) and the length of time that they had been in post (three to five years was best) were strongly related to leadership quality in terms of *monitoring value for money* and *partner agency communication*. It may take several years to ingrain these demanding aspects of management into the daily work of a centre. Interestingly, those with longer experience (i.e. over five years) tended to be weaker on those same aspects of leadership and management.
- In centres where managers held higher leadership qualifications (e.g. the National Professional Qualification in Integrated Centre Leadership: NPQICL), key centre staff were more likely to report greater levels of *safeguarding* and more *managerial delegation to the Senior Management Team*. The managers with higher leadership qualifications were also more likely to report higher *visions and standards*.
- More staff absence was associated with poorer management scores – unsurprisingly.

- Several aspects of management were noted as better in main-site centres with single-site single-lead centre managers (when compared to managers who led a cluster or a complex multi-site setup). The aspects of management that were higher in single-site single-lead centres included *training and qualifications of staff* and *organisation and management*.

Evidence-Based Practice (Chapter 5)

Evidence-based policy involves the implementation of *evidence-based practice*, often as a part of *evidence-based programmes*. Evidence-based practice originated from medicine and has since become integral to social research and policy making. Allen (2011) reviewed early interventions in order to define programmes which were of 'best quality' according to set criteria of evidence. Strand 3 fieldwork investigated the use of Allen's list of well-evidenced programmes, along with the use of other programmes, strategies and interventions for families.

What programmes, strategies or interventions do centres offer to families?

- Of the 19 well-evidenced programmes listed by Allen (2011) as relevant to the defined children's centre age group (i.e. aged 0-5), over half were implemented in some form by centres within the sample. The most commonly reported well-evidenced programmes were *Incredible Years (IY)*, *Triple P* and *Family Nurse Partnerships (FNP)*, of which 70 centres were implementing one or more. Programmes were run by centre staff in the majority of centres, although other organisations were also highly involved (particularly with *Family Nurse Partnerships*).
- A varied range of other programmes were also implemented as part of children's centre work. The most common programmes outside of the Allen list (2011) were *Baby Massage* and *Every Child a Talker (ECAT)*, although the full range included local parenting programmes, support for children with disabilities, and parental mental wellbeing. Children's centre staff reported that they ran the majority of other programmes which may have made them easier to schedule as they rarely relied on partnership working with other agencies.
- Well-evidenced programmes (as defined by Allen's list) were more often classified as followed 'in full' by children's centre staff, whereas the other named programmes were often only 'substantially' followed. Thus, there is some evidence that well-evidenced programmes tended to be self-reported as implemented more rigorously.

Overview and delivery of specifically named programmes:

- Centre staff appeared to struggle with the concept of evidence-based practice. Some gave equal weight to research evidence and personal experience. There was also tension between maintaining programme fidelity and offering programmes that appeared less demanding to families.

- The implementation of six commonly reported programmes is described in Chapter 5: three well-evidenced programmes (*Incredible Years*, *Triple P*, *Family Nurse Partnership*) and three other programmes (*Baby Massage*, *Family Links*, *Peers Early Education Partnership* [now known as *Parents Early Education Partnership*]; *PEEP*).
- There were obvious differences between the group of three well-evidenced programmes and the three others on the researcher-rated *Programme Implementation scale*. The well-evidenced programmes were implemented with more fidelity than the 'other' programmes, scoring more favourably on scales measuring *Feedback and Evaluation*, and *Fidelity to the Programme*. Typically, however, both well-evidenced and other programmes scored more highly on scales measuring *Manual Use* and *Feedback and Evaluation*, than on the *Fidelity to Programme*. Whether or not lower fidelity is the product of customising programmes for local families or some other reason (for example resources) remains a question for further research.
- Staff at the children's centres reported that the three well-evidenced programmes were more commonly run through a mix of children's centre staff and other organisations, and most frequently recruited families via referrals and targeting rather than through general open advertising within the centre. In contrast, staff reported that the three other programmes were commonly openly advertised within the centre and were often run continuously rather than with definite start and end dates.
- The actual number of participants (mainly mothers) reached by the three well-evidenced programmes over the course of a year was relatively small compared with the three 'other' programmes; for example, staff estimated that the number of families reached by the *IY* programme was 22 per year, and for *Triple P* was 23 per year. Comparatively, centre staff reported reaching higher numbers of participants within the three other programmes such as *Baby Massage* (an average of 47) and *PEEP* (an average of 104), both of which are commonly open-access and run by centre staff.
- The low numbers of families participating in the three well-evidenced programmes have important implications for detecting impact. The Strand 2 user survey may not include sufficient numbers of programme participants to reliably establish the effects of these programmes.
- Well-evidenced parenting programmes can be expensive to implement (i.e. *Incredible Years* costs approximately £1600 per participating family to run). Thus, it is easy to see why centres run so few of the more expensive programmes and instead (or in addition) choose to run programmes with less impressive credentials on the 'evidence' side.

Reach and Structure of Children's Centres (Chapter 6)

Are children's centres reaching the intended groups?

- Preliminary analysis of user postcodes showed that the majority (76%) of centres were physically located in the 30 per cent most deprived areas on the *Income Deprivation Affecting Children measure (IDACI)*, and drew the majority of their users (59%) from such areas. A small number of centres (9%) were located in less deprived areas, and drew the majority of their users from similarly less deprived areas. However, they also drew nearly a third of their users (30%) from the most deprived areas.
- Most users lived very close to their centre. Thirty per cent lived less than 500 metres from the centre, 61 per cent less than 1km, and 78 per cent less than 1.5km.
- A further report on reach will be available later in 2013/2014. This will provide further information on the nature of the areas served by each children's centre in the sample, take better account of satellite centres and their catchment areas, and address the question of non-users of children's centres in their target areas.

What structural configurations were identified during Strand 3 fieldwork?

- The 'one-stop shop' for family and children services is being replaced by complex clusters of centres and satellite sites, with particular services being delivered by particular sites. This was widely reported by the fieldwork staff carrying out visits to centres, and future ECCE reports will respond by providing evidence for this in a quantitative manner.
- Restructuring had led to emerging configurations. Earlier stages of the fieldwork found single-centre configurations or stand-alone main sites with satellites were common. However, new configurations became apparent during the 2012 fieldwork period. Some centres that were once stand-alone were becoming satellite sites for other centres, and services were being reorganised across the new group of sites.
- Some centres were found to be in transition towards cluster configurations: this is where a manager provided overall leadership across the cluster, sometimes in conjunction with other centre coordinators or administrative teams. Hub-and-spoke models were also becoming more prevalent: this is where the manager of a centre has overall line-management of other centres in the cluster, and is thus responsible for the coordination of services; and where a 'hub' centre is designated as the lead centre for provision of services. In some cases, service clustering was also becoming apparent: this is where services were outsourced to another team to work across the cluster.

Reflections on an evolving service:

- This section reflects upon the fieldwork experiences within children's centres, as reported qualitatively by the researchers 'on the ground'. It suggests possible reasons for findings within the report, and contextualises these in terms of qualitative observations made by researchers.
- Nearly every manager was interviewed as part of this first wave of Strand 3 fieldwork. As a number of the cluster reconfigurations evolved, centre managers reported changes to methods of working with other centres, and complexities in joining forces with centres in different areas or with different target families.
- For some centres, a change in lead body (examples given included a move towards the voluntary sector or local authority) had sparked off this reorganisation. Some centres discussed the benefits of reorganisation in terms of working as a network with other centres, and targeting particular priorities (although there were inevitable conflicts arising from such restructuring). Qualitative reports from researchers suggested that a number of managers were apprehensive about their future role within the organisation, particularly with the possible removal of middle management posts at centre level in favour of a higher managerial control over several sites. For some, the reorganisation had meant reduced centre hours or centre sessions as well as reduced partnership working. Others struggled to maintain the expertise of current senior staff (for example Qualified Teachers), whom might be at risk of relocation or redundancy.
- However, whilst centre staff spoke of concerns regarding reorganisation, staffing changes, and threats to multi-agency working, they were also enlisting strategies to ensure that the impact on families was minimal. Some managers spoke positively of the challenge to refocus their procedures and generally 'sharpen up' their ways of operating, both in service delivery and in multi-agency working with partners.
- Restructuring appeared to be related to the revised *core purpose* (DfE, 2012) which emphasises identifying, reaching, and helping those families 'in greatest need of support'. However, the ways in which this was identified and defined varied between centres. For example, some centres reported working with acute cases of social care work. Whilst some centres raised concerns about higher workload and their staff not having sufficient skills to deal with complex cases, others talked about retraining their workforce to meet the needs of vulnerable families; putting resources into areas of poverty; employing a clinical supervision service for staff; and providing more targeted outreach support to focus on the most disadvantaged families. Some centres reported that multi-agency responses worked well and gave examples of multi-agency partners working closely to join-up support for disadvantaged families.

Summary and Conclusions (Chapter 7)

- Children's centres were changing in 2012: the original design of a single, 'stand-alone' centre 'within pram-pushing distance' had evolved into networks and clusters. Despite financial cuts and loss of staff adversely affecting continuity and morale in some centres, few centres in the sample had actually closed; mostly they, and their services, were surviving and changing in times of austerity, and centres continued to strive to improve practice and outcomes for families and children.
- Centres did not think a single site was the key factor in centre ethos, contrary to previous assumptions about multi-agency working and partnerships focusing on providing services in the same place; other factors such as having workers willing to make contact with other services on behalf of families were more important.
- Staff were very committed, but stretched with more to do (e.g. supporting the most disadvantaged families, attending meetings outside the centre, increased paperwork related to safeguarding). Services provided by partners were reorganising (JobCentre Plus, for example) and there were fewer staff to work inside centres. In addition, some centre leaders were 'promoted' from front-line management of a stand-alone centre to a 'reconfigured' role involving management of a cluster of three or four centres or sites.
- Administrative data on centres' 'reach' showed that the majority of centres focused on disadvantaged areas and drew their users from such areas.
- Cuts were found to have affected children's centres as they have all public services. There was a shift from services consistent with universal provision to services that have a more narrowly targeted and focused approach for the most vulnerable families.
- There was great variation in the leadership and management of centres. Centres scored highest on *staff training and qualifications*, but mainly for front-line staff rather than managers. They scored lowest on *centre organisation and management*, with a likely reason being the reorganisation in response to changes in organisation and funding.
- All centres agreed that evidence-based practice should be followed, but many were confused as to the standards of evidence required for effective practice, and few implemented programmes with full fidelity. The majority of centres implemented at least one programme from the current list of evidence-based programmes (Allen, 2011), but these reached relatively few users. Centres also used programmes not on the 'Allen list' (which may have a growing research base on effectiveness) and some of them, like PEEP, reach more users and are less expensive.
- Researchers on the Strand 3 team worked hard to keep up with evolving structures and services. The work of children's centres is extremely complex,

and thus it was necessary to re-think interviewing and invent new assessment instruments in the first 18 months of the research.

- Looking forward, Strands 4 and 5 aim to demonstrate whether or not there have been measurable effects on outcomes for children and families, the cost of these, and thus the potential for improvement in life chances.

1 A Policy Perspective [Naomi Eisenstadt]

The policy background to Sure Start Children's Centres can be traced back to the early seventies. The basic model of services for pre-school children had been either part time nursery education or day care for working parents, the first usually provided by local authorities and the latter usually provided by private or voluntary sector organisations. Local authorities had also been running specialist centres for families under social service department supervision. These 'family' centres provided intensive support for families known to be at high risk of child abuse or neglect, often on the child protection register and of significant concern to social services. Following the Children Act (1989), these would be categorised by local authorities as 'children in need', that is, those children who would not reach the expectations of child development for their age without additional support. In the early seventies, the larger children's charities started to run community-based family centres that provided advice services, play group provision and more informal support for local parents, usually mothers. Many of these charities, like National Children's Homes (now renamed Action for Children) were moving from their traditional base of residential childcare to community-based approaches. They often also took referrals from social services departments, so offered a mix of targeted and open access services. These centres were normally based in poor neighbourhoods; hence although open to all in the locality they tended to serve low income families. Children's centres grew out of an era when services for young children were provided mainly by local government or the voluntary sector, with central government providing basic regulation on services but no requirements for delivery. Services were either exclusively targeted at high risk families, or open to all children or a mix of targeted and open access (Eisenstadt, 1983). At the same time a model of *combined nursery centres* was developing. These centres provided day care for working parents, but had trained teachers on their staff team.

The other critical variant in early years services was their key focus. Was the main aim of the centre to support parents with the assumption that this would lead to longer term improved outcomes for children, or was it specifically to improve the social and cognitive development of children? Nursery education was focused on children and rarely offered specific services aimed at improving parenting. Various forms of children's centres and family centres tended to offer services for parents. Childcare was designed to enable female labour market participation. This issue of focus on children's outcomes or parent support will be an important factor in the evaluation of children's centres. What came to be Sure Start Children's Centres bears the closest resemblance to the community-based voluntary sector centres, providing a wide range of services for parents and children, some targeted and some open access.

In 1997, the Labour Government came to power with a commitment to provide free nursery education for all four year olds within the first Parliament, and a commitment to set a date for the delivery of free nursery education for all three year olds. They were also committed to developing a pilot programme of *Early Excellence Centres*, organised largely on the combined nursery centre model described above (Labour Party, 1997). The expansion of childcare was a major commitment sitting alongside the various welfare to work policies. It was clear that getting lone parents into employment was unlikely to happen without a rapid expansion of affordable childcare.

Alongside provision for all children through nursery education, and provision for working parents through childcare, the Government became increasingly concerned with child poverty. In 1998, a major review was carried out on services for children under eight. The review found that families tended to be poorer when children are very young, and that poverty experienced in the first few years of life had scarring effects throughout life (Glass, 1999). As a result of the review, a new programme entitled *Sure Start* was developed, which was aimed at families with under fours living in disadvantaged areas. Sure Start was an area-based programme; that is, based in poor areas but open to all families in the area. Its main aims were particularly ambitious; as described in the first published guidance document, Sure Start was seen as 'key to the Government's drive to prevent social exclusion, raise educational standards, reduce health inequalities and promote opportunity' (Department for Education and Employment [DfEE], 1999). These goals were to be achieved through the objectives of supporting children's personal, social and emotional development, improving parenting aspirations and skills, providing benefits and housing advice, helping families back into employment, providing access to good early education, and addressing family health and life chances. These ambitious objectives still form the basis for service delivery in children's centres.

The design of Sure Start was to select particularly disadvantaged areas, develop a local partnership with local parents as well as all key agencies concerned with children, and decide on a set of services and activities that would be likely to deliver the ambitious aims of Sure Start set out in its own Public Service Agreement. The model was *tight/loose*, clear on what local Sure Start programmes were meant to achieve for their areas, but very open about the design and delivery of services that would achieve those aims. In the early days (as echoed in children's centres today) there was a very strong emphasis on community involvement, volunteers and the role of local parents in determining services. There was also a strong emphasis on the role of health and health services in promoting child wellbeing. The Sure Start Unit was jointly managed across the Departments of Education and Health. In 2000, the Spending Review doubled the size of Sure Start, from 250 to 500 local programmes, with a continued emphasis on the poorest areas in England.

In 2002, the Prime Minister's Strategy Unit carried out another review of all services for under fives. The Review found that even within government there was fragmentation between policy activities across the Sure Start Unit, Early Education and Childcare. There was particular concern that the major capital funding for Sure Start was not being strategically used to aid the needed expansion of childcare. There was also concern that the notion of a Sure Start Programme was difficult to grasp, as it was not a particular building or indeed a standard set of services. The report made three recommendations that changed Sure Start: Sure Start programmes would be called Sure Start Children's Centres; and at central government level, policy responsibility for all early years services would be under one Whitehall unit based in the Department for Education and Skills (DfES; as was). Thirdly, this new considerably bigger unit would be jointly owned across the DfES and the Department of Work and Pensions (DWP), reinforcing the need to ensure that more was done to link welfare to work programmes with childcare policy. However, this governance change from Health to DWP significantly weakened Sure Start's ability to engage locally with health services. It also marked a renewed emphasis on the role Sure Start could play in encouraging parents into employment (HMG, 2002). Again, important in the challenge of evaluating current children's centres is the various incarnations of key aims between support for improvements in parenting practice, support for improved child development, and support for reducing child poverty by encouraging parents into work. Was Sure Start about alleviating the impact of poverty on child outcomes, or was it about fewer poor children? The balance between these two has frequently shifted and continues to be argued both in practitioner and policy circles.

The next big shift in Sure Start policy, and the one that would have the most significant impact on children's centres as currently configured, occurred towards the end of 2004 with the publication of *Choice for Parents, the best start for children*. This document, jointly developed across the Treasury and the DfES, marked the end of Sure Start as a policy aimed particularly at poor areas. It promised a network of 3,500 Sure Start Children's Centres, one in every community, offering a range of parenting support services as well as directly provided childcare or easy access to childcare (HMT, 2004).

Alongside the changes in Early Years policy, radical restructuring of all children's services was beginning to take shape in 2003. The Government published *Every Child Matters*, a white paper setting out new arrangements for the governance and management of children's services at local level, as well as moving responsibility for children's social care from the Department of Health to the Department for Education and Skills (HMG, 2003). Within every top tier local authority a named Director of Children's Services would be responsible for five key outcomes for all children in the locality. The outcomes, developed through a wide ranging consultation process including children and young people, were: staying safe, enjoying and achieving,

making a positive contribution, being healthy, and achieving economic wellbeing. These changes were in a large part responsible for giving local authorities the responsibility of delivery for the vastly expanded network of children's centres described above.

Since 2004, Sure Start Children's Centres have been rolled out in three phases across England, in order to provide integrated services (e.g. health, education, welfare) for *all* young children and their families, now up to age five as opposed to the earlier Sure Start programmes which ended at age four. While the decision to ensure that all families had access to a children's centre was taken in 2004, the tightening up of the definition of precisely what would be offered in a children's centre came later, in part because of disappointing early results from the National Evaluation of Sure Start (NESS; Melhuish, Belsky and Leyland, 2005). These results showed some positive effects, but also showed that some of the very poorest families, particularly teen mothers, were not showing benefits. Ministers decided to make much more explicit precisely what a Sure Start Children's Centre was meant to deliver, not just what it was meant to achieve. This became defined as the *core offer*. All children's centres were required to deliver:

- information and advice to parents on a range of subjects including looking after babies and young children, the availability of local services such as childcare;
- drop-in sessions and activities for parents, carers and children;
- outreach and family support services, including visits to all families within two months of a child's birth;
- child and family health services, including access to specialist services for those who need them;
- links with Jobcentre Plus for training and employment advice; and
- support for local childminders and a childminding network.

Children's centres serving the 30 per cent most deprived communities would in addition offer integrated early education and childcare places for a minimum of five days a week, 10 hours a day, 48 weeks a year. Strand 3 research (as discussed within this report) looks only at children's centres that were meant to be serving the 30 per cent most disadvantaged localities and those that have been delivering the full core offer for at least two years.

Children's centres have become one of the main vehicles for ensuring that integrated and good quality family services are located in welcoming, accessible places for all families. Children's centres have always aimed to support young children and their families, particularly the most disadvantaged, in order to reduce inequalities in child development and increase school readiness. But the new commitment of a greatly enlarged programme was intended to ensure that poorer children living in better off areas were not missed, and also to ensure that there were opportunities for social class mixing, to encourage mutual support among service users. The provision of

children's centres by local authorities was enshrined in legislation in 2009, in the Apprenticeships, Skills, Children and Learning Act.

With the arrival of the Coalition Government in 2010, there was a rethinking of the role of children's centres, and in particular, a desire to ensure that the most disadvantaged families would get the most support from the centres. In July 2011, a new *core purpose* for children's centres was set out as part of a government reform of early learning. In particular, the overall aim of children's centres was redefined as '*improving outcomes for young children and their families, and reducing inequalities*' with a particular emphasis on identifying, reaching and helping those families '*in greatest need of support*' (Department for Education [DfE], 2012). This core purpose defined those services to remain universal and those which should target the most disadvantaged families. The reform also reinforced the core purpose of child development and school readiness; parenting aspirations and parenting skills; and child and family health and life chances as key foci for centre work. However, there was a reduced emphasis on a core set of services to achieve the core purpose, and a return to the earlier model of local determination of what constituted a designated children's centre.

As part of the reform, different approaches to the running of children's centres would be explored in order to allow professionals, parents and communities to have more control over the running of their children's centres (Liberal Democrats, 2011). Two changes in particular distinguish the current phase of children's centres from the earlier model. The Government is particularly interested in focusing on *child* outcomes, reducing the earlier dual purpose of improving child outcomes and encouraging parents into work. Relevant to the sharper focus on child outcomes, the Government is also interested in ensuring that children's centres increase their use of manualised, evidence-based programmes that have been subject to rigorous evaluation. In 2013, the Government published new statutory guidance for Sure Start Children's Centres (DfE, 2013). This guidance includes the requirement for children's centres to provide both targeted and universal services. However it makes clear that the centre role is to support access to these services for local families whether provided directly by the centres, or accessed elsewhere. This background raises a number of key questions for the evaluation of children's centres. This Strand 3 report addresses those that relate most directly to the provision of services.

- What services do centres typically offer children and families?
- Have these changed over recent time (e.g. as a result of changes in management or in resource levels?)
- How far have different services been integrated?
- How are the centres managed and led, and how well is this done?
- To what extent do centres use 'evidence-based programmes'?
- How well are these centres reaching the intended groups?

2 Setting the Scene [Jenny Goff]

2.1 Introduction to the in-depth study of children's centres

Background to the Evaluation of Children's Centres in England (ECCE)

NatCen Social Research, the University of Oxford and Frontier Economics (together comprising the 'ECCE Consortium') were commissioned by the Department for Children, Schools and Families (now Department for Education: DfE) to evaluate the Sure Start Children's Centre programme. The six year study aims to provide an in-depth understanding of children's centre services, including their effectiveness for children and families; and to assess their economic cost in relation to different types of services. The evaluation has a number of different elements organised into five 'strands' of work that will run until 2017.

Strand 1: Survey of children's centre leaders (led by NatCen Social Research)

The first part of the evaluation collected information on the range of family services delivered by children's centres. Leaders from a sample of approximately 500 children's centres² were interviewed on key aspects of service provision, including management, staffing, services, users, and finance. For further information on the first survey, see Tanner, Agur, Hussey and Hall with Sammons, Sylva, Smith, Evangelou and Flint (2012). The follow up survey with centre managers will occur in 2013.

Strand 2: Survey of families using children's centres (led by NatCen Social Research)

Strand 2 of the evaluation collected information from approximately 5,700 families (with children aged between 9-18 months) registered at 128³ of the children's centres included in Strand 1. Respondents provided information on their service use, family demographics, health and wellbeing. Further information on the first survey is available in the report; Maisey, Speight, and Haywood with Hall, Sammons, Hussey, Goff, Evangelou and Sylva (2012). Families visited for this part of the evaluation will be surveyed again when their child reaches the ages of two and three in order to profile children's development (via assessments of children's cognitive and social development) and investigate children's centre service use over time.

² Representative of all Phase 1 and Phase 2 children's centres in the most disadvantaged areas across England.

³ These 128 centres were taken from a core sub-sample of 120 centres, plus an extra sub-sample of eight centres which had successfully recruited users for the evaluation. For more information please refer to Maisey et al. (2012).

Strand 3: Visits to children's centres (led by the University of Oxford)

The research team carried out the first of two waves of fieldwork in 121 of the Strand 2 sample of 128 children's centres. Each visit took place over two days to assess:

- the range of activities and services that centres deliver;
- partnership working methods;
- leadership and management; and
- evidence-based practice (EBP).

Later stages of Strand 3 will include an area profiling exercise to assess each centre's 'reach'. This analysis will compare data on centre users with the data from the local area served by the children's centre. This will be reported on later in 2013 (see Chapter 6 for some preliminary analysis). The second wave of Strand 3 fieldwork will be carried out between February and July 2013. This further one-day of fieldwork across the centres visited in 2012 will assess services available for parents and families, and will investigate the views of parents participating in particular centre sessions. The second wave of fieldwork will also look at the support for parenting at the centre.

Strand 4: Analysing the impact of children's centres (led by the University of Oxford)

Strand 4 of the evaluation aims to answer the question: "*What aspects of children's centres (management, working practices, services offered) affect outcomes of both parents and their children when the child is aged three?*" This question will be explored by examining the information gathered from Strands 1 to 3. Children's Foundation Stage Profiles will be used to explore the impact of children's centres on children's later school readiness at age five.

Strand 5: Cost benefit analysis (led by Frontier Economics)

Strand 5 aims to assess the cost-effectiveness and cost benefit of children's centre services based on the impact findings in Strand 4 and cost data from 24 case studies in children's centres. For further information on the first case studies see Briggs, Kurtz and Paull (2012). Follow up case studies will take place in 2014.

2.2 Method

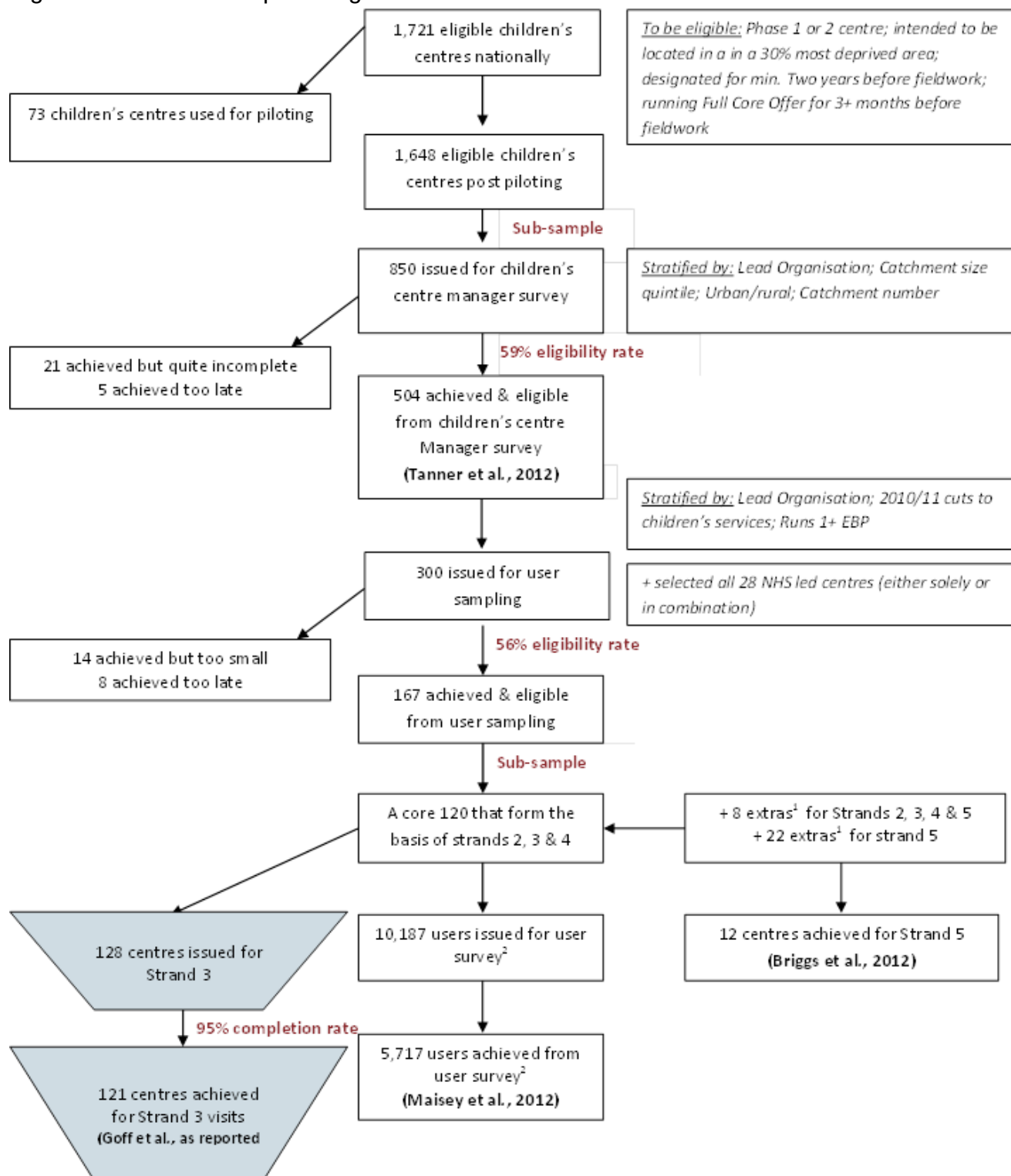
2.2.1 Sampling of target children's centres

The ECCE project is based on a nested design, with centres participating in Strands 2-5 being selected from the larger national sample of centres taking part in the centre manager survey in Strand 1. Further detail on the evaluation sampling strategy can be found in the first evaluation report published by Tanner et al. (2012), and also in Figure 2.1. This strategy is now briefly described:

- 1) A random stratified sample of 850 centres was selected for the Strand 1 “*Survey of children's centre leaders*”. Eligibility criteria for this sample were – a Phase 1 or 2 centre; intended to be located in a 30 per cent most deprived area; designated for a minimum of two years before fieldwork; running the Full Core Offer for three or more months before fieldwork. Centres were stratified to provide a representative sample of lead organisation; catchment size; urban/rural mix; and catchment number.
- 2) 300 centres were selected to take part in the Strand 2 survey. These centres were stratified by lead organisation, cuts to services in 2010/2011 and whether or not the centre was running at least one evidence-based parenting programme. One hundred and twenty eight of the 300 selected centres took part in the Strand 2 fieldwork. For further information on the sampling for the 128 children's centres, see Maisey et al. (2012).
- 3) All 128 centres that took part in the Strand 2 fieldwork were invited to take part in Strand 3 fieldwork. Of the 128 centres that were approached, 121 centres agreed to take part in the centre visits. See Figure 2.1 for further details.

As previously discussed, a random stratified sample of children's centres was carefully selected to be broadly representative of Phase 1 and 2 centres in England, whilst including all National Health Service (NHS) led centres. The achieved Strand 3 sample of 121 children's centres represents the best evidence of what ‘established’ children's centres in Phases 1 and 2 were offering across England in 2012 during the fieldwork. They will however *not* be representative of all children's centres, as the requirements for Phase 3 centres were less onerous. In particular, Phase 3 centres were not required to have childcare and a teacher or Early Years Professional (EYP). This is a requirement that has recently been removed. Children's centres are in flux nationally (structurally and in terms of offered services), hence the sample are likely to remain broadly representative of only those Phase 1 and 2 centres that are still in existence and operating. No definitive claims to generalisability can be made because the sample may not be fully representative of the national picture.

Figure 2.1. ECCE sample design



¹ Note: Extra centres were allocated to allow for potential attrition.

² Users were drawn from the same 128 centres allocated to Strand 3 fieldwork.

2.2.2 Instrument development

A number of instruments were developed to assess the different areas of interest for the Strand 3 fieldwork, covering leadership, evidence-based practice, service delivery, multi-agency working, and integration. The instruments were developed by the Oxford team in collaboration with other members of the ECCE consortium (NatCen Social Research and Frontier Economics), the DfE and the National College for School Leadership (NCSL: on a separate research grant). The instruments were piloted in seven children's centres between September and November 2011. These seven 'pilot' centres were drawn as a convenience sample from a separate set of 65 children's centres used by NatCen Social Research in their piloting work for Strands 1 and 2; these centres were thus eliminated from the sampling procedures used for the main study. Particular instruments used in this stage of the study are described in the relevant chapters of this report.

2.2.3 Researcher training and reliability

Six researchers were recruited to work on Strand 3, with a seventh acting as a research coordinator and lead for the pilot and field implementation. The remaining six researchers were trained between December 2011 and January 2012 before fieldwork commenced. Each researcher attended one full day of training at the University and two assisted training visits in children's centres alongside the research coordinator. During the fieldwork period, the first full two-day visit was carried out alongside the research coordinator to ensure a high standard of quality was maintained. The six researchers also attended a fieldwork review training day at the University and were assessed at two separate time points between July and October on their reliability to the research coordinator when administering the leadership rating scale (*Children Centre Leadership and Management Rating Scale: CCLMRS*). All researchers were found to be reliable to the research coordinator using Cohen's Kappa, with Kappa scores ranging from 0.64 to 0.99.

2.2.4 Data collection

Recruitment and visit procedure

Fieldwork was carried out between February and October 2012. Centres received a letter and email inviting them to participate in the study (Figure A1.1, Appendix A). The centres were allocated to researchers in two waves (February and April). Visits were designed to collect information on the range of activities and services that were being delivered by the named children's centre and any associated centres within their cluster; the extent of multi-agency working and integration of services; the extent and type of parenting programmes delivered by the named children's centre and any associated centres within their cluster; how programmes were delivered (with a particular focus on those considered as 'evidence-based'); and the leadership and management style of the children's centre as defined both by the person currently holding managerial control, and by other key senior staff as well.

Written informed consent was obtained prior to talking with each member of staff and, where possible, researchers undertook a tour of the centre and satellite sites in order to orient themselves. Fieldwork involved a range of methods including interviews with children's centre staff, rating scales administered by trained researchers, staff self-report, and self-completed questionnaires. Types of data collection are described within each relevant section of the report.

Completion rate

Of the 128 children's centres that were originally approached, 121 centres finally agreed to take part in the Strand 3 fieldwork. Several were initially reluctant, in view of changes to their centre's management or structure, staffing changes or staffing cuts, or the sheer pressure of time. Most were persuaded to take part after discussion with members of the Oxford team. In some cases this resulted in only partial completion of the full fieldwork, or a focus on a linked children's centre, where services (which had closed in the original centre) were now being held.

Visits have been classified as either 'partial visits' or 'full visits' depending on the areas of research investigated during the visit. Each visit collected data on one of three areas of research including leadership; evidence-based practice; and service delivery, multi-agency working and integration. Partial visits were defined as those collecting at least *some* information on any two of these elements, whereas 'full visits' collected some data on all three areas of interest. Overall, 93 per cent of the centres that were visited in this wave of fieldwork provided some information on all three areas of interest. Table 2.1 details the type of data collected within the 121 visited centres.

Table 2.1. Breakdown of 121 visits in terms of types of data collected ¹

Type of visit	Total number	% of completed visits
Full	113	93
Partial	8	7
TOTAL	121	100

¹ Partial visits collected data on two of the three areas of interest (leadership; evidence-based practice; service delivery, multi-agency working and integration). Full visits collected data on all three areas of interest.

The following chapters draw on the fieldwork data collected from these 121 children's centres. Research methods specific to each aspect of Strand 3 are described within the relevant chapter. Chapter 3 reports on service delivery, multi-agency working and integration; Chapter 4 reports on the leadership and management within the sample of centres; Chapter 5 details the use of evidence-based practice with particular reference to programmes, strategies and interventions used within the sample; Chapter 6 looks into the structural configurations and reach of the children's centres sample within Strand 3 fieldwork; and finally, Chapter 7 concludes the report.

3 Service Delivery, Multi-agency Working and Integration *[Teresa Smith, James Hall, Kityu Chu and George Smith]*

Key Findings:

- Centre managers placed particular importance on just four aspects of service delivery and ethos:
 - Being able to talk informally to staff like health visitors, midwives, or social workers
 - Having workers willing to ring up other professionals or services if parents need information or a referral to another service
 - Workers visiting families at home
 - The physical accessibility of the centre, for example to wheelchair users.
- There were mixed and often unrealistic expectations of what centres can provide. Different professional cultures created tensions especially about the balance between open access and targeted services, and between adult support and child development activities.
- It was evident that multi-agency working takes time and commitment to develop. But there were long-standing issues in some areas over data-sharing with health.
- The 'top five' services (mentioned by over 90% of centres) were stay and play, evidence-based parenting programmes, early learning and childcare, developing and supporting volunteers, and breastfeeding support.
- When a comparison was made between the services that were offered in 2011/12 and those offered in 2012/13, centres appeared to be shifting towards offering a more focused and targeted range of services for parents, and outreach to homes, in line with the revised core purpose introduced in July 2011.
- This study shows that the original model of children's centres, as discrete 'stand-alone' units for the delivery of services, was already changing to a more distributed model of service delivery.

3.1 Introduction

This chapter reports on the nature, extent and variation of children's centres service delivery, multi-agency working and integration, which has to be properly understood in order to paint an accurate picture of centres' aims and operation.

3.1.1 Background

As described in Chapter 1, providing integrated services in the community for families with young children has a long history, drawing partly on community development approaches, and partly on examples in family/maternal and child health, and in early child development and adult education. While most of the developments in bringing together services for families with under-fives took place in the 1970s, examples can be seen much earlier. The Peckham Experiment of the 1930s is one example of providing health, welfare and leisure services in one centre, in a deprived area of South London (Pearse and Crocker, 1943). Henry Morris's 'village colleges' in Cambridgeshire are another (Ree, 1973)⁴. Another mainstream strand was added in the 1960s, with the idea of an 'open door' for all welfare services, resulting in the creation of social services departments intended to provide welfare for young and old, but separately from education, health and housing (Seebohm Report, 1968). These earlier developments offered a wider mix across the age range and were rarely focused on very young children. This chapter describes how service integration within children's centres has developed: what services are on offer, how well they work together, and what the governance and management arrangements are for the range of professionals and paraprofessionals who work in centres.

3.1.2 Research questions

A semi-structured interview and questionnaire was developed in collaboration with the ECCE consortium based on a literature search on service delivery, integrated working, and partnership approaches in 2011. This was a face-to-face discussion with the centre leader. It consisted of a questionnaire about the services provided in the centre and in other associated centres or sites; and a semi-structured interview assessing centre priorities, delivery and ethos of services, management or leadership, governance, and multi-agency infrastructure, and funding changes. It was also designed to expand upon some of the data already collected in Strand 1 (Tanner et al., 2012).

⁴ For example, in the 1960s/70s in South Yorkshire under Alec Clegg; in the 1970s/ 80s with large urban community schools such as Abraham Moss in Manchester, and Stantonbury Campus in Milton Keynes.

The research topics were the following:

- **Service delivery:** what services were provided by children's centres, where and by which partner agencies?
- **Multi-agency working:** what other organisations worked as partners with children's centres, what services did they provide, and to what extent was there common practice and common priorities or shared management?
- **Integration:** what was the extent of integration, collaboration or coordination demonstrated by children's centres and their partners in philosophy (vision) and practice (service delivery and management)?

This part of the investigation aimed to study multi-agency partnership working and the services delivered. Strand 4 will study whether different patterns of multi-agency practice, different configurations and combinations of integrated services and their take-up, play any part in different child and parent outcomes. Definitions of the terms used in the chapter are provided in Appendix C1. All data presented in this chapter was self-reported by the staff of the 121 sampled children's centres.

3.2 What child and family services do children's centres offer?

The ECCE sample of 121 children's centres offered a range of child-centred and family-centred services, some focusing explicitly on adults' skills and needs, others more on the child, and other services and activities focusing more explicitly on 'capacity-building' in the community (such as working with volunteers or youth groups and community groups) which may have wider outcomes than the centre itself. Table 3.1 presents 50 child and family services that the 121 children's centres were asked about during Strand 3 ECCE fieldwork in 2012 – whether or not they offered these services, and if they did, how and when these were provided. Children's centres reported offering an average of 28 services from a list of 50; the minimum number was 13 and the maximum was 42.

Table 3.1. Services delivered through children's centres at Strand 3 Wave 1, including nature of provision (direct and/or via partners) and timing of provision (weekdays, evenings, and weekends)

Services	No. of centres offering this (max: 121)	Provision		Timing of provision			No. of centres offering this within a cluster setup
		% of centres offering this directly through centre staff	% of centres offering this via staff from 1+ partners	% of centres offering this on weekdays	% of centres offering this in evenings (6pm+)	% of centres offering this on weekends	
1 Early learning and childcare	110	78	52	97	7	7	31
2 Before school care for older children	20	40	70	100	25 ⁴	5	9
3 After school care for older children	32	69	56	100	19	6	12
4 Stay and play	119	98	24	97	1	24	39
5 Thematic stay and play (music classes/art classes)	93	84	41	95	2	12	30
6 Play and learn (stay and play for older children)	41	85	29	76	12	15	15
7 Weekend activities	77	82	34	-	3	97	31
8 Childminder development (training and support)	86	62	62	85	38	15	25
9 Childminder drop-ins	79	65	46	92	3	1	30
10 Childminders play and learn	40	65	43	98	0	0	10
11 Health watch	4	75	25	100	0	0	0
12 Speech and Language Therapy (SALT)	92	36	97	96	1	0	23
13 Breastfeeding support	109	66	85	94	13	8	33
14 Midwife clinic	86	22	97	91	12	2	23
15 Health visitor clinic	92	37	98	99	3	3	27
16 Sports and exercise for babies and children	88	83	50	94	5	11	24
17 Sport and exercise for parents	61	57	72	97	18	18	19
18 Specialist clinic	47	23	91	91	11	6	15
19 Clinical psychology services	34	12	97	88	6	0	8
20 Benefits and tax credits advice	97	33	89	92	3	5	25
21 JobCentre plus (drop-in and pc terminal)	44	27	93	95	2	5	15
22 JobCentre plus (back to work advice)	56	25	89	93	2	4	21
23 JobCentre plus (appointment only sessions)	36	17	100	92	0	0	16
24 Next steps (employment support)	35	31	94	100	9	3	11
25 Teenage parents - get into work or training	60	67	78	97	5	2	21
26 Women's back to work support	38	58	68	92	5	5	13
27 Basic IT and job skill course	52	15	94	96	6	4	19
28 Housing advice or information	81	51	84	100	2	4	28
29 Debt advice (e.g. From citizen's advice bureau)	80	28	94	94	4	4	26
30 Adult learning	105	36	98	98	11	7	33

Services	No. of centres offering this (max: 121)	Provision		Timing of provision			No. of centres offering this within a cluster setup
		% of centres offering this directly through centre staff	% of centres offering this via staff from 1+ partners	% of centres offering this on weekdays	% of centres offering this in evenings (6pm+)	% of centres offering this on weekends	
31 Further education	39	31	97	95	23	8	11
32 English for Speakers of Other Language Classes (ESOL)	55	25	93	98	5	2	28
33 Life coaching	19	53	68	100	5	0	5
34 Ante natal classes	78	41	97	78	38	12	29
35 Post natal classes	58	47	88	95	5	3	25
36 Peers and family support/parenting classes/relationship support	107	90	60	95	13	7	32
37 Peer support	39	85	21	92	18	15	11
38 Activities and hobbies for parents	52	81	71	96	10	17	17
39 Evidence-based parenting programmes	112	85	56	97	17	4	34
40 Other specialist support	41	49	80	98	17	7	11
41 Home-based services ¹	98	95	30	93	9	7	32
42 Home-based outreach services ²	102	94	32	96	11	9	31
43 Other outreach services ³	83	98	26	96	10	8	28
44 Toy library	60	77	18	92	5	7	21
45 Book Start Baby Bags/My treasure box	104	76	49	92	2	3	26
46 Sure Start resource library	38	87	6	100	5	8	11
47 Parent forum	108	94	13	91	6	6	35
A Developing/supporting volunteers	110	78	36	94	5	7	33
B Working with youth groups	34	40	25	76	35	12	13
C Developing/working with community groups	78	69	38	94	23	21	24

Notes: ¹ Merely home visits; ² As 'Home-based services' but also to deliver a service; ³ Services that are not 'Home-based'. ⁴ This 25% is an accurate recording of the responses given by 5 centres - even though before-school care is unlikely to be taking place in the evenings.

Of those services offered, an average of 63 per cent were offered directly (by centre staff); the minimum was eight per cent and the maximum 100. The services offered indirectly via partner staff showed similar percentages. Sixty two per cent of services (on average) were offered through these arrangements with partners (bearing in mind that centres could offer a combined service). A number of points should be noted about the services presented in Table 3.1. First, only five services (from the list of 50) were self-reported by over 90 per cent of the 121 children's centres:

- *Stay and play* (n=119 children's centres)
- *Evidence-based parenting programmes* (n=112; see Chapter 5 for more detail)
- *Early learning and childcare* (n=110)
- *Developing/supporting volunteers* (n=110)
- *Breastfeeding support* (n=109)

When taken together, these five services characterise the kind of services that children's centres in England were offering to families in 2012. It was also common for these five programmes to be delivered *directly* by children's centres through their own staff. Over 90 per cent of the centres that offered stay and play, and which developed and supported volunteers, did so directly through centre staff. Even breastfeeding support was offered directly by children's centre staff in over 66 per cent of the sampled centres. This latter figure compares to the 85 per cent of children's centres who reported delivering breastfeeding support *indirectly* via staff from a partner organisation⁵. Note that the other four most commonly offered services listed above were offered indirectly by less than 60 per cent of centres (see Table 3.1 for exact percentages). All five of these services were being delivered during weekdays in over 94 per cent of the sampled centres.

Second, there was a good deal of variation in how children's centres were organising and delivering their family services in 2012. As might be expected, the method and timing of the delivery of services varied depending upon the appropriateness of this for each service. For example, the services that were most commonly delivered during the evening were *antenatal classes*, *childminder development*, and *working with youth groups* – evening activities likely to be used by people busy during the day. The mix of staff from the centres and partner agencies, and the mix of specialist and basic activities was more complex. More specialist services, such as Speech and Language Therapy (SALT), midwife or health visitor clinics and other specialist clinics, support from clinical psychologists, benefits and tax credits advice, housing advice, IT, employment and skills advice and training, English for speakers of other languages, and adult learning, tended to be offered by workers from partner agencies. Many of these agencies were mentioned in the centre managers' interviews as particularly important for providing essential services for the most vulnerable families, with housing and money difficulties, for example. These services require specialist skills but they meet very common needs: SALT for instance is an effective way of intervening early with language delay, a highly prevalent problem with long-term consequences. By contrast, stay and play (that is, drop-ins for younger children and their families) was mainly provided by centre staff. This open access activity was mentioned in the centre managers' interviews as important for making contact with new centre users, for front-line prevention ("keeping an eye" on how families were coping), picking up on issues and "using your antennae to find out what is happening in the community". This could seem low-level, but again managers were clear that the quality of staff was vital for this sort of work, as it was for the 'community capacity building' work with volunteers or youth and community groups also mainly provided by centre staff.

⁵ Note: It was possible for centres to report that they offered a service both directly and indirectly through a combination of their own staff and staff from a partner organisation.

It is worth noting that Table 3.1 shows an example of the consequences from the reorganisation of children's centres during the 2012 fieldwork period (see Chapter 6). The right-most column of Table 3.1 shows that the delivery of services through a broader 'cluster' setup of children's centres was already common. The implication is that the original model of children's centres as discrete 'stand-alone' units for the delivery of services was already changing to a more distributed model of service delivery.

3.3 A comparison of the services offered by children's centres in 2011 and 2012

The 2012 Strand 3 data was gathered from an achieved sample of 121 children's centres out of a target sample of 128. As a result, when comparisons are made between this 2012 data and the data gathered during the 2011 Strand 1 survey of children's centre leaders (see Tanner et al., 2012), the achieved longitudinal sample size is limited to the same 121 centres that participated during this earlier fieldwork. Table C2.1 in Appendix C2 presents 11 different categories of service and shows how the number of children's centres offering these changed between 2011 and 2012. Eight out of the 11 categories of service were offered by 90 per cent or more of the sample of 114 children's centres visited during 2012. Only '*before and/or after school care for older children*' was an uncommon category of service as it was offered by no more than 28 per cent of the centres – in either 2011 or 2012. Considering change over time, a broad stability in the breadth of categories that were on offer was identified. Of the 11 categories of services considered, there was a statistically significant increase in only two (and these were all of a small effect size, $r < 0.3$): '*childcare and early years education*' ($p < 0.05$) and '*health-related services*' ($p < 0.05$). However, although the figures shown in Table C2.1 suggest general stability in terms of the *categories* of services that were offered between 2011 and 2012, these results do not extend to changes in *specific* services. Additionally, it must be borne in mind that the 2011 and 2012 data were gathered through two different procedures.

While Table C2.1 describes *categories* of services, Table C2.2 in Appendix C2 documents changes in *specific* services between 2011 and 2012. Three of the four services offered by more children's centres in 2012 than in 2011 were specifically for parents: evidence-based parenting programmes (small effect size), sport and exercise for parents (small effect size), and outreach (medium effect size). The fourth service that saw an increase was early learning and childcare for under threes (small effect size). Of the six that saw decreases, some were 'peripheral' to the centres' core activities – services such as stay and learn for older children (small effect size), childminder drop-in (small effect size), and specialist support (medium effect size). Other services that saw reductions were replaced by more targeted

ones, with informal peer support (large effect size) and hobbies for parents (small effect size) replaced by the more structured evidence-based parenting programmes.

3.4 Multi-agency working and integration

This section describes the multi-agency working arrangements and integration that characterised the ECCE sample in 2012, with information coming from structured interviews with the manager who was most knowledgeable (whether a centre manager, or the manager of a ‘cluster’ of children’s centres). A descriptive overview first provides a snap-shot of the organisational setup and working practices in use. (This also looks forward to the ‘configurations’ of children’s centres presented in Chapter 6.) The remaining subsections then consider different elements of multi-agency working and partnerships: the *shared visions* of children’s centres with their partners, the *delivery and ethos* behind services, *collaborative working arrangements* with partner agencies and organisations, and the impact of 2011-12 *funding changes* in the context of changes to the delivery of services. This picture of multi-agency working and partnerships is then complemented by a more detailed in-depth perspective in Section 3.5, drawing on the open-ended questions in the interviews with managers. Considered together, these two sections allow broad trends to be identified, and provide highly detailed examples which prevent an over-simplification of the varied and complex ways in which children’s centres are structured and function.

3.4.1 Descriptive overview

Firstly, the managers’ professional backgrounds were established. Four main areas of professional experience were asked about: *social work/social care/community work, education, health* (physical or mental), and *working in the voluntary sector*. Two professional backgrounds were particularly common. First, thirty two per cent of managers had a professional background that was solely educational (39 of 121). Second, seventeen per cent of managers came from a background of solely social work/social care/community work (21 of 121). Table C3.1 in Appendix C3 presents the full breakdown of all the reported professional backgrounds.

Managers were then asked a series of questions that described four central aspects of their children’s centre: whether the centre *operated as part of a cluster*, whether the centre *used satellite sites*, how the centre perceived its *reach area*, and how the centre *recruited its users* – the parents, children, and families who used its services.

Half of the managers interviewed (61 of 121) stated that their centre was part of a cluster or that it operated as part of a multi-site arrangement. More than half of these managers (47 of 61) said they managed the cluster overall. Managers typically controlled three centres or sites; the minimum number was one and the maximum

was eight. The majority of managers (49 of 61) were involved in coordinating the planning and delivery of services, with most (38 of 61) having a deputy coordinator in place.

Nearly three quarters of managers interviewed (89 of 121) reported that their children's centre delivered services through sites that they did not own or run: over 90 per cent of these sites were community-based, such as a community centre or church hall. This widespread use of community-based sites was also in contrast to the reported use of directly run satellite sites which were used by roughly one in four children's centres (31 of 121). Table C6.1 in Appendix C6 shows the use of satellite sites.

Managers were also asked about the 'reach area' of their centre (see Chapter 6 for a more detailed analysis of centres' 'reach' using postcode data). All bar one of the interviewed managers noted that their children's centre had a reach area that was defined by the local authority (n=120), and local authorities sent data about the reach area to all bar three of the children's centres (n=118). Regardless of whether local authorities sent such data however, all the managers claimed to keep data on who was using their centre from within the local reach area, and 75 per cent kept data about who was not using their centre from these areas (n=90). One hundred of the managers (83% of n=121) claimed that they had to 'reach' a certain number (or percentage) of children and families from their defined reach area. Ninety three per cent shared data about their reach areas with partner agencies and organisations (n=112).

Finally, managers were asked about the recruitment of families. All bar one mentioned referrals (n=120). All bar two of the managers kept a register of centre users (n=119). Names of potential users were sent to 74 per cent of the centres (n=89). Visits by centre staff to potential users took place in 79 per cent of the sample (n=96).

3.4.2 Priorities: vision and partnership

Managers were first asked who they meant by 'partner agencies' or 'partner organisations'. Ninety per cent used these terms to describe all the agencies/organisations that they worked with (n=109), three per cent to describe only those partners that were worked with on a commissioning or contractual basis (n=3), and 11 per cent of centres used these terms in another fashion (n=13). When it came to establishing shared visions and partnerships across children's centres, a three-point coding scheme used to frame the responses by managers estimating the proportions of their partner agencies involved (0= none, 1=some, 2=all) of the following four questions:

1. Thinking about all of your partner agencies, how many would you say are close to you in terms of any shared visions?
2. Thinking about all of your partner agencies, how many are important in providing services to your target groups?
3. Thinking about all of your partner agencies, how many are important in reaching the largest number of children and families in your reach area?
4. Thinking about all of your partner agencies, how many have you jarred against/had conflict with?

The first question asks about the extent of shared vision with partners, the second focuses on target groups, the third on 'reach' and the fourth asks about serious disagreement or conflict. Table C6.2 in Appendix C6 presents descriptive statistics for these four questions. Responses to the four questions were used to generate statistics on an overall *Vision and Partnership* scale. This scale ranged from 0-8, was derived for 119 centres, and had a median score of 5, a minimum score of 4, and a maximum score of 8. These descriptive figures indicate that centres tended to score towards the positive end of this scale – greater vision and partnership. Considering the four individual questions, a moderate to high level of shared vision with partners was identified. Vision sharing with partner agencies was particularly high in the context of providing services to a centre's target groups (question 2, 65% responded with the highest response option). Qualitative comments from the centre managers on shared vision and practice with partners are given in Section 3.5.

3.4.3 Services: delivery and ethos

Managers were asked to rate 11 aspects of the structure, organisation and operation of their children's centres in terms of importance when attempting to make the services offered accessible to families and children. (Table C6.3 in Appendix C6 presents the results, with all aspects measured on 5-point ordinal scales from 'unimportant' to 'critical') The 11 different aspects of centre structure and working arrangements varied in how they were rated. Centre managers placed particular importance on just four aspects in particular (over 88% of managers believed each of these to be either 'very important' or 'critical'):

1. Being able to talk informally to staff like health visitors (88% of managers thought that this was either 'very important' or 'critical')
 - E.g. corridor discussions with professionals (such as health visitors, midwives, social workers, or teachers) rather than going through a formal referral
2. Having workers willing to ring up other professionals or services if parents needed information or a referral to another service (97%)
3. Workers visiting families at home (89%)
4. The physical accessibility of the centre, for example to wheelchair users (91%)

By contrast, only 19 per cent of the managers viewed their centre being open in the evening as either '*very important*' or '*critical*', while 50 per cent of managers thought this to be only '*slightly important*' or even '*unimportant*'. *Having services all together in one place* and *the centre being open at the weekends* came out lowest (only one third of the managers thought either of these to be critical or very important). This is perhaps unsurprising, given the variety of ways in which children's centres were structured (Chapter 6) and the wide number and variety of offered services (see Section 3.2) and evidence-based programmes (see Chapter 5). But it is very surprising indeed when the original vision of the 'one open door' is brought to mind, as argued in Chapter 1 and Section 3.2.

Finally, all 11 questions concerning the delivery and ethos of services were summed to form a *Service Delivery and Ethos scale* (with a potential range of 0-44 and with n=115 centres having a score created). Achieved scores ranged from 21 to 42 with an average of 31. The implications are that: 1. centres varied strongly from one another in terms of their service delivery and ethos, 2. the scale was sensitive to these differences, and 3. there was a tendency for centre managers to score their centre higher rather than lower (as might be expected). This scale is presented graphically in Figure C3.1 in Appendix C3.

3.4.4 Management/leadership, governance, and multi-agency infrastructure

Managers were asked about multi-agency working *at the management level* of children's centres. Interviewees were asked six questions that required them to estimate the proportion of their partner agencies and organisations with whom they collaborated in various ways, as measured on a three-point ordinal scale (0 '*Not at all or not in practice*', 1 '*In practice with some partners*', 2 '*In practice with everyone*'). These questions were about information-sharing protocols, joint training, referral procedures, and informal ways of keeping in touch (see Table C6.4 in Appendix C6 for the results in full).

The most common collaborative working practices that managers claimed to have with their partner agencies and organisations concerned referral procedures and informal ways of keeping in touch. Sixty six per cent of the managers claimed to have agreed referral procedures for Team Around the Child (TAC) with all partners, while 77 per cent claimed this for the Common Assessment Framework (CAF). This full collaboration over referrals is not surprising, given that it is a statutory requirement. The majority of managers (62%) claimed that their centres maintained informal ways of keeping in touch with all of their partner agencies and organisations as well. Again, this response is unsurprising.

Lower managerial-level collaborative working was found when it came to joint training and protocols for the sharing of information. It was most common for centres to both offer, and be included in, joint training with only some of their partner agencies (true for 81% and 83% of the managerial responses to each question respectively). Thirteen per cent of managers said that they were not included in training organised by any of their partner agencies, and this was the highest level of non-collaboration reported. When it came to information sharing protocols, the managers of the sampled children's centres were broadly divided into two groups; 49 per cent claimed that they had such protocols with only some of their partners while 45 per cent claimed to have these with all their partner agencies and organisations. Section 3.5 gives examples of some of the reasons that might explain such variation between children's centres when considering multi-agency working at the managerial level of children's centres.

3.4.5 Funding changes

Many local services were experiencing cuts as a result of the economic climate and the Government's austerity drive. All 121 children's centre managers were asked about recent funding changes, and what aspects of their working practices were being affected. Only seven per cent of managers (n=9) claimed at the time of interview in 2012 that their centre had never experienced changes in services due to either direct reductions in funding or more indirect funding restrictions. By contrast, 30 per cent of managers (n=36) said such changes had occurred before the 2011/12 financial year, and 72 per cent said these had occurred during the 2011/12 financial year. Eighty per cent of the managers interviewed in 2012 anticipated changes to services due to funding reductions/restrictions in the coming financial year 2012/13.

The 121 managers were then asked to clarify the nature of the 2011/12 reductions/restrictions in funding that had led to changes in services. The most common reason was that staff were being withdrawn by partner agencies or organisations (43%). Next was withdrawal of funding from lead agencies (42%), followed by indirect restrictions/reductions (38%), and finally, direct funding cuts by partner agencies (32%).

Considering the impact of the 2011/12 funding reductions and restrictions, it is perhaps not surprising that managers identified an increase in their own responsibilities as the most common direct impact (claimed by 56% of managers). In descending order, the remaining impacts involved the following:

- Loss of staff (48%)
- Loss or reduction in opportunities for the professional development of staff (38%)
- Loss or reduction of services for particular groups of users (30%)
- Overall reduction in the delivery of services e.g. centre hours/days (24%)

- Loss or reduction of service(s) in particular locations (21%)
- Reduction in take-up of services by users on a regular basis (11%)

Together, these changes suggest that reductions and restrictions to funding in 2011/12 were more commonly affecting staff, then reductions in services, and least commonly the take-up of services by users. Such a conclusion is also in keeping with centres that tried to maintain the number of families 'reached', over and above (but in addition to) the number of services that they delivered, as noted in some of the manager interviews. Forty two of the 121 interviewed managers also noted additional impacts: for example, *"...people are spread very thin- things have been hollowed out. Everyone has taken on additional responsibilities."*

Managers were then asked the same questions about what they expected for the coming financial year 2012/13 (note they were interviewed in 2012). Considering *reasons* for funding reductions/restrictions first, this time the most common response from managers was that they were expecting future funding withdrawals from lead agencies (reported by 47% of managers, five percentage points higher than the current reason). The second most common response was indirect restrictions/reductions (expected by an additional two percentage points of managers – now 40%), the third was funding cuts by partners agencies (37%, up five percentage points), and the fourth was partner agencies withdrawing staff (now 36%, a reduction of seven percentage points).

Considering the expected *impact* of funding reductions/restrictions in 2012/13, again managers believed an increase in their own responsibilities would be the most common direct impact (claimed by 50% of managers, six percentage points lower than the 2011/12 reported figure).

In descending order, the other likely future impacts were:

- Loss of staff (43%, down five percentage points)
- Reduction in take-up of services by users on a regular basis (41%, up 30 percentage points)
- Loss or reduction in opportunities for the professional development of staff (32%, down six percentage points)
- Overall reduction in the delivery of services - e.g. centre hours/days (32%, up eight percentage points)
- Loss or reduction of service(s) for particular groups of users (23%, down seven percentage points)
- Loss or reduction of service(s) in particular locations (21%, no change)

From the above expected 2012/13 impacts due to funding restrictions/reductions, it is clear that managers feared there would be a reduction in the take-up of services by regular users, up from 11 per cent of managers in the 2011/12 financial year, to

41 per cent in the then upcoming 2012/13 financial year – an additional 30 percentage points.

3.5 An in-depth perspective on multi-agency working and integration

In addition to the quantitative analysis of the interviews with managers just presented, a more qualitative, in-depth analysis now follows of the material from the open-ended questions with managers. The aim here is to flesh out the statistics and give examples.

3.5.1 ‘Reach’ and neighbourhood: the children’s centres’ catchment areas

The open-ended discussions with centre managers following on from the survey topics on reach and catchment areas expanded considerably on their type of area and the problems found, highlighting a mix of individual and neighbourhood difficulties. While some pointed out that their catchment areas were very mixed in terms of disadvantage, with better-off pockets (as described in Chapter 6) having less unemployment and fewer housing problems, most thought that poverty and unemployment were the biggest neighbourhood problems affecting families in their reach areas. Managers picked out different concentrations of individual problems in different reach areas. Some areas were thought to have tight-knit communities; others were very fragmented. Managers thought health and mental health issues affected many people, and that there were high rates of depression, post-natal depression, low self-esteem and low aspirations with many families facing problems of stigma. Teenage pregnancy, lone parents, drug and alcohol abuse, obesity, child exploitation and domestic violence were also thought to be common problems associated with high unemployment and poverty. Some managers described these individual problems as long-term and inter-generational.

In general, managers thought that the neighbourhoods their centres served with the highest concentrations of deprivation included high rates of unemployment; high rates of illness and long term illness; high mortality rates; poor housing, high levels of temporary housing, multi-occupation and overcrowding, privately rented housing in poor repair; high rates of children growing up in families on benefit; lone parent families; high rates of young children with poor language development; high rates of 16 year olds leaving school without educational qualifications; adults with poor literacy rates and high levels of teenage pregnancies. Some managers described areas with a high number of ethnic minority families – some in well-established communities, others more recent arrivals, and concentrations of refugees and

asylum seekers. In a few cases, managers described having to deal with extremist religious and sexist groups and gang culture, in the local neighbourhoods.

Examples include the following:

- “Unemployment, high domestic violence, high teenage pregnancy, high numbers of families with children on child protection plans.”
- “Prejudice within area against other cultures.”
- “Lots of families do not have food; obesity, tooth decay, low levels of breastfeeding, high smoking rates.”

3.5.2 Engaging families: data, recruitment and registration

Open-ended discussion with the centre managers added depth to the quantitative analysis of engaging families, expanding on difficulties in obtaining data about potential users from partner agencies, and the different strategies for contacting and engaging with families in their catchment areas.

Obtaining official new birth data for families in their catchment areas proved to be a huge topic for centre managers – unsurprisingly, as services for babies and their families were seen as both the point of access for families, the best moment to begin to build trust, and also the best time to assess the need for early prevention. Many managers spoke warmly of their relationships with health visitors and midwives; they described how data on new births was routinely sent through to the centres, and how health visitors gave out registration forms and information about the children’s centre on their first visit to new parents. The actual process they described varied, however; the contact point might be midwives and the antenatal clinics, or the registration of the birth in the hospital, or children’s centre staff visiting the baby clinics, or health visitors visiting the new family at home. Examples included the following: “health visitors take a registration form and the children’s centre programme when they go on new birth visits, and when the parents come to the health clinic they bring back the form and the centre will then contact the family”.

Satisfaction was by no means the universal experience, however, and a good deal of frustration was expressed. Many managers reported difficulties in obtaining official new birth data (and there were comments that even when the data were available these were not always correct): “no live birth data as Health consider it confidential, and do not share it”; “Health reluctant to share birth data, which makes it difficult to plan strategies”. Managers made various comments and suggestions to improve the situation. It would be easier to plan strategically if centres had the official new birth data, so they knew which families to prioritise for visiting and how best to plan services for those in need; information-sharing protocols would make it easier to plan and deliver appropriate services. Referrals by health visitors and social workers (usually through the Common Assessment Framework [CAF] procedure) were

frequently mentioned (as were referrals by housing workers, GPs, school doctors, or nurseries), but social care workers would only refer if families reached levels of serious need (the next section shows that there was often disagreement on the definition). These difficulties with data-sharing had been common since Sure Start. Children's centres found it difficult without adequate statistics to plan how best to target resources where they were most needed, and difficult to intervene early before major problems developed.

Other engagement strategies included welcome postcards sent to other agencies; once families had registered and picked up the cards, children's centres could make contact. A few centres received details of all families known to the social services. More pro-active and community-based strategies to publicise the work of the children's centres and attract families were widely commented on. Face-to-face contact with families during registration was thought to make a big impact, as it gave families a better understanding of the centre. Door-knocking, newsletters, word-of-mouth publicity within the community, and use of volunteers to spread the word were often mentioned. Centres ran events to attract parents ("we walk around the neighbourhood with leaflets and balloons to get parents interested"). Some managers spoke of groups that were hard to engage (fathers for example): some male carers were reluctant to register with the centre because they feared they would lose benefits and did not wish to be identified.

3.5.3 Shared vision: partnership, targeting, and reach

An enormously long list of organisations and agencies as partners was compiled by the centre managers – both statutory and voluntary, and in the community. Some focused on children (childcare, speech and language support, for example), and some explicitly on parents (adult learning, benefit advice), but many focused on parents and children together (Home Start is an example). Six clusters of services delivered *in partnership* with outside agencies were identified:

- Health (health visitors and midwives; Child and Adult Mental Health Services [CAMHS] and mental health support, speech and language support, healthy eating);
- Social work/social care for targeted family support services;
- Schools for their universal reach;
- JobCentre Plus (employment support), credit unions and Citizen Advice Bureaux (CABs: for benefit and debt advice);
- Other agencies such as housing, adult education (mentioned particularly for English as an additional language), the youth service, the police, the fire service for its accident prevention role;
- Services and groups in the community such as libraries (important for language and literacy awareness), toy libraries, women's refuges and

Women's Aid dealing with domestic violence, parenting and safeguarding services, childminding networks and teams, Home Start.

Health services were key agencies most often mentioned by centre managers as particularly close in terms of shared vision, and also most important in providing services to their target groups. Health visitors focused on birth onwards, and provided an enormous amount of support to all families with young children, as well as specialist support and early identification of problems ("working at an early stage to identify needs"). Midwives also played a vital role in improving babies' life chances; their role with postnatal care for young teenage mothers was specifically mentioned. This was a mix of universal 'reach' and highly targeted support.

Social care focused on targeting, managing the most vulnerable cases, giving opportunities to families, building resilience and personal identity; they were thought to provide the best quality support with the best outcomes.

JobCentre Plus was given as an example of the agency most likely to have the largest 'reach' for families in the centres' catchment areas, with an active role in encouraging lone parents and male carers (back) into work ("getting families off benefits and out of poverty"), and providing guidance for job seekers. There were many services to help parents improve their skills and prepare them for the world of work, such as job training organisations and adult education courses helping parents gain confidence and self-esteem. In areas with high numbers of ethnic minority families where English was not the first spoken language, adult education provided English for Speakers of Other Languages (ESOL)/English as an Additional Language (EAL) courses. For children, Speech and Language Therapy (SALT) aimed to improve speech and communication skills and boost children's outcomes; this service also aimed to improve the quality of care in local settings.

Centre managers also listed other organisations and agencies such as local schools ("to ensure reaching as many families as possible"), Home Start, Money Matters, debt management and legal services, and teams dealing with housing ("early identification of families in need"), and homeless and temporary accommodation as other important partnerships helping to improve outcomes for families and individuals. Educational psychologists and the CAMHS service helped families with mental health needs, coping with low self-esteem, low aspirations and stigma; the services were provided by experts, and also provided support and advice and a "good listening ear".

Managers of the few children's centres in rural areas in the study talked of facing particular problems with transport and long distances between services. Managers spoke of the importance of play/outreach buses going out into rural areas which other transport did not reach; this was described as particularly important in addressing social isolation. Overall there was a lot of emphasis on improving

outcomes for children, and the quality of provision provided, for example, by the childminding teams and Special Additional Learning service, which focused on identifying difficulties and supporting children to improve outcomes.

3.5.4 Disagreements and lack of sharing

The picture of shared vision is generally positive so far. However, while managers described many partners sharing the same vision, they also spoke about a number of tensions and difficulties. These were partly practical, the result of a number of agencies and services sharing the same space (“the health visitors come in and move the sofas around”). But more fundamentally, difficulties can be inherent in multi-agency working: workers from different professional backgrounds and cultures; a perceived lack of understanding of the role of children’s centres, and a feeling of “not being taken seriously”; and more structural difficulties to do with different funding streams, and different professional imperatives when restructuring and cuts to funding and staff took hold. However, as one centre manager put it, “there are difficult working relationships, but this is not conflict; learning to work together takes time.”

Different professional backgrounds and cultures were expressed in phrases like “the midwives use a different language when talking to parents”. There was tension over universal access: health visitors, for example, might restrict data sharing because the centre’s computers were ‘open access’. Services had different targets that had to be met; they had different thresholds of eligibility for families seeking their services, or referred by the centres. Sometimes centre managers thought that other services had unrealistic expectations of what centres could offer. Social care, for example, expected centre staff to work with highly vulnerable families (“social services are delegating work to children’s centres”; “social care has unrealistic expectations about what a children’s centre can offer”), and there were frequent disagreements over the thresholds for referral of children or families. JobCentre Plus was criticised by a number of centres for a lack of shared vision, failing to see the benefits of a multi-agency approach, and withdrawing services from the centres (“not meeting the legal requirements”). There was tension between targeting and universal services; managers stressed they had to meet Ofsted requirements for universal provision. The clash in ethos was expressed by one manager who spoke of the difference between “what was needed by families” and “what was offered by the services”: thus neatly encapsulating the difference, and tension, between the concepts of ‘user-led services’ and ‘professionally-led services’. There were also examples of tension with other children’s centres working with different agendas and models.

Centre managers commented that other agencies and services needed to understand and respect each other’s roles and skills in order to work harmoniously to deliver the support and care that families need: lack of communication is due to

different targets, priorities, professional standards and expectations. Appendix C4 provides examples.

3.5.5 Making services accessible

Children's centres managers thought that making centres accessible would encourage more families to get engaged; it was essential to create an environment where parents felt they would be listened to, and could trust staff and have confidential discussions when necessary. Their more open-ended comments included practical comments like "the name of the centre puts people off"; "opening times should include weekends and evenings, to get fathers into contact"; "services need to be free, we need a crèche for adult learning". Some comments were more downbeat: "we need transport for groups: but there is no money to support transport for families any more"; "we need more resources and more funding to keep access going". Other comments focussed on staff: "staff need to be non-judgmental and prepared to listen; we need flexible structures and staff with the right personality". Quality was important: "good facilities make the centre a desirable place". Other comments stressed the balance needed to offer families help with difficult issues: "the willingness to use assertive outreach techniques, be friendly, and persist in keeping relationships going". Appendix C5 provides examples stressing the importance of open access and a welcoming atmosphere.

There were also less optimistic comments, however. Some managers spoke about the difficulty of making their centres welcoming while they were in the throes of reorganisation. Others mentioned lack of space for group activities. Parents had to be persuaded that activities such as evening or weekend events were 'value for money' when these had to be paid for.

3.5.6 Trust and collaboration: formal and informal working relations

One manager who described the importance of multi-agency partnerships noted that collaboration is "vital as no one is expert on everything; it gives families access to expertise and skilled professionals. We gain more knowledge by multi-agency working." Some managers described this as a process: "we are working towards having team meetings and working together with joint training". Most were very positive: "we have good professional relationships with social workers and the health visitors; the seven children's centres have separate lead agencies with different responsibility but the same vision"; "we work well with the partnership, we have good representatives on the Advisory Board". Joint events were important for developing good working relations ("annual multi-agency events", "Centre Development Day"); so were regular meetings ("breakfast meetings hosting discussions", "community lunches", "partnership lunches"), and evolving the right structures (monthly senior management meetings, network meetings, local children's centre manager meetings,

Local Management Boards, Partnership Advisory Boards, health visitor forum, local authority cluster meetings, locality partnership groups, centre champions).

There were however limiting factors - time was one. Funding was another ("partners cannot join after hours for training as there are no funds"). Different systems and cultures in different agencies occasionally created difficulties: "it's frustrating when other organisations have different systems and targets"; "some services are too tick boxy; social care only produce reports and reviews; this makes it hard for the children's centre, which opens at 8am and has to deal with all problems"; "children's centres are still seen as the poor relations by some agencies". Some partner agencies had to reorganise their services as a result of internal changes: "JobCentre Plus used to be on site, but now the children's centre is only left with a list of jobs on the laptop." A few centre managers saw the cuts in a more positive way: "less money and our higher workload has forced us to work collaboratively and in a positive way"; "we could not deliver services unless we all work collaboratively with other agencies." As one manager commented, working collaboratively meant "accepting that you can't have everything just the way you wanted." Several just said "avoid duplication".

3.5.7 The impact of cuts on multi-agency collaboration

"We cannot plan in the long term, we are more reactive than pro-active, resulting in a fragmented service year on year; and cuts bring staff insecurity", one centre manager commented on the cuts. Staff had to work longer hours and with a higher workload. Opening hours and universal services had been reduced. Withdrawal of service by JobCentre Plus was noted in several centres. Multi-agency working had been affected as agencies reduced their input into children's centres: "agencies do not think outside the box any more, thus increasing the pressure on multi-agency working"; "there is less time for multi-agency collaboration." One manager gave an example of home visiting taken away from the children's centre responsibility and given to social care: the centre now had to deliver 'intervention programmes'. There was an example of the teenage pregnancy team and the education welfare advisors being cut, and another example of a centre asked to pick up services like breastfeeding support.

There were occasional comments about the impact of funding cuts on the balance between universal and targeted services. One manager said they had to introduce charging for universal services, and relied increasingly on volunteers and parents to maintain universal services. Another said there was tension between targeted work and the Core Purpose in relation to early intervention and prevention programmes. One manager, however, commented that restructuring had forced a clearer vision, with a sharper focus on targeted work.

3.5.8 Key themes and managers' conclusions

Five themes were evident in the centre managers' conclusions. First was the importance of experience over expertise. Qualifications were seen as less valuable than life experience in the field. Second, children's centres did not have the legal right or responsibility to intervene in families, and therefore had to rely on multi-agency collaboration. So having a good working relationship with partner agencies was essential. Collaborative working was the key to solving community problems. Third, community development was seen as the way forward: "community work is everything we do." Workers had to understand the neighbourhood. Fourth, there was a hint that commissioning threatened universal services; and thus marked the shift to targeting evident throughout the study. And fifth, a telling phrase on which to end this paragraph: "working with vulnerable people means you are an advocate."

While these key themes identified by managers are critically important for understanding how the children's centres in this study operated, the issues they identify may not be the most critical for child or adult outcomes. It is important to remember that professionals' opinions may not necessarily coincide with views held by parents. To take just one example reported earlier in this chapter – while managers appear to believe that locating services on one site is no longer important, parents might have something different to say.

3.6 Summary and Conclusions

This chapter starts with three questions: first, which services were the Strand 3 centres delivering; second, who did they work with as partners and how were they developing multi-agency approaches; and third, what was the extent of shared vision and practice between the centres and their partners. How well did the centres perform?

Centres continued to offer a very large number and range of services, both by their own staff and staff from partner agencies, in the evenings and weekends as well as during the day; but a comparison between 2011 and 2012 suggested that this 'scatter-gun' provision was shifting to a more focused and targeted approach.

Almost all the centres defined all the agencies they worked with as partners. Developing multi-agency approaches and partnerships took time, however, and there were many stumbling blocks along the way. Both informal and more formal arrangements worked well. But there was considerable discussion about the years of contact required to build trust and understanding between professionals from different professional backgrounds, training and cultures, and the problems around data-sharing (particularly with health) provided one illuminating example. Nevertheless, there was a high level of shared vision and practice between centres

and their partners, particularly in relation to working with the targeted groups given priority.

The biggest surprise in this chapter goes back to the meaning of integration. Centre leaders were asked to rank the factors they thought most important in making their centres accessible to users. Previous research focused on co-location of services – the idea that all services were under one roof, with a welcoming ‘open door’. But what mattered to centre leaders now was having staff willing to ring up other professionals on behalf of parents; parents being able to talk informally with a range of professionals such as teachers, social workers, health visitors and midwives; and outreach workers visiting families at home. Perhaps co-location of services has declined in importance, as the ‘stand-alone centre’ has given way to a variety of ‘cluster’ and ‘hub-and-spoke’ arrangements. What matters now is a more ‘people-focused’ coordination of services, with an emphasis on communication.

4 Leadership and Management [Jenny Goff, Rebecca Smees, James Hall, Kathy Sylva, and Pam Sammons]

Key Findings

- In a comparison of various aspects of leadership, the quality of a centre's *organisation and management* was rated as lower than other aspects of leadership such as *vision and mission* and *staff recruitment*. This is likely a consequence of the reconfiguration of centres and tightening of centres' funds, together prompting staff redeployment and turnover. The leadership item rated lowest was *staff meetings and consultation*. This item was rated as '*inadequate*'. This may reflect the move towards clustering and the difficulty of bringing staff together.
- In centres where managers held higher leadership qualifications (e.g. the National Professional Qualification in Integrated Centre Leadership: NPQICL), key centre staff were more likely to report greater levels of *safeguarding* and *more managerial delegation to the Senior Management Team*. The managers with higher leadership qualifications were also more likely to report higher *visions and standards*.
- The length of time managers had been in post was associated with two aspects of leadership and management. Those managers who had been in post for between three to five years self-reported the greatest extent of *monitoring value for money* and the most *partner agency communication*.
- Several aspects of management were assessed as better in 'main-site centres with single-lead centre managers' (when compared with clusters or complex multi-site setups). The aspects of management that were higher in single-site centres included *training and qualifications of staff* and a centre's overall *organisation and management*. It is possible that leading in a single-site centre makes staff communication easier, and face to face interactions with staff more likely.
- Questionnaires given to managers and key staff showed both positive and negative results. On the one hand, the majority of staff were positive about the *vision and purpose* of children's centres, and believed that users were treated *equally and fairly*, and *felt safe in the centre*. However managers reported more favourable levels of *Continuing Professional Development (CPD)* and of *working with partner agencies* than their key staff.

4.1 Introduction

Research within schools and pre-schools has drawn attention to the importance of good leadership practices, particularly with regards to the effect upon pupil outcomes⁶. A number of categories of effective leadership practice have been described as highly relevant within the Early Years, as demonstrated within Siraj-Blatchford (2009, cited in Sammons, Sylva, Chan and Smees, 2010:1). Studying the current provision for leadership and management within the sample is important for understanding the practices within different centres. Different models of leadership might be explored further within the evaluation.

In order to study leadership and management within children's centres, two complementary instruments were developed by the University of Oxford⁷: a questionnaire to investigate staff perceptions and experiences, and a rating scale to assess leadership and management practices entitled the *Children's Centre Leadership and Management Rating Scale* [CCLMRS; Sylva, Chan, Good and Sammons, 2012]. The *questionnaire* had two versions that allowed for triangulation of results; the first version was for self-completion by leaders of children's centres and the second covered similar dimensions, and was completed by up to three 'key staff' from each centre. The *rating scale* was administered by a researcher through an interview with the centre manager and other members of the Senior Management Team (SMT: e.g. family support/outreach manager, children's centre teacher). Administration of the scale also involved scrutiny of existing documents as evidence of their practice. For full development of the two instruments, see Appendix D5.

4.1.1 Introducing the CCLMRS

The CCLMRS is an interview and document-based assessment that measures the quality of management-level practices within a children's centre, as evidenced by documentation and interview. The scale is administered by a trained researcher who rates the centre using a set of statements (or indicators) which form an incline of quality. The CCLMRS consists of 20 items, grouped under five domains of quality (or subscales as detailed in Figure D1.1, Appendix D1). Items are rated on a 6-point scale from '0=*Inadequate*' to '1=*Adequate*' to '3=*Good*' to '5=*Outstanding*'. For further information on the implementation of the scale and variety of literature that might be reviewed as part of the process, see Figure D1.1 in Appendix D1. Whilst the CCLMRS was validated through expert review and research into relevant literature and policy, it is important to note that the scale has not yet been validated

⁶ Leithwood, Day, Sammons, Harris, and Hopkins, 2006a and 2006b; Leithwood, Louis, Anderson, and Wahlstrom, 2004; Day, Sammons, Hopkins, Harris, Leithwood, Gu, Brown, Ahtaridou & Kington 2009; Sylva, Melhuish, Sammons, Siraj-Blatchford, and Taggart, 2004.

⁷ These two assessments were developed from a small-grant from the National College for Teaching and School Leadership (NCSL as they were the known) in 2010.

against other assessment instruments. Ratings should therefore only be used as a method to compare centres in terms of their leadership and management. For further information on the scale, see Sylva et al. (2012⁸).

4.2 CCLMRS findings: Children's Centre Leadership and Management Rating Scale

4.2.1 Leadership and management within the children's centre sample

The CCLMRS was developed and piloted in 2010, and reviewed once again in 2011 during a period of relative stability within children's centres. During scale development, children's centres were designated to offer a 'core' set of services (as defined in Chapter 1) and therefore a number of higher-scoring indicators were based upon serving this 'full core offer'. However, the first wave of Strand 3 fieldwork was implemented during a period of change, bringing with it uncertainty around job security and management (see Chapter 6). Centres were unlikely to score highly on different domains of leadership when managers were new in post and therefore unaware of previous centre protocols. It was also unlikely for centres to receive high scores when they were not involved in the day to day coordination of the centre.

The mean CCLMRS total score across the sample of centres was 2.2, equating to an '*adequate nearing good*' range of quality ($n=107$, $SD=0.71$), and the distribution of mean quality ratings across the sample are presented in Figure 4.1⁹. The ECCE study afforded the first use of the CCLMRS as a research tool.¹⁰ Further studies must be carried out in order to check the validity of this scale against other tools measuring similar concepts.

⁸ A fuller 22-item 'General Research' version of the CCLMRS is available from Sylva, Chan, Good and Sammons (2011a). The 20-item CCLMRS administered within ECCE was edited as a result of piloting to make the scale specifically usable for ECCE. An equivalent 'user-friendly' 22-item version was developed for the National College to be used as a professional development tool by centre managers (Sylva, Chan, Good and Sammons, 2011b).

⁹ Mean total scores for the CCLMRS are displayed in Table D3.1, Appendix D3.

¹⁰ The normally distributed scores presented in Figure 4.1 suggest that centres are scoring at both the high and lower ends of the scale, with a central tendency.

Figure 4.1. Distribution of mean quality ratings displayed for the Total CCLMRS scale

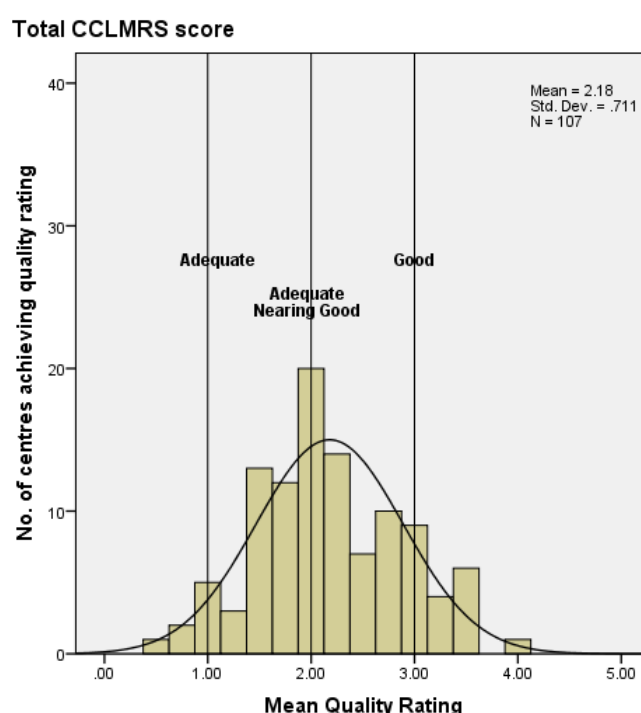


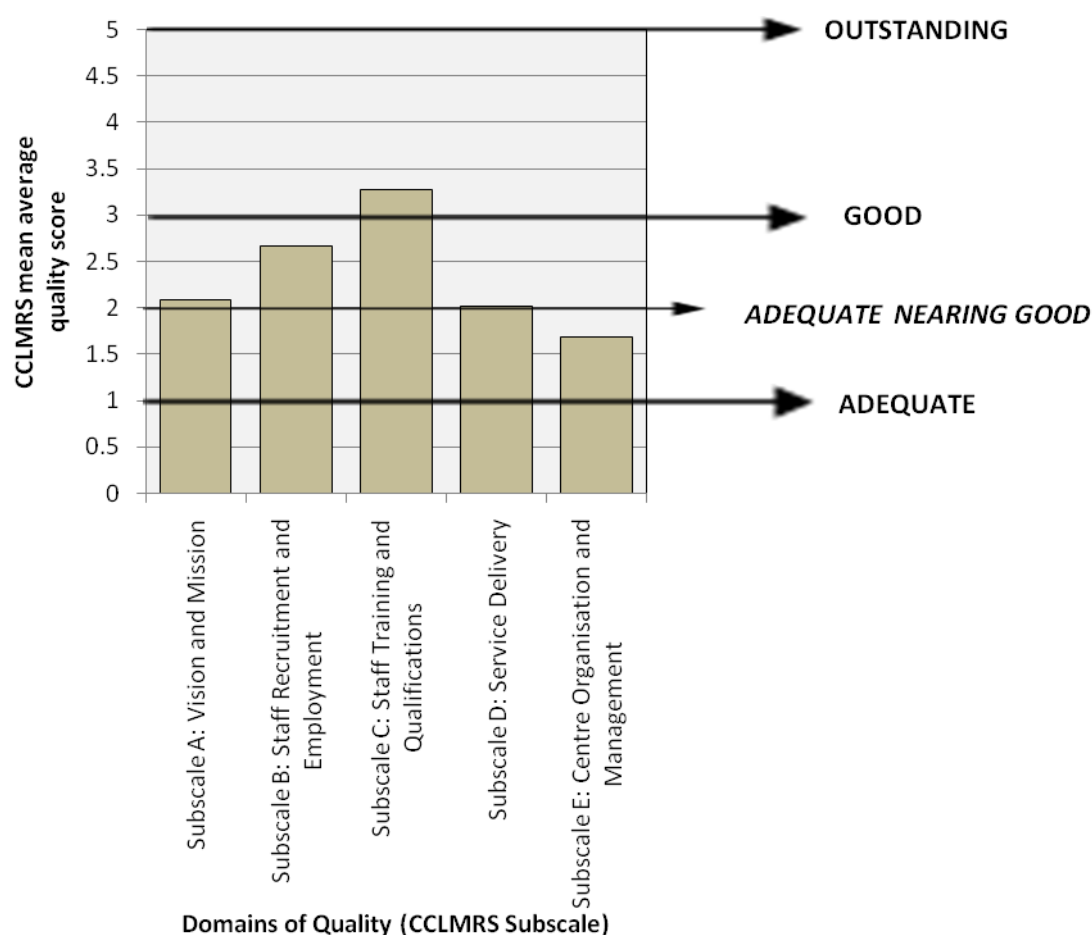
Figure 4.2 and Table D1.1, in Appendix D1 compare the mean scores across the five domains of quality (i.e. *Vision and Mission*, *Staff Recruitment and Employment*, *Staff Training and Qualifications*, *Service Delivery*, *Centre Organisation and Management*). Figure 4.2 shows how centres scored between 1.7 and 3.3 across the five domains, where a score of one is ‘adequate’, three is ‘good’ and five is ‘outstanding’. Whilst keeping in mind that the quality levels were initially relevant to centres visited during the period of development and piloting in 2010-2011, this study found that no domains of quality were rated as ‘outstanding’ or progressing towards ‘outstanding’ (i.e. a score of between 4 and 5)¹¹. *Staff Training and Qualifications* was the only domain of quality to score a rating of ‘good’ (with a score of 3 or more). Three domains of quality were scored between the ‘adequate nearing good’ range (scoring between 2 and 3): the *Vision and Mission*, *Staff Recruitment and Employment*, and *Service Delivery* items. The *Centre Organisation and Management* item was scored only ‘adequate’ (scoring between 1 and 2).

A number of reasons may explain why centres scored lowest on the *Organisation and Management* domain. Some centres reported limited control over budgeting due to centralised management at local authority level, and little or no capacity to predict future funding allocation or expenditure. Reorganisation (as discussed in Chapter 6) might also be a factor; for example lower scores on the *staff meetings and consultation* item were sometimes due to challenges involving multi-agency partners

¹¹ Whilst the CCLMRS was validated through expert review, it is important to note that the scale has not yet been validated against other assessment instruments, and therefore the incline/ levels of quality may need further research.

at meetings, and *branding and publicity* may have been due to prioritisation of tasks arising from more pressing needs (i.e. regarding restructuring and staff redeployment).

Figure 4.2. Comparison of mean quality ratings across the five domains of quality within the CCLMRS



4.2.2 Scores for individual CCLMRS subscales

This chapter will now look into more detail at the mean ratings for each of the five subscales within the CCLMRS, and reasons why particular scores were given. These analyses are important because accounting for the extent and nature of leadership and management within the sample is essential to understanding the practices within children's centres. For further information on what each of the subscales measure (and the various indicators interrogated) see Figure D1.2 in Appendix D1. Mean ratings for each item within the subscales are presented in Table D1.2, Appendix D1.

All mean values presented within these sections have been rounded to one decimal place.

The Vision and Mission subscale: Centres scored a mean rating of 2.1¹² on the *Vision and Mission* subscale (n=115, SD=0.93), which equates to a quality rating of ‘adequate nearing good’. Figure 4.3 shows the distribution of mean scores for the *Vision and Mission* subscale.

The Staff Recruitment and Employment subscale: Centres scored a mean rating of 2.7¹³ on the *Staff Recruitment and Employment* subscale, representing an ‘adequate nearing good’ score (n=115, SD=0.96). Figure 4.3 shows the distribution of scores. The bulk of this ‘adequate nearing good’ score was related to the ‘professional development of staff’ item which scored a mean of 3.7 (a rating of ‘good’: n=115, SD=1.30, see Table D1.2, Appendix D1). Informal discussions with centre managers during the visit suggested that although allocated funds for training had sometimes been altered as a result of budget changes, managers were committed to prioritising the professional development of staff through the sourcing of free or outside-funded opportunities. It was understood that further development of skills was important for continuity and succession planning, and higher scores on this domain of leadership and management confirmed this was a priority within the sample.

Figure 4.3. Distribution of mean quality ratings displayed for the *Vision and Mission* subscale and the *Staff Recruitment and Employment* subscale



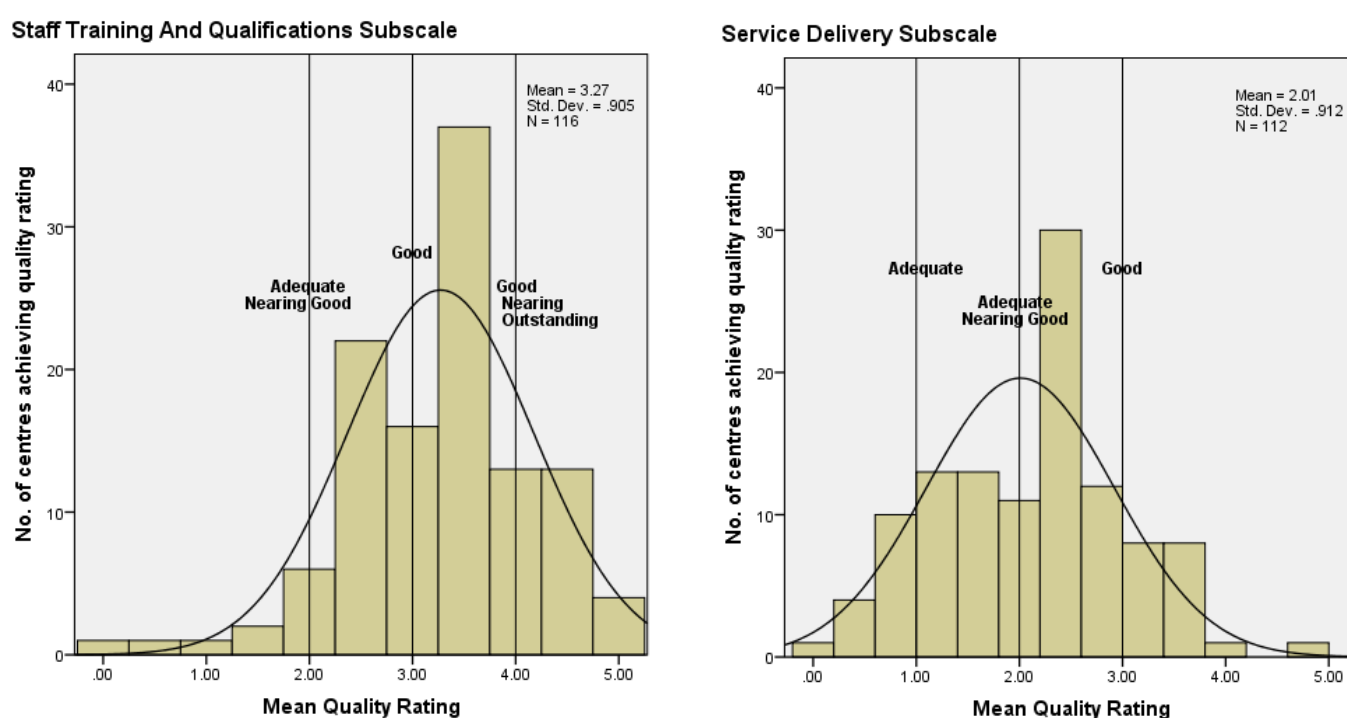
¹² For the full range of mean scores across the 115 centres providing data on the *Vision and Mission* subscale, see Table D3.2 in Appendix D3.

¹³ For the full range of mean scores across the 115 centres providing data on the *Staff Recruitment and Employment* subscale, see Table D3.3 in Appendix D3.

The Staff Training and Qualifications subscale:

This subscale was created in line with many other studies that have found staff qualifications to have a positive impact upon the quality of the setting (Sylva, Melhuish, Sammons, Siraj-Blatchford and Taggart, 2004). The mean rating for the *Staff Training and Qualifications* subscale was 3.3¹⁴ (n=116, SD=0.91). This domain of leadership and management was found to be the highest of all five domains within the sample, reflecting a ‘good’ quality score. Figure 4.4 displays the distribution of scores. The higher scores for experience and qualification showed that the staff were generally well qualified. Indicators regarding the qualifications of non-senior staff measured the prevalence of Level 3 qualifications. A number of centres noted that the minimum requirement for employment of non-senior staff was now at Level 3 grade, resulting in centres scoring maximum marks on this indicator, and thus offering a welcome explanation for why the ‘*qualifications and experience of other centre staff*’ item achieved such a high score of 4.5 (‘*good nearing outstanding*’: n=116, SD=1.01, see Table D1.2, Appendix D1).

Figure 4.4. Distribution of mean quality ratings displayed for the *Staff Training and Qualifications* subscale, and the *Service Delivery* subscale



The Service Delivery subscale: The mean score for the *Service Delivery* subscale was 2.0¹⁵ (n=112, SD=0.91), reflecting an ‘adequate nearing good’ quality score (see Figure 4.4 for the distribution of scores). Chapter 3 suggests reasons for the

¹⁴ For the full range of mean scores across the 116 centres providing data on the *Staff Training and Qualifications* subscale, see Table D3.4 in Appendix D3.

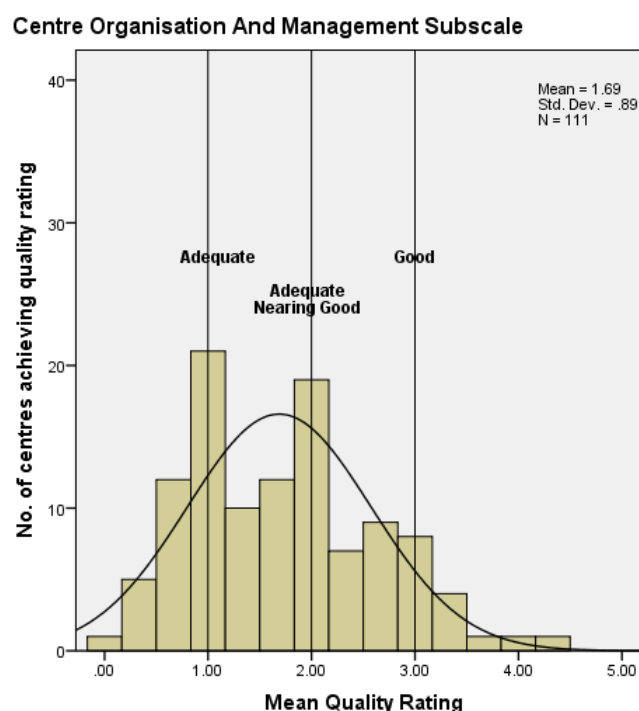
¹⁵ For the full range of mean scores across the 112 centres providing data on the *Service Delivery* subscale, see Table D3.5 in Appendix D3.

'adequate nearing good' quality score in terms of multi-agency working. The lowest scoring items within this domain of quality were *multi-agency partnerships* (mean=1.4, n=115, SD=1.2), *parent consultation and community engagement* (mean=1.6, n=115, SD=1.42) and *parenting and family support* (mean=1.9, n=114, SD=1.21), as shown in Table D1.2, Appendix D1. These scores might reflect the difficulties voiced by centre staff regarding engagement of other agencies (for example employment-related organisations). Centres reported difficulties in consulting with parents not currently involved in the centre, as they "*do not know who the non-users are*". Those centres who scored more highly on the *parent consultation* item sometimes informally discussed commissioning (or involvement with) a survey of families within the locality; or good links with health visitors and midwives carrying out new birth visits (using this opportunity to consult with potential children's centre users).

The Centre Organisation and Management subscale: The mean rating for the *Centre Organisation and Management* subscale was 1.7¹⁶ (n=111, SD=0.9), reflecting only an 'adequate' quality score. Figure 4.5 displays the range of scores. The lowest scoring item for this subscale, and indeed the whole CCLMRS scale, was *staff meetings and consultation* which scored 'inadequate' (mean=0.97, n=115, SD=1.3, full details shown in Table D1.2, Appendix D1). One of the most prominent difficulties that became evident during implementation of this subscale was the regularity of meetings specified within the scale (i.e. fortnightly). Centres working to capacity under high workload, and those employing part-time staff found it more difficult to instigate regular meeting times. Difficulties were also noted with encouraging the attendance of multi-agency partners and other children's centre deputies or managers at meetings.

¹⁶ For the full range of mean scores across the 111 centres providing data on the *Centre Organisation and Management* subscale, see Table D3.6 in Appendix D3.

Figure 4.5. Distribution of mean quality ratings displayed for the *Centre Organisation and Management* subscale



4.2.3 Reflecting on the evidence for leadership and management

As noted earlier within this chapter, the CCLMRS scale was implemented during a period of flux, and a number of the indicators which may have previously scored 'good' or 'outstanding' quality within 2010 and 2011 were no longer scoring so positively, particularly during staff reorganisation. Some newer staff may have lower scores due to being unaware of the history behind policies (for example, the mission statement), or when procedures might be updated (for example job descriptions, the structured induction process). Some centres discussed reviewing procedures less frequently than required by the scale (for example, annual review of written induction procedures; biannual review of mission statement), in order to prioritise immediately urgent tasks such as improving family outcomes and targeting disadvantaged families. Indicators requiring long-term strategic planning or reflection, and multi-agency partnerships, scored less highly within this altering landscape of children's centres due to the short term nature of funding, changes in budgets and staff reorganisation. Many children's centres found it challenging to demonstrate improvements in outcomes for families (which was a requirement for a score of 'outstanding' on the CCLMRS).

A number of the challenges faced by leaders between summer 2011 and spring 2012 (as noted by Sharp, Lord, Handscomb, Macleod, Southcott, George and Jeffes, 2012) link into issues that were faced within the ECCE project (see Chapter 6 for a further discussion on the changing landscape of children's centres). 'Remaining

positive in a period of great change' (Sharp et al., 2012:54) was listed as a challenge to leadership, which corroborates with managers who felt that their leadership was being stretched and they were having to design delivery creatively in order to continue their offer of universal provision during a time when targeted work was a prominent focus. Removal of the requirement for professionals such as Qualified Teachers or staff with Early Years Professional Status (DfE, 2010) may have made it more challenging to score highly on the *child learning* item which required high quality guidance to be supplied by relevant professionals.

A second challenge faced by centres is '*improving status and training*' (Sharp et al., 2012:54). This challenge is relevant to issues of succession planning and staff training. Budget limitations sometimes led to a reduced training capacity to all but necessary or free/outside-funded training opportunities. Senior staff who expressed a wish to take-up the National Professional Qualification in Integrated Centre Leadership (NPQICL) sometimes struggled to find funding or the time to be released from work to study.¹⁷ Conversely, higher scores on *professional development of staff* showed that centres were committed to providing '*good*' quality professional development for their staff in order to sustain their staff team and maintain expectations of a changing service.

A third challenge listed by Sharp et al. (2012:55) is '*ensuring positive impact and improved outcomes*'. Ofsted inspections requiring evidence of a positive improvement in outcomes has led to insecurities over how to demonstrate results with families, and turn data into meaningful information in order to aid improvements in delivery. Some managers reported difficulties in finding ways to document particular outcomes (despite having access to case studies and data), and managers embraced the use of varied data collection tools to monitor elements of their family work (including wider use of standardised tools used in evidence-based programmes, and learning journeys for individual children to highlight progress against the Early Years Foundation Stage [EYFS]). The CCLMRS item *achieving positive outcomes* was particularly challenging in this regard, with centres scoring a mean average of 2.22.

The CCLMRS was developed and piloted during a period when children's centres were tasked to offer a multitude of services and coordinate the delivery of these with a number of agencies sharing the same vision. This fieldwork afforded the opportunity to trial the rating scale within a large number of real settings. However, fieldwork occurred during a period of great change which caused difficulties for implementation the scale. Whilst the centres visited were 'established' given their

¹⁷ Intention to attend the NPQICL course for senior staff was a prerequisite for scoring highly on the *qualifications and experience of senior staff* item (as mentioned as a recommendation in prior Sure Start Practice Guidance): however this more difficult indicator limited the ability for centres to achieve outstanding (centres achieved a mean average score of 2.01 for this item).

sampling from Phase 1 and Phase 2 children's centres (see Chapter 2 for further details); the extent of reorganisation and flux, and reduction in funding or changes to other agencies has meant that some of the previously strong links to multi-agency partners have been weakened. This has made it less likely for the centres to score highly on management items that rely on strong multi-agency links. Whilst variation clearly exists across the sample in terms of current management and leadership practices, future revisions of the scale might benefit from a reassessment of the quality ratings to ensure a greater spread of scores across the sample.

4.3 Leadership Questionnaire findings

In addition to the development of a quality rating scale (see Section 4.1), the first wave of Strand 3 fieldwork also studied centre leadership and management using a questionnaire that assessed the quality and effectiveness of leadership in children's centres from the perspective of managers and key centre staff. For further information on the development of the questionnaire, see Appendix D5.

The structure of the questionnaire

The questionnaire was developed as two coordinated versions: one to be completed by centre managers, and one to be completed by key staff. The centre manager version contained 17 areas that were grouped under five sections. Two types of question were responded to on a six-point scale (with a few exceptions, see Figure D2.1, Appendix D2): either extent of agreement with the statement (*Disagree strongly-Agree strongly*), or existence of a practice/activity within the centre (*Not at all – A great deal*). Where possible, the key staff version of the questionnaire contained questions that were adapted from the version designed for centre managers. Full details of the leadership questionnaire content can be found in Figure D2.1, Appendix D2.

4.3.1 Perspectives on centre management from centre managers and key staff

In total, 108 centre managers and 267 key staff from 121 children's centres returned information on the leadership questionnaire. Both centre managers and key staff were very positive in their replies to a number of aspects of leadership and management, especially on the broad *vision and purpose* section, as well as on the more specific *leadership style* area. For example, approximately 90 per cent of respondents strongly agreed that *children and parents felt safe* in their children's centre; *were treated equally and fairly*; and there was the suggestion that safeguarding procedures were in place and that these were understood by staff¹⁸. More than 90 per cent of the centre managers suggested they were ready to learn

¹⁸ Implied from the question, "Children and parents/carers feel safe in our centre".

from (and alongside) others and placed high value on building trust-based relationships with staff and families¹⁹. Table D4.1 in Appendix D4 presents the leadership questions to which 90 per cent or more of the managers responded in a strongly positive fashion.

However, managers were not consistently positive across all of their replies to the questionnaire. In particular, over three quarters of centre managers reported issues around administration and income. For example, 78 per cent of managers found it difficult to balance administration duties and leadership (responses: 'slightly', 'moderately', and 'strongly' agree), while just under half found it difficult to make unpopular decisions. Additionally, more than half disagreed with the statement that *'staff posed little problem to the running of the centre'*.

It was not just issues with administration and income that the managers and key staff noted to be potentially problematic. For example, four out of ten managers felt that there was room for more development of: multi-agency work, training, and the pursuit of funding²⁰. Furthermore, both half of the centre managers and half of the key staff agreed that it was *'difficult to improve outcomes for the neediest children and families'* (responses: 'slightly', 'moderately', and 'strongly' agree) and that *'staff needed more training to improve support for 'at-risk' children and families'*. Table D4.2 in Appendix D4 presents these less positive views of centre managers on children's centre leadership. Moreover, distributed leadership was not found to be universally implemented across all 121 of the sampled children's centres. In particular, there was again agreement between managers and key staff, whereby four out of ten managers and key staff reported centre staff to have a *'limited role in decision-making'* and two-thirds of both managers and key staff also noted that centre staff had a limited role in *'budget decisions'*. Parent and community involvement was an area that was also limited for many centres (see Table D4.3 in Appendix D4). For example, nearly two thirds of centre managers agreed that parents/carers had *'too little involvement in the day to day provision of services'*, and half agreed there were *'too few opportunities to take on paid work'*.

4.3.2 Developing factors to measure children's centre leadership

A large volume of questions were asked within the manager and key staff questionnaire to assess as broad a range of leadership practices as accurately and consistently as possible (see Figure D2.1 in Appendix D2). However, although the broad range of information provided both breadth and depth to the understanding of leadership within children's centres, in its original form (with a high degree of detail) it was unsuitable for future analyses (including the Impact analyses which will take place in Strand 4). It was therefore important to ascertain a smaller number of

¹⁹ Implied from the questions, *"I place high value on building trust-based relationships with staff and families"* and, *"I am ready to learn from (and alongside) others"*.

²⁰ Implied from the question, *"The multi-agency focus & partnership-working within our centre needs further development"*.

measures that accurately captured the core elements of the assessed leadership practices. This section documents the derivation of these measures. An exploratory investigation was carried out to determine whether fewer measures could be constructed that accurately represented the information within the leadership questionnaires using two statistical procedures; Exploratory and Confirmatory Factor Analyses (EFA/CFA). These statistical procedures suggested that it was possible to accurately represent the information gathered through the leadership questionnaires with fewer measures (termed ‘factors’). This conclusion was reached through a combined analysis of the data from both the centre manager and key staff questionnaires as they shared the majority of their *items*, *areas*, and *sections*²¹.

Subsequently discussed in turn, four separate series of factor analyses were carried out that together identified 17 factors of leadership. The four separate series of factor analyses each looked at a different ‘aspect’ of leadership:

- Collaboration and integration of services,
- Monitoring, use of data, and CPD within the centre,
- Vision and purpose,
- Distributed leadership, SMT leadership, valuing staff and staff involvement.

1. Collaboration and integration of services

Centre managers and key staff responded to a number of questions/items that were related to a centre’s integration of services, as well as their collaboration with external stakeholders and partner agencies. A factor analysis of these questions identified five robust factors²² and these are shown in Table D4.5 in Appendix D4, along with associated questions/items. When these factors were operationalised as mean scores (see Table D4.6 in Appendix D4), centre managers and key staff were found to be most positive about the extent of *parent/community engagement* and least positive about *integrated & multi-agency working* and *partner agency communication*.

2. Monitoring, use of data and Continuing Professional Development within the centre

Centre managers and key staff were asked a number of questions that were related to the monitoring of services, the use of data, and CPD. A factor analysis of these

²¹ However, the responses of centre managers did not closely match those of key staff. The strongest associations are shown in Table D2.1 in Appendix D2, were only medium in terms of effect size, and concerned: *collaborating with local childminders* ($r=0.46$, $p<0.001$); *collaborating with local primary schools* ($r=0.40$, $p<0.001$); and *observing interactions* ($r=0.40$, $p<0.001$). Conversely, the lowest level of agreement arose for items related to CPD and the extent to which children’s centres *worked with partner agencies*.

²² Labelled: Collaborative working; Integrated and multi-agency working; Partner agency cohesion; Partner agency communication; Parent/community engagement.

questions identified five robust factors²³ and these are shown in Table D4.7 in Appendix D4 along with associated questions/items. When these factors were operationalised as mean scores (see Table D4.8 in Appendix D), *Continuing Professional Development* was found to be scored highly for both centre managers and key staff - although key staff were less positive about CPD than managers. *Use of data*, although again scoring highly, was also reported less positively by key staff than by centre managers. However, while CPD and the use of data were scored more highly by centre managers than key staff, the opposite was true when it came to assessment of a *manager's ability to ensure value for money* ('monitoring value for money' factor). For this factor, key staff rated centre managers more highly than centre managers did of themselves. Finally, *monitoring through observation* was the lowest scored of all five of the factors, and this was the case for both centre managers and key staff.

3. Vision and purpose

The third aspect of leadership that was explored through factor analysis concerned *vision and purpose*. For this aspect of leadership, centre managers and key staff were asked a number of questions that formed three factors²⁴ (see Table D4.9 in Appendix D4). When these factors were operationalised as mean scores (see Table D4.10 in Appendix D4) centre managers were found to be more positive about the *vision and standards* of their centre and its *level of safeguarding* than key staff. However, the responses from both managers and key staff were extremely favourable for all three of the *vision and purpose* factors. For example, nine out of ten centre managers strongly agreed that children and families felt safe in the children's centre, and a similar proportion also felt that staff were well-trained to implement safeguarding/child protection procedures.

4. Distributed leadership and staff inclusion in decision making

The fourth and last aspect of leadership that was explored through factor analysis techniques concerned the degree of *distributed leadership* (including SMT leadership) and aspects of *staff inclusion in decision making* within the centre. For this aspect of leadership, centre managers and key staff were asked a number of questions that formed the four factors²⁵ that are shown in Table D4.11 in Appendix D4. When these factors were operationalised as mean scores (see Table D4.12 in Appendix D4) centre managers and key staff were found to be most positive about the extent to which staff *were valued* and the level of Senior Management/Senior Leadership Team (SMT/SLT) *delegation of leadership*. Conversely, both centre managers and key staff rated a centre's *distributed leadership* and *staff involvement*

²³ Labelled: Use of data; Continuing Professional Development; Monitoring and evaluation activities; Monitoring through observation; Monitoring value for money.

²⁴ Labelled: Vision and standards; Safeguarding; Focus on learning.

²⁵ Labelled: Valuing staff; Distributed leadership; Senior Management Team/leadership delegation; Staff involvement in decision-making.

in decision making more poorly. One possible reason for the disparity between how managers and key staff rated these two sets of factors concerns the delegation of decision making powers within the centre. Both the *distributed leadership* and the *staff involvement in decision-making* factors contained questions that have more to do with the delegation of power than do the factors measuring the extent to which *staff are valued* and the degree of *SMT/SLT leadership delegation*.

4.4 Relating the quality of leadership and management to the characteristics of managers and children's centres

The final part of this chapter considers whether statistically significant relationships were evident between the leadership of children's centres and both the characteristics of centres and of their managers. These analyses are reported to meet one of the ECCE (Strand 3) objectives to 'identify the extent of variation in leadership and management'. To this end, the leadership measures that have been documented in this chapter (both the CCLMRS and the questionnaire) were examined in relation to a number of background measures – the majority of which were also obtained during this fieldwork. The relationship between centre leadership and the characteristics of managers are considered first (in Section 4.4.1), before moving on to the characteristics of centres (in Section 4.4.2). Four characteristics of managers are considered: their gender, their age, their qualifications (both academic, and those directly related to leadership), and the length of time that they have held their managerial position. Three characteristics of centres are considered: withdrawal of resources and reduction of services, the level of staff absence over the preceding 12 month period, and which 'Typology of Provision'²⁶ a centre belonged to.

4.4.1 Characteristics of centre managers

Gender and age of the centre manager

Almost no differences between male and female managers were identified in terms of their leadership. The only significant gender difference noted out of the 17 factors that were identified within the leadership questionnaire, was that female managers responded significantly more positively than male managers for *safeguarding*, and this was a medium sized effect ($r=0.32$; $p=0.001$). However, this conclusion needs to be treated with caution as there were only eight male managers (out of a sample of 121). There were no significant differences found between male and female managers on the five CCLMRS subscales²⁷.

²⁶ The "Typologies of Provision" were developed as part of, and are described within, the ECCE baseline Strand 1 Report (Tanner et al., 2012).

²⁷ The five CCLMRS subscales are titled, 'Vision and Mission'; 'Staff Recruitment and Employment'; 'Staff Training and Qualifications'; 'Service Delivery'; and, 'Centre Organisation and Management'.

Considering the age of the centre managers and how this was related to centre leadership, individuals were grouped into three categories: *40 years or below*, *41-50 years old*, and *over 50 years old*. When assessing the age of manager against the 17 factors identified from the leadership questionnaire, managers who were older than 40 were significantly more likely to report higher levels of *CPD*²⁸, stronger *vision and standards*²⁹, and higher scores for *valuing staff*³⁰ than younger managers (i.e. those under 40). Table D4.13 in Appendix D4 presents the mean differences between the age-groupings on these factors of leadership as self-reported by managers. Using a 1-6 scale, managers aged under 40 scored at least 0.3 points lower on average on the *CPD* and *valuing staff* factors, and at least 0.15 points lower on average on *the visions and standards* factor (again: see Table D4.13 in Appendix D4). In addition, the key staff within centres that were run by older managers were also more likely to report significantly higher levels of *safeguarding* than those with a younger manager³¹. Finally, of the five CCLMRS subscales, higher scores for the *Staff Training and Qualifications* domain were found for centres that were run by the oldest grouping of centre managers (51 years old and above)³².

Highest qualification level of the centre manager

Two qualifications of centre manager were considered: their highest academic qualification, and their highest qualification as related to leadership³³. These were considered in relationship to the 17 questionnaire factors and the five CCLMRS subscales. The majority of centre managers were found to hold higher rather than lower levels of qualifications. For example, three quarters of centre managers held academic qualifications of *degree level or higher* ($n=83$, 77%) while a similar proportion (78%) also held the highest level of leadership qualification (National Professional Qualification for Integrated Centre Leadership [NPQICL], National Professional Qualification for Headship [NPQH], or a Masters in a related subject). Table D4.14 in Appendix D4 presents the levels of qualification that were reported by the managers of children's centres in full detail.

No significant associations were found between the managers' level of academic qualification and the factors from their self-reported leadership questionnaires. That said, the key staff from centres which were run by managers who held higher academic qualifications were significantly more likely to report stronger centre *vision and standards*³⁴. This was however the only statistically significant difference between either of the two leadership questionnaires (for managers and key staff) and

²⁸ A medium sized effect; $\eta^2 = 0.099$, $p=0.004$

²⁹ A small sized effect; $\eta^2 = 0.058$, $p=0.045$

³⁰ A medium sized effect; $\eta^2 = 0.073$, $p=0.020$

³¹ A medium sized effect; $\eta^2 = 0.100$, $p=0.005$

³² A medium sized effect; $\eta^2 = 0.092$, $p=0.008$

³³ Which captured qualifications including the National College's National Professional Qualification for Integrated Centre Leadership (NPQICL), and the National Professional Qualification for Headship (NPQH).

³⁴ A medium sized effect, $\eta^2 = 0.064$, $p=0.035$

the academic qualifications of centre managers. Regarding associations with the CCLMRS, the level of centre manager academic qualification was significantly related only to the *Staff Training and Qualifications* subscale, with more qualified managers scoring higher³⁵. This finding should be interpreted with caution however, as this CCLMRS subscale is directly informed by the centre manager's qualifications. Overall, there was little evidence that the academic qualifications of centre managers were related to the aspects of centre leadership described in this chapter.

Centre managers with higher academic qualifications were *not* more likely to hold higher leadership qualifications; the two types of qualifications were unrelated. Key staff rated managers with higher leadership qualifications as significantly better at two of the 17 questionnaire factors: *safeguarding*³⁶ and *SMT leadership delegation*³⁷. There was also a tendency for centre managers who held higher leadership qualifications to self-report higher *vision and standards*³⁸. When considering the five CCLMRS subscales, higher leadership qualifications were unrelated to any subscale score.

Length of time in post

Approximately a third of the centre managers who completed the leadership questionnaire had been managing the centre for *less than three years* (37%), a third *between three and five years* (33%), and a slightly smaller proportion for *five years or more* (30%). Of the 17 factors that were identified within the leadership questionnaires, only manager views on *monitoring value for money* differed significantly according to the manager's time in post³⁹. Centre managers in the middle group (managing for three to five years) reported the highest scores whereas those who had been managing for the shortest period (less than three years) reported the lowest. There was, however, an additional tendency for managers who had been in post for three to five years to report greater *partner agency communication* than managers who had been in post for less than three years⁴⁰. This tendency was also apparent in the views of the key staff. Again, managers who had been in post for three to five years (rather than less than three) worked in centres where key staff reported higher levels of *integration*⁴¹, *monitoring through observation*⁴², and *monitoring and evaluation activities*⁴³. There was also a tendency for the *Service Delivery* subscale on the CCLMRS to be rated as poorer in centres where the manager had been in post five or more years⁴⁴.

³⁵ A medium sized effect, $\eta^2 = 0.071$, $p = 0.024$

³⁶ A small sized effect, $r = 0.19$, $p = 0.048$

³⁷ A small sized effect, $r = 0.22$, $p = 0.026$

³⁸ A small sized effect, $r = 0.17$, $p = 0.085$

³⁹ A medium sized effect, $\eta^2 = 0.093$, $p = 0.008$

⁴⁰ A small sized effect, $\eta^2 = 0.051$, $p = 0.078$

⁴¹ A small sized effect, $\eta^2 = 0.050$, $p = 0.089$

⁴² A small sized effect, $\eta^2 = 0.056$, $p = 0.060$

⁴³ A small sized effect, $\eta^2 = 0.054$, $p = 0.073$

⁴⁴ A small sized effect, $\eta^2 = 0.051$, $p = 0.081$

4.4.2 Centre characteristics

Withdrawal of resources and reduction of services

When considering those centres scoring low on the *Centre Organisation and Management* CCLMRS subscale, a statistically significant but small relationship was found between scores on the CCLMRS and a researcher-created measure on resource and service changes between 2011 and 2012⁴⁵ ($r=-0.24$; $p=0.03$). This indicates that, on average in the 2011/12 financial year, the lower a centre's organisation and management score, the more likely they were to be in centres where resources had been withdrawn and services reduced.

Staff absence

The level of staff absence in the last 12 months was reported by centre managers as *high* in five centres (5%), *average* in a further 36 (37%) and *low* in the remaining 56 centres (58%) that provided this information⁴⁶. Combining *high* and *average* absence, due to small numbers in the highest group ($n=5$), staff absence was found to be significantly related to only one of the five CCLMRS subscales: *Organisation and Management*. Where there was greater *Organisation and Management*, there was a small but significant tendency for less staff absence ($r=-0.21$, $p=0.04$).

Considering next the 17 factors that were identified from the leadership questionnaires (one completed by managers, the other key staff), 11 of these were found to be significantly related to rates of staff absence. Table D4.15 in Appendix D4 presents the associated mean differences that were obtained after comparing centres with average/high versus low staff absence. When a centre was characterised by higher staff absence rates (high/average), both centre managers and key staff were more negative about *CPD opportunities*⁴⁷, the *vision and standards* of the centre⁴⁸, *valuing staff*⁴⁹, and *distributed leadership*⁵⁰. Additionally, key staff from centres with higher absence rates also reported poorer *collaboration*⁵¹ and *integration*⁵², whereas managers reported lower levels of *data use*⁵³, *monitoring and evaluation activities*⁵⁴, *focus on learning*⁵⁵, *monitoring value for money* and *monitoring through observation*⁵⁶.

⁴⁵ A 0-7 measure of the extent to which centres reported withdrawn resources and services in 2011/12 was created from seven yes/no questions concerning funding changes (listed in Chapter 3, Section 3.4.5). This measure was then statistically compared to the CCLMRS subscale of *Centre Organisation and Management* to determine whether the level of centre organisation was related to the magnitude of resource withdrawal and service reduction.

⁴⁶ Eleven centre managers did not respond to this question.

⁴⁷ managers: medium size effect, $r=0.30$, $p=0.003$; key staff: small size effect, $r=0.22$, $p=0.033$

⁴⁸ managers: small size effect, $r=0.27$, $p=0.007$; key staff: small size effect, $r=0.20$, $p=0.051$

⁴⁹ managers: medium size effect, $r=0.37$, $p<0.001$; key staff: medium size effect, $r=0.31$, $p=0.003$

⁵⁰ managers: small size effect, $r=0.22$, $p=0.032$; key staff: small size effect, $r=0.22$, $p=0.035$

⁵¹ A small sized effect, $r=0.22$, $p=0.033$

⁵² A small sized effect, $r=0.26$, $p=0.011$

⁵³ A small sized effect, $r=0.22$, $p=0.032$

⁵⁴ A small sized effect, $r=0.21$, $p=0.041$

Centre membership of the ‘Typologies of Provision’ that were identified from baseline Strand 1 data

The baseline Strand 1 report (Tanner et al., 2012) included an exploratory statistical analysis of nine characteristics of 492 children’s centres which captured key aspects of a centre’s management and leadership, user take-up, provision of services, and form and structure. The exploratory procedure suggested that four ‘typologies’ were apparent within the sample of children’s centres⁵⁷. The key characteristics that distinguished the four typologies were (in matching numerical order):

- Centres with managers who lead multiple centres
- Centres that use other regular venues (those not owned or managed by the centre)
- Main-site centres with single-lead centre managers
- Centres that use satellite sites (those owned or managed by the centre)

Only two of the 17 factors of leadership identified from the leadership questionnaire were found to differ significantly across the four typologies. *Monitoring through observation* (as rated by both managers and key staff) was found to vary significantly⁵⁸ between typologies, with centres characterised as ‘Main-site setups with single-lead centre managers’ being rated the highest out of the four typologies. Interestingly, this typology also scored the highest on the children’s centre’s ‘focus on learning’ (as self-reported by managers), with the difference between the typologies verging on statistical significance⁵⁹. The differences between the four typologies on these leadership factors are documented in Table D4.16 in Appendix D4.

Only two of the five CCLMRS subscales varied significantly across the four typologies. The *Training and Qualifications subscale* was highest in centres characterised as ‘Main-site setups with single-lead centre managers’⁶⁰, as was the *Centre Organisation and Management subscale*⁶¹. The means underlying these statistically significant differences are presented in Table D4.17 in Appendix D4.

Since the typology of provision distinguished as ‘Main-sites with single-lead centre managers’ scored significantly higher when considering centre leadership via both the 17 factors and the five CCLMRS subscales, this suggests that managers of

⁵⁵ A small sized effect, $r=0.21$, $p=0.047$

⁵⁶ Although the relationship between the staff absence rates of a children’s centre and the leadership factors of *monitoring value for money* (small size effect, $r=0.19$, $p=0.059$) and *monitoring through observation* (small size effect, $r=0.18$, $p=0.079$) just failed to reach the minimum acceptable 95% significance threshold.

⁵⁷ For more information and a fuller description of these typologies, see the Strand 1 Report, Tanner et al. (2012).

⁵⁸ No overall effect size available; managers: $p=0.022$; key staff: $p=0.030$

⁵⁹ No overall effect size available; managers: $p=0.051$

⁶⁰ No overall effect size available; $p=0.013$

⁶¹ No overall effect size available; $p=0.054$

these centres were scoring significantly higher in terms of their centre leadership. However, the exact reason for this difference is a question for future research. It could be that the managers of such centres have an easier task when it comes to providing appropriate and effective leadership (no satellite sites or other regular venues, and just one centre to manage), but it could also be that these managers are significantly better trained and/or have greater experience.

4.5 Summary and Conclusions

Centres within this sample showed some variation across five different domains of management and leadership. Only one domain of leadership and management as measured on the *Children's Centres Leadership and Management Rating Scale (CCLMRS)* was rated on average as 'good' – this was *Staff Training and Qualifications*, demonstrating a commitment to ensuring that staff were qualified and trained to support families and children, in line with recent Government initiatives to improve qualifications of staff. The lowest scoring domain of quality was *Centre Organisation and Management*. This appeared to be the consequence of "churn" related to centre reorganisation (showing a significant relationship with centres facing the most withdrawal of resources and reduction in service), and high levels of staff deployment and turnover. With regard to improving the standards of *centre organisation and management*, it might be helpful for centre staff to use periods of change as an opportunity to develop new protocols for aligning organisational procedures, and to review current successful and ineffective practices. Centres may benefit from using evaluative tools such as the Self Evaluation Form (SEF), or the free National College for Teaching and Leadership research tools (Sylva, Good, and Sammons, 2011) as a method of supporting staff to recognise areas for improvement. It would also be helpful if centrally managed procedures (for example, the updating of centre protocols and central control over recruitment procedures) could allow some flexibility, to meet staff needs at centre level.

The responses of centre managers and key staff to the leadership questionnaire gave many pointers as to how children's centres were being led. For example, most managers reported that they encouraged their staff to share best practice, work together across services and boundaries, and felt they facilitated staff to work collaboratively. At the same time, the managers and key staff of children's centres also clearly discriminated between those aspects of centre leadership that they believed to be better functioning from those that they found to be more problematic. Those aspects of leadership that were most positively reported upon included the *vision and purpose* within which the centre operated (e.g. the valuing of trust-based relationships with staff and holding high expectations for their work), as well as the maintenance of more *mandatory* elements (in particular: safety, safeguarding, and equity). The positive aspects of leadership aside however, both managers and key

staff noted difficulties when it came to *incorporating others within the management structure* of a children's centre. This was most apparent when it came to: bringing together partner agencies, developing multi-agency work, incorporating parents within service delivery, and managers delegating leadership beyond their immediate Senior Management Team (SMT). Around half of the managers noted that they found it difficult to make unpopular decisions, and felt that some staff may pose a problem to the running of the centre. However, managers reported higher levels of Continuing Professional Development and of working with partner agencies, than their key staff did. The staff views however may be closer to the truth because Chapter 3 has shown the majority of managers reported that budget cuts were reducing professional development activities.

This chapter also investigated the relationship between the leadership and management of a children's centre and characteristics of managers or of the centres themselves. Of manager gender, qualifications (academic and professional leadership), age, and length in post, it was only the age of managers and the length of time that they had been in post which were strongly related to leadership. Qualifications (mostly degree or above) and gender (mostly female) made very little difference to leadership, as assessed through either the CCLMRS or the self-report questionnaire completed by managers and their key staff. However, managers with leadership qualifications such as the NPQICL were seen by their staff as being significantly better at SMT leadership delegation and safeguarding. Older managers were more likely to report higher levels of CPD, stronger *vision and standards*, and higher levels of *valuing staff* than their younger counterparts, while also achieving higher scores on the CCLMRS *Staff Training and Qualifications* scale. All these findings indicate that older managers are associated with better centre leadership. The relationship between a manager's time in post and leadership indicated that managers who had been in post for three to five years had their leadership style rated by key staff as more favourable than managers holding their position for either a longer or shorter period.

During periods of management reorganisation centres would benefit from recognising current leadership expertise within the SMT, and understanding that it takes time to ingrain particular concepts (for example, understanding how to monitor value for money or enhance partner agency communication). Considering variations to the leadership style within centres by the characteristics of centres themselves, increased staff absence was strongly associated with poorer leadership. Centres characterised as 'Main-site centres with single-lead centre managers' were also associated with particularly positive centre leadership as assessed by both the self-report and the externally rated CCLMRS measure. The aspects of management that were higher in single-site centres included *training and qualifications of staff* and overall *organisation and management*. Clearly the demands of managing a cluster or a multi-site centre are very great, and some managers have not yet come to terms

with them. The fieldwork documented a move away from single-site centres towards clusters and multi-sites; a move that may show the tension between the rationalisation of resources and the ease of managing them. With centres increasingly moving towards cluster models, it would be helpful to learn from current single-centre managers about what makes their leadership practices so strong. In order to retain high quality leadership, managers should ideally be in place at each site; although understandably this is a cost that centres cannot bear in the current landscape.

In summary, leadership is known to be important but academic qualifications appear not to be its key ingredient. However, training in children's centre leadership was related to two aspects of effective management: delegation of leadership across the SMT, and safeguarding practices. What mattered most for quality of leadership and management was the manager's age, and being in post for long enough to make a difference, but not so long as to get stale; more than three years of experience was 'good', but more than five was less good. Finally, staff absence was associated with low leadership quality, but it is difficult to know which comes first.

5 Evidence-Based Practice [Kathy Sylva, Jenny Goff and James Hall]

Key Findings

- Staff reported a widespread use of well-evidenced programmes (particularly *Incredible Years*, *Triple P* and *Family Nurse Partnership*). Centres also reported running a varied range of programmes not considered to be evidence-based at the time of Allen's (2011) review of evidence-based programmes (for example *Baby Massage*, *Every Child a Talker* and the *Solihull Approach*).
- The actual numbers of participants (mainly mothers) who were reached by well-evidenced programmes over the course of a year was relatively small compared with other programmes. For example, centre staff estimated that the average number of families reached by the *Incredible Years* programme was 22 per year, and for *Triple P* was 23 per year. Comparatively, staff reported reaching higher numbers of participants within other programmes such as *Baby Massage* (an average of 47 per year) and *Peers [now Parents] Early Education Partnership* (PEEP: an average of 104 per year). One potential explanation for this might be their more frequent use of open-access delivery.
- The low numbers of families participating in the three well-evidenced programmes discussed in this chapter have important implications for detecting impact. The Strand 2 user survey may not include sufficient numbers of programme participants to reliably establish the effects of these programmes.
- Well-evidenced parenting programmes can be expensive to implement (i.e. *Incredible Years* costs approximately £1600 per participating family to run). Thus it is easy to see why centres run so few of the expensive programmes and run instead (or in addition) programmes with less impressive credentials on the 'evidence' side.
- While centres showed some understanding that well-evidenced programmes (i.e. those with Randomised Control Trial evidence) should be followed 'in full', other programmes were rolled out in a more variable manner, perhaps due to resource limitations or the view that modifications would better suit local parents.
- Well-evidenced programmes were implemented with more fidelity than the 'other' programmes. Greater fidelity is known to be linked to better outcomes.
- Centre staff appear to struggle with the concept of evidence-based practice. Some gave equal weight to research evidence and personal experience, while others were confused over the importance of ensuring fidelity versus tailoring programmes to appear less demanding to families.

5.1 Introduction

5.1.1 Defining terminology

Evidence-based policy involves the implementation of *evidence-based practice*, often as an integral part of *evidence-based programmes*. Evidence-based practice originated from medicine, where Randomised Control Trials (RCT) are used to form a strong body of evidence in justification of the use of particular treatments (Metz, Espiritu and Moore, 2007). A number of definitions from differing disciplines have been put forward over the years to expand the concept of evidence-based practice beyond medicine.

A starting point is: *'Using an intervention, program or treatment that has been established as effective through scientific research according to a set of explicit criteria. These are interventions that, when consistently applied, consistently improved client outcomes'*.

(Lederman, Gómez-Kaifer, Katz, Thomlinson and Maze, 2009:23)

In order for a practice to be considered as evidence-based, the skills, techniques or strategies used should be demonstrated as effective through the use of RCTs and rigorous research, typically on more than one occasion so that the results are shown to be replicable (Lederman, Gómez-Kaifer, Katz, Thomlinson and Maze, 2009). Evidence-based practices can be evident within a number of programmes, approaches or interventions, but these can only typically be classed as an *'evidence-based programme'* if several evaluation standards have been met and replication of the programme has been successful. More specifically, the term 'programme' is commonly used to refer to *'a social intervention program, designed to alter the knowledge, skills, or behavior [sic] of the participants'* (Lederman et al., 2009:23).

5.1.2 Early intervention and the use of well-evidenced programmes

In 2011, a report written for the UK Government by the Early Intervention Review Team⁶² noted how early experiences can be important determinants of later life, including triggers for, *'crime (especially violent crime), poor examination results, higher rates of teenage pregnancy, lower rates of employment, higher rates of depression and suicide and later substance abuse'* (Allen, 2011:19). The report raised the importance of applying an intervention before life experiences can influence child wellbeing or cause problems that become resistant to change, arguing that early intervention is more cost-effective and more successful than later interventions.

⁶² Headed by Graham Allen MP.

Early intervention is important for improving social and emotional outcomes, which are more difficult to support later in life (Allen, 2011; also echoed in Heckman, 2006). Nearly half of the children who present with early-onset conduct problems (often around the ages of three and four) will progress towards serious later life issues including 'crime, violence, drug misuse and unemployment' (Scott, 2010). If early circumstances place a child's current or future wellbeing at risk, families can be referred to intervention programmes including (amongst others) those tackling mental health problems, parenting skills, child language development, domestic violence, substance abuse and parent-child emotional attachment. Lederman and colleagues (2009:22) however, argue that although *'some services help, some services are actually harmful, and some services have no effect at all'*. It is therefore vitally important to clarify which programmes are most likely to be effective in particular situations. Scott (2010) described the delivery of one particular parenting programme (*Incredible Years*) to children aged between three and eight, who had been referred to the Child and Adult Mental Health Service. The programme (delivered by trained clinicians) largely reduced child conduct problems, and showed lasting effects when re-measured one year on (Scott 2010). As a number of 'early intervention' programmes aim to reduce the likelihood of later serious life events, it is important that programmes used early are known to be effective and replicable. Programmes that are considered as evidence-based (or well-evidenced) might be considered most successful for such early intervention.

Allen's team (2011) were asked to identify the most promising early interventions that could be applied *'before the development of impairment to a child's wellbeing or at an early stage of its onset; interventions which either pre-empt the problem or tackle it before it becomes entrenched and resistant to change'* (Allen, *ibid*:67). Allen's team evaluated age-appropriate interventions (policies, programmes and practices) against four clear standards of evidence, with regards to whether they were 'best quality' or 'good enough quality' in terms of: 1) evaluation quality, 2) size of impact, 3) intervention specificity, and 4) system readiness (see Figure B4.1 in Appendix B4). This evaluation studied some of the interventions identified by Allen which are aimed towards the 0-5 age range. Using the specific criterion, Allen's team identified 19 age-appropriate interventions that were of 'good enough' quality - i.e. combining a strong evidence base with impact - to promote the development of social and emotional skills (detailed in Table 5.1). Allen described this list as containing the 'most proven' policies, programmes, or practices in terms of the standards of criteria, and gave each programme a score to reflect the level of

‘standard’, as shown in Table 5.1.⁶³ Current challenges to rolling out such well-evidenced interventions include fidelity, and the cost of training and implementation:

‘Too few innovative programmes are in a position where they can be applied more widely. Many programmes start on a relatively small scale, often trial basis, with well trained staff who understand the programme and the theory that underpins it. Providing on a larger scale is more difficult. More staff are needed and they can need high levels of training and motivation to keep the programme running with fidelity.’

(Allen, 2011:59)

Table 5.1. Early Interventions highlighted by Allen (2011) for families with children aged between 0-5

Standards of Evidence (1=highest– 3=lowest)	Interventions for <i>all children</i>		Interventions for <i>children in need</i>	
	1	Curiosity Corner -As part of ‘Success for All’ <i>Incredible Years</i> ¹ Let’s Begin with the Letter People Ready, Set, Leap! Success for All		Early Literacy and Learning <i>Incredible Years</i> ¹ Multidimensional treatment Foster Care (MTFC) <i>Nurse Family Partnership</i> (NFP) Parent Child Home Programme
	2	Bright Beginnings		Parent Child Interaction Therapy (PCIT)
	3	Al’s Pals Breakthrough to Literacy I can Problem Solve Parents as Teachers <i>Triple P</i> ¹		Brief Strategic family therapy Community Mothers Dare to be You Even Start Healthy Families America Healthy Families New York High/Scope Perry Pre-School <i>Triple P</i> ¹

¹Note: Interventions marked as italic are intended ‘for all children’ as well as ‘for children in need’.
Table derived from Allen’s groupings (2011).

This chapter explores the range and type of age-appropriate programmes, strategies or interventions which are on offer to families within the ECCE sample of centres (i.e. those families being visited as part of the Strand 2 survey of families: Maisey et al., 2012), and whether available programmes are defined as well-evidenced according to Allen’s 2011 review. The chapter then explores how particular programmes were run.

⁶³ This list of 19 programmes (dated 2011) should be considered as a ‘living list’ of programmes which can be – and should be - altered and adapted as other programmes meet the same standards of evidence.

5.2 Programmes, strategies or interventions offered by children's centres

Each children's centre was sent a short questionnaire for self-completion by a member of staff with appropriate knowledge of work with families, in order to assess the range of programmes, strategies or interventions that families receive via the centre. The questionnaire provided a list of the well-evidenced programmes mentioned in the Allen Review (2011), along with a further list of 38 other programmes, strategies or interventions that had come to the attention of the team through relevant literature, expert opinion, recommendations, or during visits to children's centres. Respondents were also given the opportunity to list additional programmes that were being used during the fieldwork period. Further details regarding the questionnaire used can be found in Appendix B2. Overall, 119 of the 121 children's centres provided details on the questionnaire.

5.2.1 Well-evidenced approaches (drawn from Allen's list, 2011)

Table 5.2 documents the 19 well-evidenced programmes listed by Allen (2011) and their implementation across 119 centres (out of the full sample of 121) that provided this information. Eleven of the nineteen listed programmes were reported by respondents as being 'currently implemented' in some form (i.e. either followed 'in full', 'substantially' followed, or inspired by/based upon). From most to least used, these were: *Incredible Years (IY)*, *Triple P*, *Family Nurse Partnership (FNP)*, *Early Literacy and Learning Model*, *Parents as Teachers*, *High/Scope Perry Pre-school*, *Success for All*, *Parent Child Home programmes*, *Breakthrough to Literacy*, *Community Mothers programme*, and *Even Start*. *I Can Problem Solve* was reported by a single centre as being 'ready to implement' (i.e. staff were trained to use the approach but not currently using it, or there were plans to start running the approach within six months).

Table 5.2 shows that only three of the well-evidenced programmes were widely-used across the sample: 1) *IY* (implemented in 41% of the centres, ready to implement in a further 9%); 2) *Triple P* (implemented in 39%, ready to implement in a further 7%); and 3) *FNP* (implemented in 24%, ready to implement in a further 2%). Overall, 70 centres were running either one or more of these top three programmes. Furthermore, two of these programmes (*Triple P* and *IY*) were also particularly likely to be run by children's centre staff (in 38 and 34 centres respectively, of those currently implementing/ ready to implement the programmes). These two programmes were also noted within the 2011 Allen Review as being used within children's centres (Allen, 2011:52). Whilst the majority of the widely used well-evidenced programmes were run by children's centre staff, a large number were also led by staff from another agency or from a separate (unrelated) children's centre.

Table 5.2. List of well-evidenced programmes as defined by Allen (2011); and their implementation within the first wave of Strand 3 fieldwork (through self-report by children's centre staff)

Programmes, strategies or interventions used with families	Level of Implementation (n; % of the 119 who provided this data) ²			Who runs these programmes? ¹ (n= those currently implementing or ready to implement)				
	Currently Implementing	Ready to implement (but not currently)	Not implementing	This children's centre staff	Staff of a linked or clustered centre	Staff employed by the cluster specifically for this purpose	Staff from another agency / unrelated cc	Other
Incredible Years (<i>Webster Stratton</i>)	49 (41.2)	11 (9.2)	59 (49.6)	34	6	3	23	4
Triple P (<i>'Positive Parenting Programme'</i>)	46 (38.7)	8 (6.7)	65 (54.6)	38	6	3	13	2
Family Nurse Partnership (<i>FNP</i>)	28 (23.5)	2 (1.7)	89 (74.8)	1	1	1	22	5
Early Literacy and Learning Model (<i>ELLM</i>)	3	0	116	0	0	0	1	1
Parents as Teachers (<i>PAT</i>)	3	0	116	1	0	0	2	0
High/Scope Perry Pre-School	2	0	117	1	0	0	0	0
Success for All programmes (Other)	2	0	117	1	0	0	1	0
Parent Child Home Programme	1	1	117	1	0	0	1	0
Breakthrough to Literacy	1	0	118	0	0	0	1	0
Community Mothers' Program	1	0	118	1	0	0	1	0
Even Start (<i>Family Literacy Program</i>)	1	0	118	0	0	0	0	0
I Can Problem Solve (<i>ICPS</i>)	0	1	118	1	0	0	0	0
Al's Pals	0	0	119	0	0	0	0	0
Brief Strategic Family Therapy Program (<i>BSFT</i>)	0	0	119	0	0	0	0	0
Bright Beginnings Early Intervention Program (<i>BBEIP</i>)	0	0	119	0	0	0	0	0
Curiosity Corner (as part of the ' <i>Success for All</i> ' programme)	0	0	119	0	0	0	0	0
DARE to be You (<i>DTBY: Decision-making; Assertiveness; Responsibility; and Esteem</i>)	0	0	119	0	0	0	0	0
Healthy Families America (<i>HFA</i>)	0	0	119	0	0	0	0	0
Healthy Families New York (<i>HFNY</i>)	0	0	119	0	0	0	0	0
Let's Begin with the Letter People (<i>Led by Abrams Learning Trends</i>)	0	0	119	0	0	0	0	0
Multidimensional Treatment Foster Care (<i>MTFC</i>)	0	0	119	0	0	0	0	0
Parent Child Interaction Therapy (<i>PCIT</i>)	0	0	119	0	0	0	0	0
Ready, Set, Leap! (<i>LeapFrog</i>)	0	0	119	0	0	0	0	0

Total n = 119 (Centres that provided data on the programmes used)

¹ Note: Multiple providers may deliver or implement a well-evidenced programme per children's centre. Not all centres provided information on who runs the programme, and thus in some cases this is left blank.

² Percentages rounded to 1dp.

The *Incredible Years* programme (IncredibleYears.com, 2012) has relatively extensive start up and running costs (e.g. training, DVD and manual purchase) and

requires intensive supervision and consultation to enable trainee group leaders to become accredited to run the programme (which at the time of writing equated to approximately £455⁶⁴). It is important to both achieve accreditation, and maintain a high level of fidelity; and informal discussions with centre staff suggested that it was financially difficult to run programmes when a crèche must also be arranged for the children. It can therefore be cost-effective for a particular team or organisation to train and purchase the materials, and then roll out the programme across a group of centres in the area (see Chapter 6 for further information on service clustering). This interpretation is consistent with Allen (2011) who notes a local authority which had taken such an approach to introducing programmes across the region.

In comparison to *Triple P* and *Incredible Years*, Table 5.2 also shows that the *Family Nurse Partnership (FNP)* programme was rarely run by children's centre staff, implemented instead by another agency or unrelated children's centre (in 22 of the centres implementing or ready to implement the programme). *FNP* is a preventative programme carried out by specially trained nurses through structured home visits to young first-time mothers, and it is therefore expected that staff from another agency (i.e. trained nurses) would carry out the majority of this work with families due to their specialist training.⁶⁵

Table B1.1 (Appendix B1) explores the nature of programme implementation in more depth for the three most used well-evidenced programmes shown in Table 5.2 (*IY*, *Triple P* and *FNP*). The questionnaire was completed via respondent self-report and therefore responses should be considered with caution. In the majority of cases the programmes were reported as being followed 'in full'⁶⁶ (i.e. 41 of the 49 centres implementing *IY*; 39 of the 46 centres implementing *Triple P* and 18 of the 28 implementing *FNP*). A much smaller number of centres reported programmes to be only 'substantially' followed (i.e. seven of the 49 implementing *IY*; five of the 46 implementing *Triple P*, and three of the 28 implementing *FNP*). A few centres reported programmes to be 'inspired or based upon' the original (i.e. only one of the 49 implementing *IY*, and two of the 28 implementing *FNP*). Informal comments from a couple of the centre staff suggested that some of the well-evidenced programmes required a longer-term commitment from the families and were quite demanding. As

⁶⁴ The fee itself is \$400, and other costs relate to preliminary consultation and equipment (IncredibleYears.com, 2012).

⁶⁵ It is important to note that *FNPs* may have been carried out in a higher percentage of centres than the 24 per cent detailed in Table 5.2, as the work is not a core feature of children's centre offer (and therefore might not have featured as part of the centre timetable). In a number of cases qualitative discussions suggested that the centre played an invaluable role in the signposting and referral of eligible young mothers to *FNP* programmes. As a mainly NHS-funded initiative, the Government has shown a commitment to covering approximately 15 to 20 per cent of the eligible population by 2015, and funding has been ringfenced. Parents are often recruited to take part in the programme prior to birth and potentially before the parents come into contact with a children's centre.

⁶⁶ It is important to remember that classification of 'implementation type' was through respondent self-report and therefore has not been validated. No verification was carried out by the researchers with regards to the actual content and roll out of the implementation.

a result, some staff informally reported curtailing courses to suit needs of the parents, or implementing ‘taster’ or ‘pre-programme’ sessions to give families an impression of the course, and to make the principles of the programme available to families who may not otherwise engage in a strict course of sessions. Table B1.1 (Appendix B1) also considers the ways in which centres reported being ready to implement a programme. In all 11 of the centres which were ready to implement the *IY* programme, staff reported that they were trained to use the programme but not currently using it. Two of these centres had plans to begin running *IY* within six months. Of the eight centres reportedly ready to implement the *Triple P* programme, seven were trained in the programme, and two were planning to start running the programme within six months. Comparatively, one of the two centres reportedly ready to implement *FNP* stated that staff were trained in the programme, and one was planning to start running the programme within six months.

5.2.2 Other named programmes, strategies or interventions used with families

This section includes information about a further list of other named programmes, strategies or interventions included in the questionnaire but not present on Allen’s (2011) list of well-evidenced programmes (Table 5.3). It is possible that some of these programmes might now be considered as using ‘evidence-based practice’, but they did not meet Allen’s robust criteria at the time of his review in 2011. A total of 35 out of the other 38 programmes listed were reported as being currently implemented and all of these (plus an additional programme that was ready to be implemented) are shown in Table 5.3. Two programmes were reported as being most used across the sample: 1) *Infant/Baby Massage* (implemented in 72% of the centres, with 2% of centres ready to implement the programme); and 2) *Every Child a Talker* (ECAT: implemented in 57% of the centres, with 4% ready to implement the programme). Children’s centre staff were reported as most commonly running both of these (68 centres running *Baby Massage*, and 46 centres running *ECAT*); followed by staff from another agency or an unrelated children’s centre (ten centres running *Baby Massage*, and eight running *ECAT*).

A further five programmes, strategies or interventions were reported as being highly used⁶⁷: the *Solihull Approach* (24% of centres currently implementing, 9% ready to implement), *Family Links* (23% of centres currently implementing, 2% ready to implement), *Early Support Programme* for disabled children (19% of centres currently implementing, 4% ready to implement), *ICAN* (18% of centres currently implementing, 3% ready to implement), and *Peers (now Parents) Early Education Partnership: PEEP* (18% of centres currently implementing, 4% ready to implement).

⁶⁷ By ‘highly used’ the authors mean that at least 20 of the 119 children’s centres in the sample were running these programmes, strategies or interventions.

Table 5.3. List of other well-known programmes, strategies or interventions (not on Allen's list) and their implementation within wave 1 of the Strand 3 fieldwork (through self-report by children's centre staff)

	Level of Implementation (n; % of the 119 who provided this data) ²			Who runs these programmes? ¹ (n= those currently implementing or ready to implement)				
	Currently Implementing	Ready to Implement (but not currently)	Not implementing	This children's centre staff	Staff of a linked or clustered centre	Staff employed by the cluster specifically for this purpose	Staff from another agency / unrelated cc	Other
'If you use any of the following programmes, strategies or interventions with families are they' ³ :								
Infant/Baby Massage	86 (72.3)	2 (1.7)	31 (26.1)	68	3	3	10	3
Every Child a Talker (ECAT)	68 (57.1)	5 (4.2)	46 (38.7)	46	2	6	8	7
Solihull Approach/Programme	28 (23.5)	11 (9.2)	80 (67.2)	22	3	1	6	5
Family Links Nurturing Programme/'Parenting Puzzle'	27 (22.7)	2 (1.7)	90 (75.6)	23	1	0	4	0
Early Support programme (for disabled children)	22 (18.5)	5 (4.2)	92 (77.3)	9	3	1	6	6
ICAN	21 (17.6)	3 (2.5)	95 (79.8)	16	3	0	6	1
Peers Early Education Partnership (PEEP: now called Parents Early Education Partnership)	21 (17.6)	5 (4.2)	93 (78.2)	19	2	1	1	1
Strengthening Families Strengthening Communities	17	3	99	7	4	2	8	1
Pregnancy Birth and Beyond	14	0	105	6	2	0	9	0
Preparation for Birth and Beyond	13	1	105	6	2	1	8	0
Parents, Early Years and Learning programme (PEAL)	11	6	102	13	0	0	0	1
Strengthening Families Program (SFP)	11	3	105	4	1	1	4	2
Wider Family Learning (WFL – funded by BIS)	11	1	108	1	2	2	3	3
Mellow parenting	10	5	104	7	0	1	5	3
Parents Involved in their Children's Learning (PICL)	10	2	107	9	0	1	1	1
Family Literacy, Language & Numeracy (FLLN)	10	0	109	1	0	3	6	0
Enhanced Triple P	9	2	108	4	2	2	2	2
Targeted Family Support (Action for Children)	9	1	109	4	0	2	1	2
Relationship support programmes	8	2	109	4	0	0	4	1
Pathways Triple P-Positive Parenting Programme	7	3	109	7	1	1	1	0
Mellow babies	6	1	112	5	0	0	2	1
Stepping Stones (Part of Triple P)	6	1	112	4	1	2	0	0
Positive Parenting – Time out for Parents	6	1	112	3	0	0	2	0
Families And Schools Together Programme (FAST)	5	0	114	3	1	1	1	0
Parents Plus Early Years Programme	4	1	114	2	0	0	1	0
Video Interactive Guidance	4	1	114	1	0	0	3	0
"Noughts to Sixes" Parenting Programme	4	4	111	1	0	0	0	1
Mellow bumps	3	2	114	3	0	0	1	0
Parents as First Teachers – Born to Learn (PAFT)	3	0	116	3	0	0	0	0
Parenting Matters	3	0	116	2	0	0	2	0
New Forest Parenting Programme	2	1	116	3	0	0	2	0
Promotional Interviewing	2	0	117	2	0	0	0	0
"Fives to Fifteens" basic Parenting Programme	1	1	117	0	0	1	0	0
4 Children, Children Centre Approach	1	0	118	0	0	0	0	0
Springboard Project	1	0	118	1	0	0	0	0
Hit the Ground Crawling	0	1	118	0	1	0	0	0

Total n = 119 (Centres that provided data on the programmes used)

¹ Note: Multiple providers may deliver or implement a programme per children's centre. Not all centres provided information on who runs the programme, and thus in some cases this is left blank.

² Percentages are rounded to 1dp.

Similarly to the highly reported *Baby Massage* and *ECAT*, children's centre staff ran the majority of each listed 'other' programme (see Table 5.3). Table B1.2 (Appendix B1) details how the top seven commonly reported 'other' programmes were implemented (i.e. *Baby Massage*, *ECAT*, *Solihull Approach*, *Family Links*, *Early Support Programme*, *ICAN*, and *PEEP*). As before, with the well-evidenced programmes drawn from Allen's list (2011), all seven other programmes were self-classified as followed 'in full' in more centres than 'substantially' followed (i.e. 76 centres reportedly carrying out *Baby Massage* noted that the programme was followed 'in full', compared with 8 reporting that it was 'substantially' followed; 34 centres reportedly carrying out *ECAT* were following this 'in full' compared with 17 centres 'substantially' following, and so on).

A larger proportion of the seven other programmes were reported as 'substantially' followed (as opposed to followed 'in full') than when considering the three highly reported well-evidenced programmes (addressed in section 5.2.1: *IY*, *Triple P* and *FNP*). This suggests that there might be more variation to the running of the other programmes discussed within this section.⁶⁸ Whilst relatively low numbers of the well-evidenced programmes were reported as being 'inspired by or based upon' the named approach, a much larger number of centres reported running programmes that were 'inspired by or based upon' some of the programmes listed here (i.e. 15 centres were running programmes 'inspired by or based upon' *ECAT*; 6 centres on *Solihull*; 2 centres on *Early Support Programme*; 4 centres on *ICAN*; and 4 centres on *PEEP*).

In addition to the two lists of programmes previously discussed, the questionnaire also asked staff to provide details of unlisted approaches which the centre delivers and believed to be either based upon some form of evidence⁶⁹ and research; or considered by staff as beneficial to families. Five of the supplementary programmes were recorded more than three times across the sample (see Table 5.4): *Freedom programme* (eight centres); *Bookstart programme/corner* (six centres); *Healthy Exercise and Nutrition for the Really Young (HENRY)*, five centres); *Speak Easy* (four centres); and *Positive Parenting*⁷⁰ (four centres).

⁶⁸ No verification was carried out by the researchers with regards to the actual content and roll out of the implementation.

⁶⁹ The definition of 'evidence' is user-defined and consequently broader than that used within Section 5.2.1.

⁷⁰ Note: It is not possible to distinguish this programme name from the Triple P (Positive Parenting Programme) due to the method of data collection used (i.e. respondent self report).

Table 5.4. Most commonly mentioned programmes that were not on ECCE lists

Other programmes, strategies or interventions that were listed as used with families	Number of centres (n)
Freedom programme	8
Bookstart programme/corner	6
HENRY (Healthy Eating and Nutrition for the Really Young)	5
Speak Easy	4
Positive Parenting	4
Pattern Changing	3
Family learning	3
Changes Programme	3
Baby Yoga	3
Steps	2
SOUL Record- Soft Outcomes Universal Learning and Family Support Package	2
Skills 4 Life	2
Share Plus	2
REAL project	2
Protective Behaviours	2
Personal Development	2
Literacy Champions/book buddies	2
Hanen	2
Handling anger/managing behaviour	2
Fab Tots	2
Cook and Eat	2
Breastfeeding support	2
Antenatal classes (could be National Childbirth Trust, NCT)	2
1,2,3, Magic	2
<i>[Plus a further 141 programmes that were each named only once]¹</i>	141

¹Note: See Table B4.1 in Appendix B4 for a non-abridged version of this table which provides full detail of all the 141 programmes that were each mentioned only once by the sample of 119 children's centres.

5.3 Differences in delivery of specifically named programmes

Aside from the questionnaire which was used to scope the range of programmes, interventions and strategies implemented across the sample, respondents were also asked to provide further detail on up to three of their most well-attended and currently implemented programmes. A '*focus programme*' selection procedure was defined, which took into account which staff were available to interview during the visit (as detailed in Appendix B2). During the interview, three scales were implemented to measure specific elements of the programme that could reflect the

rigour of ‘*programme implementation*’; ‘Feedback and Evaluation’, ‘Manual Use’, and ‘Ensuring Fidelity to Programme’⁷¹. Scores for these three scales were created using the median average, taken from a number of three-point ordinal scale questions which were scored ‘inadequate’, ‘satisfactory’ or ‘good’ (for the development of these scales, see Figure B2.1 in Appendix B2).⁷² Of the 121 children’s centres visited, 118 returned details on at least one focus programme. The broad picture of how children’s centres are, on average, approaching the delivery of programmes, interventions, and strategies with families is presented in Appendix B4.

Thirteen programmes were reported on by four or more children’s centres (see Table 5.5). This table is not reflective of the number of centres running the programme (defined in Tables 5.2 to 5.4 presented earlier), but rather of the number of centres that chose to discuss each programme in depth.

Table 5.5. Thirteen programmes most discussed in detail by centres

Programmes, strategies or interventions that were focused on during the detailed interviews¹	Number of centres (n)
Infant/Baby Massage	60
Incredible Years (Webster Stratton) ²	39
Triple P (Positive Parenting Programme) ²	35
Family Links Nurturing Programme (includes Parenting Puzzle)	21
Peers Early Education Partnership (PEEP)	14
Solihull Approach and/or groups	12
Every Child a Talker (ECAT)	11
Positive Parenting – Time out for Parents (Led by Care for the Family)	6
Family Nurse Partnership (FNP) ²	5
Mellow parenting	5
Parents, Early Years and Learning programme (PEAL)	5
Strengthening Families Strengthening Communities	5
Freedom Programme	4
[Plus 56 programmes reported on through interview by a maximum of two centres] ³	87

¹ Focus programmes were selected for discussion using the ‘*Focus Programme Selection Criteria*’ detailed in Appendix B2. ² Shaded programmes fell into the list of well-evidenced programmes defined by Allen (2011) as shown in Table 5.2. ³ See Table B4.5, Appendix B4 for a non-abridged version of this table which provides the full list of 87 ‘focus’ programmes that centres provided detail on.

⁷¹ Questions contributing to the ‘Feedback and Evaluation’ score included nature and frequency of feedback, type of evaluation, presence of formal evaluation and independent evaluation. Questions contributing to the ‘Manual Use’ score included type of documentation, use of session plans, and frequency of reference to manual. Questions contributing to the ‘Fidelity to Programme’ score included frequency of checklist use, frequency of supervision, and external fidelity checks.

⁷² The *Programme Implementation Scale* was used to rate the responses of the respondent, and scales were applied post-interview by researchers. It is important to remember that levels of implementation were developed from the research literature regarding how well-evidenced programmes are run. Levels have not been validated against other scales or quality ratings, but used here as a means to compare programmes in terms of the rigour of their implementation.

Less than one quarter of the 13 most commonly discussed programmes were well-evidenced programmes according to Allen's criteria (2011). Respondents were asked to prioritise discussion of programmes which were 'most attended' by families at the centre, thus suggesting that more parents are attending programmes not showing demonstrable success by Allen's (2011) standards.

The final part of this chapter revisits a selection of the programmes chosen as a focus for more detailed discussion with centre staff. It is important to describe the implementation of named programmes in order to assess the reasons behind why they are running, and whether they are followed with rigour. Three of the thirteen most commonly discussed programmes were well-evidenced according to Allen (2011) and are reviewed here (i.e. *Incredible Years*, *Triple P*, and *Family Nurse Partnership*). Nine of the remaining 'other' programmes were commonly discussed with centre staff, and thus those reported by the largest numbers of centres (i.e. *Baby Massage*, *Family Links* and *PEEP*) are also reviewed in detail here. This allows a comparison between the implementation of a selection of well-evidenced and other named programmes which the ECCE sample of families (Strand 2) have the opportunity to access. Appendix B3 describes the implementation of each of the six programmes, which will now be reviewed comparatively. Note that the numbers of centres reporting on particular programmes are sometimes small (i.e. between 5 and 60 centres per programme), and so some findings should be read with caution.

5.3.1 Three well-evidenced programmes

The following section discusses the self-reported implementation of three particular well-evidenced programmes as discussed with staff (within 39 centres implementing *Incredible Years*, 35 centres implementing *Triple P*, and five centres implementing *Family Nurse Partnership*). Some findings should be treated with caution due to the low numbers of centres providing information on each programme. Staff running *IY* and *Triple P* within this sample of centres reported similar characteristics in terms of how widely the programme was used (i.e. international), the programme focus (i.e. parents and children), the top three outcomes that they were working to achieve (i.e. parenting skills for behaviour, attachment between parent and child, and child social and emotional development), who was responsible for choosing the programme (i.e. local authority and children's centre staff) and reasons behind the choice. Both programmes were reported to run in a time-bound manner across weekly sessions. *IY* and *Triple P* were both reported as taking in referred families and targeting specific families for the programme, as well as using open advertising within the centre. Key differences within this sample of centres included that *IY* was more often reported as being run by a mix of organisations, and *Triple P* highly reported as run by centre staff.

Triple P appeared to be slightly more flexible across a number of domains: staff within the 35 centres reported *Triple P* as sometimes run in a one-to-one fashion and within the home (this could be expected given that one-to-one work is one particular element of the *Triple P* programme and *IY* is commonly run within group sessions). Centres also reported variability in terms of the number of times *Triple P* was run per year. *Triple P* and *IY* scored similarly in terms of the researcher-rated *programme implementation* scale. Both scored in the majority 'good' for scales measuring 'feedback and evaluation', and 'manual use', but lower on the scale measuring 'fidelity to the programme': nearly half of the centres providing information on *Triple P* and *IY* scored inadequate on 'fidelity', and nearly half scored satisfactory.⁷³

The number of centres reporting on *Family Nurse Partnership* were very small (n=5), and therefore scores on the researcher-rated *programme implementation* scale are not presented here. Whilst *Triple P* and *IY* were broadly similar in terms of their self-reported roll out and programme implementation, *FNP* presented a different pattern.⁷⁴ Staff reported *FNP* as being run through a mixture of organisations rather than solely through children's centre staff. Parental mental health was one of the two most highly reported outcomes listed for this programme (the other being attachment between parent and child), a different focus to the *IY* and *Triple P* programmes. Also in comparison, the health services featured much more prominently both within the list of persons responsible for commissioning the programme and also for the reasons behind why it was chosen. All five centres reporting on *FNP* noted running the programme at least fortnightly as a one-to-one programme in homes. *FNP* was also reported as being implemented either only once a year, or on a continuous basis. Overall, centre staff knew little about the *FNP* programme (despite its implementation across nearly one quarter of the sample); mainly because this programme was often led by health professionals.

Of the other two well-evidenced programmes discussed in detail by staff, *IY* appeared to have the strictest mode of delivery (i.e. high frequencies of leadership by outside professionals, group sessions run regularly within the centre and less variability in terms of numbers of families). *Triple P* implementation showed slightly more variability.

⁷³ 13 out of 34 centres providing data on *IY* scored *Satisfactory* on the 'Fidelity to the programme' measure. A further 13 out of 34 centres reporting on *IY* scored *Inadequate*. In comparison, 17 out of 33 centres providing data for this measure on *Triple P* scored *Satisfactory* on the 'Fidelity to the programme' measure. A further 15 out of the 33 centres reporting on *Triple P* scored *Inadequate*.

⁷⁴ Staff answering questions about *Family Nurse Partnership* were often bystanders to the actual programme (which was run by a mixture of organisations) and were therefore unlikely to have information regarding how nurses evaluated the programme, and how frequently nurses made reference to a manual. Scores for *FNP* therefore *should not* be seen as reflective of the programme as a whole.

5.3.2 Three other named programmes

This next section describes the self-reported implementation of three other named programmes which were not well-evidenced at the time of Allen's review in 2011 (*Baby Massage*, *Family Links* and *PEEP*). As in the previous section, the number of centres providing data on a few of the programmes were low (i.e. 60 centres implementing *Baby Massage*, 21 centres implementing *Family Links*, and 14 centres implementing *PEEP*) and thus some findings should be treated with caution. One can see that *Baby Massage* and *Family Links* shared a number of commonly reported characteristics. Both *Baby Massage* and *Family Links* were described as having the same breadth of use (i.e. international), target individuals (i.e. parents and children), and similar characteristics of implementation. Staff in all 60 centres reporting on *Baby Massage*, and all 21 centres reporting on *Family Links* claimed that the programmes were run in a time-bound manner; the majority of which were also run via weekly sessions and groups at the centre (although one-to-one sessions were fairly common). *PEEP* on the other hand was categorised as a 'national programme' often running on a weekly continuous basis at the children's centre. Staff reported using high levels of 'open' advertising for the programmes (i.e. 55 of 60 centres reporting on *Baby Massage*, 15 of 21 centres reporting on *Family Links*, and 13 of 14 centres reporting on *PEEP*) as well as more varied levels of targeting and referrals. It is thus of little surprise that *PEEP* reached the greatest number of families of the six programmes discussed in Section 5.3 (average of n=104 per year), perhaps due to the drop-in and continuous nature of the session. Staff may have reported reaching fewer families through *Family Links* due to running the programme in a time-bound manner, but they did report reaching a high number of fathers.

The local authority and children's centre staff were reported as being equally heavily involved in choosing *Family Links* and *PEEP* within centres, whereas *Baby Massage* was reported as being most commonly chosen by centre staff. The 21 centres running *Family Links* relied most heavily on a mix of children's centre staff and other organisations for implementation, whereas those running *Baby Massage* (n=60) and *PEEP* (n=14) more commonly ran programmes solely through children's centre staff. The three programmes were all reported to be working towards outcomes specific to each intervention, although the outcomes reported for *Family Links* were identical to those identified within *IY* and *Triple P* (i.e. parenting skills for behaviour, attachment between parent and child, and child social and emotional development).

Varied reasons were reported for why the three programmes had been chosen. Staff discussing *Baby Massage* commonly reported on its suitability to families; those running *PEEP* reported on positive outcomes in other centres, prior research suggesting a measureable impact and suitability to families; and those running *Family Links* described choosing this programme on the basis of prior research suggesting a measureable impact, and the programme having been listed as an

evidence-based programme. Staff believed all three of these were ‘evidence-based’ to some extent (i.e. staff from 30 of the 60 centres running *Baby Massage*, 17 of the 20 centres running *Family Links*, and 10 of the 14 centres running *PEEP*)⁷⁵.

However, at the time of writing none were listed as evidence-based using the criterion specified by Allen (2011). This may mean that the programmes were described as evidence-based by local authorities (for example, as a recommended programme for implementation), or it may be a belief held by staff who witness the benefits of the programme. The three ‘other’ named programmes were compared on their scores using the researcher-rated *programme implementation scale*. All three programmes scored in the majority ‘good’ on their use of a ‘manual’, however *Family Links* was the only programme to score in the majority ‘good’ on use of ‘feedback and evaluation’. None of the three programmes scored well on ‘fidelity to the programme’.

In some ways, one could suggest that the *Family Links* programme was most conceptually linked to the well-evidenced programmes discussed earlier. Staff reported *Family Links* as aiming at the same outcomes targeted by two of the well-evidenced approaches (*IY* and *Triple P*). *Family Links* also displayed the highest scores of all ‘other’ named programmes when recorded against the *programme implementation scale*, and was more commonly run by a separate organisation. All 21 centres reporting on *Family Links* discussed receiving referrals into the programme from other agencies, and following only a time-bound structure. Although *Family Links* is said to ‘*evaluate(..) well in before/after and qualitative studies*’ (Current Control Trials Limited, 2013), it is however not yet evidenced by the strong criterion set by Allen and his team (2011) nor did it display any significant differences in score changes between control and intervention groups at three or nine months, by a Randomised Control Trial (RCT: Family Links Research Team, 2011; Current Control Trials Limited, 2013). *PEEP* and *Baby Massage* worked well as open access programmes, which centre staff were able to run alone. Over half of the centres running each programme believed that their programme had been chosen due to having an evidence-base; therefore there appears to be a fundamental misunderstanding at centre level with regards to what entails a well-evidenced programme. As with the well-evidenced approaches, these other programmes also struggled to score satisfactorily on the ‘fidelity to programme’ scale, thus suggesting that the programmes were not being run according to the developers’ guidelines.

5.3.3 Comparing the six selected programmes

Family Nurse Partnership is not included in the comparison of scores on the researcher-rated *Programme Implementation* scales due to the lesser knowledge of respondents reporting on *PNP* implementation. When comparing both the well-

⁷⁵ N= number of centres providing data for this question.

evidenced programmes (*Incredible Years*, and *Triple P*) with the ‘other’ programmes (*Baby Massage*, *Family Links*, and *PEEP*) there were differences in scores on the *programme implementation scale* (see Table 5.6). Typically, the well-evidenced programmes were strongest on ‘manual use’ and ‘feedback and evaluation’. *IY* had the overall highest scores on ‘fidelity to the programme’ with 7 out of the 34 centres scoring ‘good’.

Table 5.6. Modal researcher scores on the Programme Implementation Scale, for Incredible Years, Triple P, Baby Massage, Family Links and PEEP

Programme	Modal score for <i>Feedback and Evaluation</i> (no. of centres/no. providing full data on the measure) ¹	Modal score for <i>Manual Use</i> (no. of centres/no. providing full data on the measure) ¹	Modal score for <i>Ensuring Fidelity to the Programme</i> (no. of centres/no. providing full data on the measure) ¹
Incredible Years	Good (23/39)	Good (33/34)	Satisfactory (13/34) & Inadequate (13/34)
Triple P	Good (20/35)	Good (30/33)	Satisfactory (17/33) & Inadequate (15/33)
Baby Massage	Satisfactory (36/60)	Good (45/58)	Inadequate (43/58)
Family Links	Good (20/21)	Good (21/21)	Inadequate (12/21) & Satisfactory (8/21)
PEEP	Satisfactory (9/14)	Good (10/14)	Inadequate (11/14)

¹ A score of ‘Good’=2/2. A score of ‘Satisfactory’ =1/2. A score of ‘Inadequate’= 0/2. If two scores are listed (using &), they are both similarly common.

The researcher-rated scores on the *programme implementation scale* were then compared with the staff self-reported scores on how fully the programme was being run within the centre (i.e. followed in full, substantially followed or inspired by/ based upon: Section 5.2). Table B1.3 in Appendix B1 compares the researcher-rated ‘fidelity to programme’ scores against the staff-reported scores on implementation of the programmes. For all five programmes listed, it is clear that staff beliefs of running a programme ‘in full’ are at odds with the researcher-rated scores of fidelity. For example, of the 28 centres reportedly following *IY* in full according to their answers on the self-report questionnaire, only seven were scored by researchers as ‘good’ on ‘fidelity to the programme’. Similarly, only one of the 27 centres reportedly following *Triple P* in full scored *good* on ‘fidelity to the programme’, as did only one of the 53 centres reportedly running *Baby Massage* in full; one of the 20 centres reportedly running *Family Links* in full, and none of the 11 centres reportedly running *PEEP* in full. Thus whilst centres may believe they are implementing programmes more

rigorously (by following a programme 'in full'), a far smaller number were shown to implement key features of running well-evidenced programmes with fidelity, for example, through the use of checklists, supervision, and external fidelity checks.⁷⁶

The well-evidenced programmes were more commonly run by a mix of children's centre staff and other organisations, which could suggest teams with specific training are working alongside the children's centre staff to implement the programme. The well-evidenced programmes were referring and targeting families as opposed to using general advertising, and were also more likely to be run in a time-bound manner. In contrast, the 'other' programmes were usually advertised openly within the centre (along with targeting of specific families) and particular programmes (i.e. *Baby Massage* and *PEEP*) were likely to run continuously. It is hardly surprising that the 'other' programmes were reported as reaching more families than the well-evidenced programmes within this sample. Overall however, a number of the programmes (both well-evidenced and 'other') were said to target similar outcomes. The most frequently targeted outcomes included: 'parenting skills for behaviour', 'attachment between parent and child', 'child social and emotional development' and 'parental mental health'.

Seventy centres reported that they were running at least one of the top three well-evidenced programmes in some form. Whilst the top three well-evidenced programmes were used widely across this sample, they were indeed reaching fewer families (i.e. ranging from an average of 22 and 25 families per year) than 'other' programmes which were not currently classified as well-evidenced (which ranged from an average of between 30 and 104 families per year). Recent guidance regarding Incredible Years estimates a cost of £1600 per parent, including setup costs (National Institute for Health and Clinical Excellence [NICE], 2013; Curtis, 2011)⁷⁷. If well-evidenced parenting programmes such as *IY* cost approximately £1600 per participating family to run, and centres note running approximately two groups a year (with 8-12 parents in attendance), then the maximum number of families receiving this well-evidenced service would be 24 at a cost of £38,400. This could equate to more than the salary of a full time, front line staff member, and thus it is easy to see why centres run so few of the expensive programmes and run programmes instead (or in addition) with less impressive credentials on the 'evidence' side.

⁷⁶ Tables B1.4 and B1.5 in Appendix B1 show comparative scores for the 'Manual Use' and 'Feedback and Evaluation' *Programme Implementation Scales*.

⁷⁷ This is based on 12 parents attending an IY group. Without setup costs, the fee is estimated at £1209 (Curtis, 2011).

5.4 Summary and Conclusions

Over half of the programmes assessed by Allen (2011) as ‘well-evidenced’ were implemented by children’s centres within the sample. Seventy centres were implementing one or more of the three most commonly reported well-evidenced programmes (i.e. *Incredible Years*, *Triple P* or *Family Nurse Partnership*). Other organisations and unrelated children’s centres were highly involved in the running of such programmes. A varied range of ‘other’ programmes, strategies and interventions were also implemented as part of children’s centre work. These were more often run by children’s centre staff. The most common programmes outside of Allen’s (2011) list of well-evidenced programmes were *Baby Massage* and *Every Child a Talker (ECAT)*, although the full range included other local parenting programmes, support for children with disabilities, and parental mental wellbeing. Children’s centre staff and commissioners would benefit from greater understandings of the reasons for running well-evidenced programmes (given the upfront cost and delay for outcomes). However, some staff informally reported on the benefits of offering a package of programmes (including a mixture of both well-evidenced and other programmes), which allow the most disadvantaged families to engage with the centre before taking on the more intensive evidence-based programmes.

Well-evidenced programmes were more likely to be reported as followed ‘in full’ by children’s centre staff, whereas the other named programmes (i.e. those not on Allen’s 2011 list) were often reported as only ‘substantially’ followed. This demonstrates that the well-evidenced programmes listed by Allen were thought of by staff as being implemented more rigorously when compared to other programmes. Importantly, when programmes reported by staff as followed ‘in full’ were compared with researcher-ratings on a measure of the rigour of *programme implementation*, very few scored highly on ‘fidelity to the programme.’

Six of the most common programmes were considered within this chapter: three well-evidenced programmes as defined by Allen (2011; *IY*, *Triple P*, and *FNP*), as well as three other named programmes not on Allen’s 2011 list (*Baby Massage*, *Family Links*, and *PEEP*). There were differences between the group of well-evidenced programmes and the others when compared using a researcher-rated *programme implementation scale* to measure the rigour of programme implementation. The well-evidenced programmes received higher scores on the items measuring ‘feedback and evaluation’ and ‘fidelity to the programme’. Moreover, there was greater staff understanding as to why the well-evidenced programmes were being run. Typically however, both well-evidenced and other programmes scored more highly on scales measuring ‘manual use’ and ‘feedback and evaluation’ than on the ‘fidelity to programme’, a difficulty echoed in Allen (2011). Whether or not lower fidelity is the product of customising programmes for local families (or else resource reasons) remains a question for further research. It

would be helpful to provide centre staff with greater information regarding the importance of fidelity and maintaining replicable outcomes with families. Staff might also benefit from outside support, to ensure that any programme adjustments are made for the benefits of the family, and within the specified parameters of the programme.

The three well-evidenced programmes were reported by staff as being more commonly run through a mix of children's centre staff and other organisations, and families were most commonly recruited via referrals and targeting, as opposed to general open advertising within the centre. In contrast, the three other named programmes were commonly advertised openly within the centre and likely to run continuously on a regular basis, as opposed to in a time-bound fashion with definite start and end dates. The three well-evidenced programmes reached fewer users per year than the other named programmes, most likely due to the higher training and running costs of implementing them. On the basis of this finding, it is likely that fewer users will have participated in 'well-evidenced' programmes than in 'other' programmes, making it more difficult for ECCE Impact analyses (Strand 4) to show an impact of well-evidenced programmes. The extensive costs of programme implementation and training for well-evidenced programmes might be reduced by selecting a couple of the well-evidenced programmes to run via a 'service clustering model' across the local authority (see Chapter 6 for further information on this model of working). A team of individuals could be trained and regularly assessed as meeting the required standard of programme roll out, who would be responsible for the sessions throughout the area.

Chapter 3 reported that the large majority of the centres within the sample claimed to be using 'evidence-based programmes' (n=112). However, there is serious confusion at centre level as to the standards required for effective practice. It would be beneficial if Allen's 2011 'permeable list' of well-evidenced programmes could be reviewed and updated on a regular basis, to ensure that centres and commissioners have access to the most current lists of recommended programmes. The majority of centres implemented at least one well-evidenced programme as defined by Allen (2011); these reach few users however, with a typical centre running two groups for parents each year and with eight to twelve parents attending each. Although it is tempting to conclude that centres should offer more well-evidenced programmes, there are cost implications to this. Centres often use programmes that were not classified as well-evidenced at the time of writing; some of which demonstrate a growing research base on effectiveness. Less-evidenced programmes may be helpful to engage families who then go on to participate in well-evidenced programmes, and many of these may reach large numbers of users as they are less expensive. The well-evidenced programmes attract more referrals, so are more targeted; almost all report using a manual, but few can manage to implement with full

fidelity. Evidence-based practice is a highly contentious topic, with disagreements as to whether practitioners' experiences and perceptions should be considered evidence for effectiveness, as opposed to scientific evidence from statistical evaluations.

6 Reach and Structure of Children's Centres

[Jenny Goff, George Smith and Kathy Sylva]

Key Findings

- Preliminary analysis of user postcodes showed that the majority (76%) of the sampled Phase 1 and 2 centres were physically located in the 30 per cent most deprived areas on the income deprivation measure of children, and drew the majority of their users (59%) from such areas. A small number of centres (9%) were located in less deprived areas and drew the majority of their children from similarly less deprived areas. However, they also drew nearly a third of their users (30%) from the most deprived areas.
- Most users lived very close to their centre. Thirty per cent lived less than 500 metres from their centre, 61 per cent less than 1km away, and 78 per cent less than 1.5km away.
- Qualitative information showed that the 'one-stop shop' model for delivering family and children services was being replaced by complex clustering of centres and satellite sites, with particular services being delivered by particular sites. The second wave of Strand 3 fieldwork in 2013 aims to provide quantitative data on the shift towards clustering.
- Some services were also becoming clustered across several centres, where the provision was available across different sites (either simultaneously or periodically). It is likely that this was for reasons of efficiency especially when it means that highly trained professionals can offer specialised services across a number of centres.
- During fieldwork it became apparent that reorganisation of centre structure and staffing was taking place across a number of centres. In particular, researchers noted a reduction of 'middle management' staffing posts in favour of high level management control across several sites.
- Centres appear to be moving towards a new core purpose (DfE, 2012). Researchers noticed examples of reduced universal services, increased levels of targeted acute social care work, and increased participation in multi-agency teamwork across local authorities.

6.1 The local areas served by the sampled Sure Start Children's Centres: prelude to 'reach' report in October 2013

6.1.1 Background: administrative data and 'reach'

One of the key objectives of the first two phases of the Sure Start Children's Centre programme was that they should serve areas, families and children with high social needs. To achieve this objective, centres in the first two phases of the programme were intended to concentrate on local areas that fell into the most disadvantaged 30 per cent of areas on the Income Deprivation Affecting Children Index (IDACI). IDACI is a measure of children living in households on a low income. The IDACI, which forms part of the national Index of (Multiple) Deprivation (IMD), is reliably available at the so-called Lower Level Super Output Areas (LLSOAs) that typically have populations of around 1500 people. The IDACI measure was released by Government in 2004, 2007 and most recently in 2010. It uses the most up-to-date information available at the time.

The idea of a centre's 'reach' could be interpreted as how comprehensively each centre serves areas of high social need in its locality. This requires some estimation of what area in fact each centre serves and which criteria of need each centre applies. Thus, while areas of high social need will contain *concentrations* of families and children in social need, there will be other families and children living in less disadvantaged neighbourhoods, who have high social or other needs. This issue of reach is compounded by the fact that while most children's centres have defined catchment areas, there is no obligation on families to stick to these boundaries. In many urban districts, neighbourhoods served by one centre may contain users who (choose to) attend another centre nearby: for example, Maisey et al. (2012) reported on the take-up of family services within other children's centres as well as the named centre.

The first base for assessing how well each centre serves its local area is to work out each centre's *de facto* catchment area based on the majority of its users. For this, individual user postcodes can be used. Once this area is established, then it can be tied into a very large volume of administrative data that is now available, for example at LLSOA level. Such data can also be linked to the user sample to give further contextual data on their immediate neighbourhood, and also to the centre, to provide information on its social setting.

For this Strand 3 report, the user postcode data on 14486 users/potential users gathered from the 128 centres that formed the sampling frame for Strand 2 (see Maisey et al., 2012) has been drawn upon. There are thus seven more centres in this analysis than in the rest of the Strand 3 report. All the analyses reported in this

section were also carried out on the Strand 3 sample of 121 centres. The results were virtually the same. As there were a few more centres and more users, this section draws on the results for all 128 centres.

6.1.2 Where are children's centres and their users located?

For this analysis, two sets of information have been used – the approximate home location of the users/potential users (based on the grid reference of their home postcode centroid) and the location of the centre they attended. Both sets of information can be linked to other datasets, giving more information about the nature of the immediate local area or details of the children's centre. In this initial analysis, the user postcode data supplied by the centres contained no information on whether the child attended the main centre or a satellite or clustered centre. This refinement will be taken into account in the next report (autumn 2013). If some users attended local satellites rather than the main centre, this could reduce the travel distances reported below.

Table E6.1 in Appendix E sets out the distribution by region in England for the 128 centres, their users/potential users and a benchmark distribution. This was drawn from the national Together for Children database (TfC; August 2009, now maintained by EC Harris) of just over 2000 centres in Phases 1 and 2 that were offering a full service when the research study began. Overall there is good coverage, though the North East, with only five sampled centres, is under-represented while the West Midlands, with 22 sampled centres, is over-represented. Some areas, such as London, appear to have larger than average centres and the users/potential users sampled in London make up nearly 25 per cent of the total. By contrast, the North West appears to have smaller centres and so its users/potential users are rather less well represented.

Table E6.2 in Appendix E shows the distribution by local authority type, against the national database benchmark in 2009. The spread is good overall, although London Boroughs are slightly over-represented, and other unitary authorities the reverse. Note the Merseyside and Tyne and Wear metropolitan areas that have high levels of disadvantage, have only one sampled centre each.

6.1.3 Targeting disadvantaged areas

Postcode data for centre location and users/potential users shows the distribution across types of area defined by the decile level on the IDACI measure of Income Deprivation Affecting Children. This measure was one of the key criteria for allocating Phase 1 and 2 centres. This might be met either by the *physical* location of the centre or the home locations of the users (or both). Table 6.1 shows the distribution of the 128 sampled centres on the IDACI measure. Note that higher (and

less disadvantaged) deciles 6-10 have been collapsed as they contain few centres. Note also, the IDACI 2010 measure has been used in the present analysis⁷⁸.

Table 6.1. Distribution by deciles of IDACI (IMD 2010) by local authority type: sampled centres

	Deciles of IDACI						Total
	Most Deprived 1	2	3	4	5	Least 6-10	
London Borough	13 50.0%	9 34.6%	3 11.5%	1 3.8%	0 .0%	0 .0%	26 100.0%
Other Metro District	14 36.8%	10 26.3%	4 10.5%	4 10.5%	2 5.3%	4 10.5%	38 100.0%
Other Unitary	5 20.8%	8 33.3%	4 16.7%	3 12.5%	2 8.3%	2 8.3%	24 100.0%
County	5 12.5%	9 22.5%	13 32.5%	5 12.5%	3 7.5%	5 12.5%	40 100.0%
Total	37 28.9%	36 28.1%	24 18.8%	13 10.2%	7 5.5%	11 8.6%	128 100.0%

Centres in all local authority types cluster in the most deprived three deciles of the IDACI. Overall, more than 76 per cent are physically located in these areas, rising to 96 per cent in the London Boroughs. Centres in counties have 68 per cent in the three most disadvantaged deciles. More than half (55%) of all children in the most deprived 10 per cent of areas live in households on basic means-tested benefits or a similarly low income, whereas only two per cent in the 10 per cent least deprived areas are in that position. The sampled centres are slightly more skewed towards disadvantaged areas than the overall national benchmark set of 2051 centres.

Table 6.2 gives the distribution of users/potential users in the 128 sampled centres. As would be expected, individual users/potential users show more scatter (than the centres) and are slightly less concentrated in the most deprived areas. Fifty-nine per cent overall come from the most deprived 30 per cent on the IDACI measure, rising to nearly 80 per cent in London Boroughs, but only 41 per cent in counties.

⁷⁸ IDACI 2010, IDACI 2007 and IDACI 2004 all correlate very highly at LLSOA level (above 0.92). Just three centres (of the 94 centres) located in the most disadvantaged 30 per cent of areas on the IDACI 2007 are *not* in this category in IDACI 2010 (they are in the next decile 4). In fact, overall there are three more centres (97 out of the 128 centres) in the most disadvantaged 30 per cent on IDACI 2010.

Table 6.2. Distribution by deciles of IDACI (IMD 2010) by local authority type: users/potential users

Local authority type	Deciles of IDACI						Total
	Most Deprived					Least	
	1	2	3	4	5	6-10	
London Borough	1284 37.0%	935 26.9%	545 15.7%	211 6.1%	184 5.3%	311 9.0%	3470 100.0%
Other Metro District	836 22.2%	962 25.6%	609 16.2%	407 10.8%	291 7.7%	659 17.5%	3764 100.0%
Other Unitary	508 21.2%	478 19.9%	291 12.1%	208 8.7%	351 14.6%	563 23.5%	2399 100.0%
County	375 8.3%	810 17.9%	675 14.9%	840 18.6%	317 7.0%	1508 33.3%	4525 100.0%
Total	3003 21.2%	3185 22.5%	2120 15.0%	1666 11.8%	1143 8.1%	3041 21.5%	14158 100.0%

Another way of presenting this information is to cross-tabulate centre location with user/potential user location on the IDACI measure. Table 6.3 shows the results. Centres physically located in the 10 per cent most deprived areas (in row 1 of Table 6.3) draw *most* of their users/potential users from the most highly deprived three deciles (75%). There are relatively few (11%) from the least deprived five deciles in these centres. By contrast, centres located in the less deprived areas (deciles 6-10) appear to draw rather fewer of their users/potential users from the top three most deprived deciles. The small number of centres (11 centres or 8.6% of the sample) located in the least deprived five deciles draw about 28 per cent of their users/potential users from the 30 per cent most deprived target areas, but by contrast, draw 46 per cent from areas classified as being in the least deprived five deciles. These centres may use other criteria of need to recruit their users.

Table 6.3. Distribution by deciles of IDACI (IMD 2010) by centre and users/potential users location

Centre Location on IDACI	User/Potential User Location on IDACI						Total
	Most Deprived	IDACI deciles				Least	
	1	2	3	4	5	6-10	
1 Count	1829	952	558	339	310	480	4468
Most deprived	40.9%	21.3%	12.5%	7.6%	6.9%	10.7%	100.0%
2 Count	738	1479	492	348	306	550	3913
	18.9%	37.8%	12.6%	8.9%	7.8%	14.1%	100.0%
3 Count	322	349	615	379	181	686	2532
	12.7%	13.8%	24.3%	15.0%	7.1%	27.1%	100.0%
4 Count	35	223	225	385	147	629	1644
	2.1%	13.6%	13.7%	23.4%	8.9%	38.3%	100.0%
5 Count	29	114	98	71	111	282	705
	4.1%	16.2%	13.9%	10.1%	15.7%	40.0%	100.0%
6-10 Count	50	68	132	144	88	414	896
Least Deprived	5.6%	7.6%	14.7%	16.1%	9.8%	46.2%	100.0%
Total Count	3003	3185	2120	1666	1143	3041	14158
	21.2%	22.5%	15.0%	11.8%	8.1%	21.5%	100.0%

6.1.4 Home to centre: how far do families travel?

Finally, the question of how far users/potential users travel to the centre is addressed. This may well depend on the *type* and *regularity* of use (e.g. users may travel more regularly and further for full-day childcare). The postcode data supplied has no information on type of use. But it is possible to calculate the distance from home to centre. At this point we have simply used the ‘crow flies’ distance rather than actual travel distances or travel time. The ‘crow flies’ distance will understate the actual travel distance and will ignore physical boundaries (rivers, railways etc.) but give a general idea of magnitude. ‘Crow flies’ distance is calculated on the basis of the user/potential users home postcode grid reference (in urban area very close to actual location) and the national grid reference of the children’s centre’s postcode. At this point no account has been taken of satellite centres that might reduce travel distance for some users.

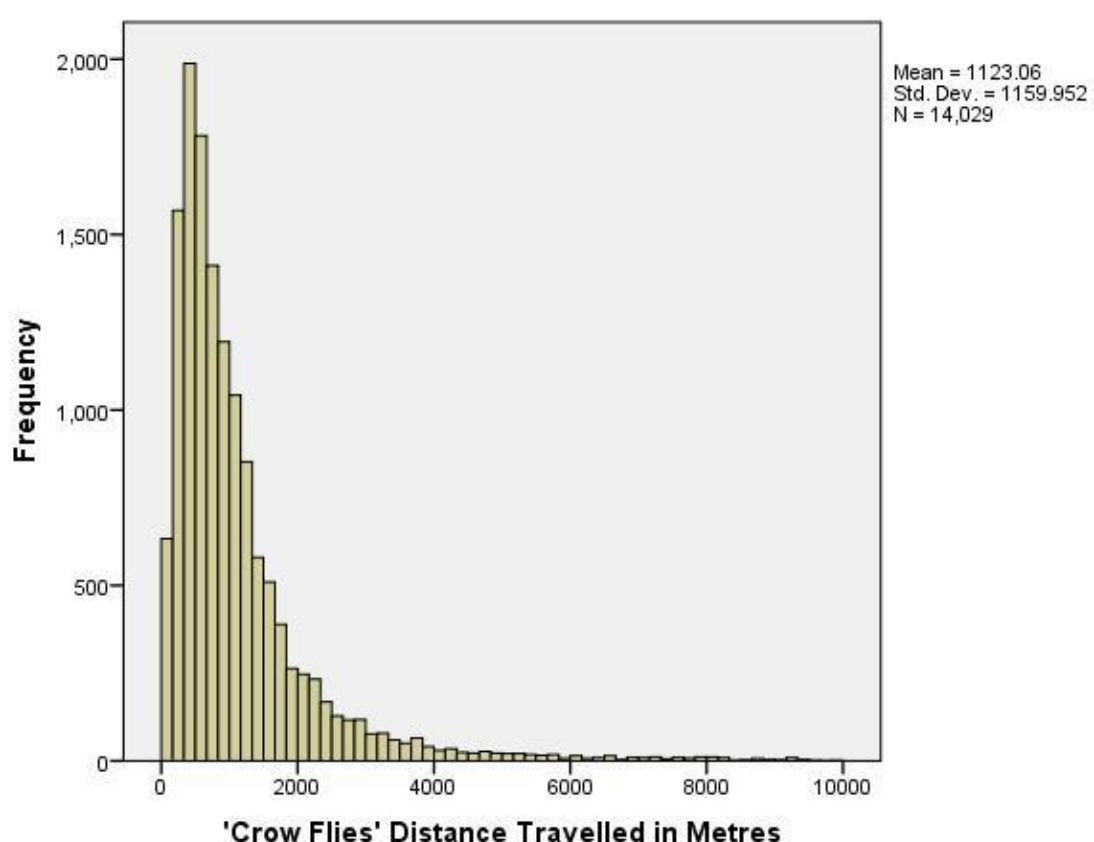
Overall, the distance travelled suggests a very compact distribution, that is, most centres’ users/potential users live nearby. The average distance travelled is just less than 1.3km and this falls to 800 metres if the more appropriate median measure is used⁷⁹. Some centres have a small number of users at a very considerable distance from the centre (a few well beyond any possible daily commuting distance). This is

⁷⁹ The median measure is less affected by unusually long and short distances and so provides a more typical value.

likely to be a result of split families, weekly commuting, grandparent care or other reasons.

Less than one per cent of users/potential users lived more than 10km from their centre (and some of these may in fact use a satellite centre). If this group of 130 cases is omitted, the remaining 14029 live on average about 1.1km from their centre (Figure 6.1). Users/potential users at 30 centres have an average travel distance of less than 800 metres.

Figure 6.1. Distribution of all users in terms of distance from their centre in metres ('crow flies' measure). Note: this excludes those living at more than 10km distance



Looking at the distance travelled by users/potential users against the level of deprivation in their home area, there is a more or less linear relationship between the average distance travelled and the level of deprivation in the home area. Users/potential users from the poorest decile on the IDACI measure, on average travel the least distance; those in the better-off deciles travel furthest. Table 6.4 shows this pattern.

Table 6.4. Mean distance in metres travelled to centre by user/potential user by home area IDACI (IMD 2010) decile

IDACI deciles of users' home location	Mean distance	N	Std. Deviation
1 Most deprived	743.27	3000	768.4
2	849.22	3178	813.9
3	929.72	2112	849.7
4	1145.07	1659	1030.4
5	1517.38	1124	1427.0
6-10 Least deprived	1779.10	2955	1564.4
Total	1123.06	14029	1160.0

Note: users/potential users more than 10km excluded.

Part of this may be explained by the nature of the areas – more deprived areas are likely to be much more densely populated. But part may be proximity to the nearest children's centre. This pattern is even more pronounced if the full data set is used (including those at more than 10km distance – though these may be affected by the effect of satellite centres). However if the effect of the physical location of the centre is examined (Table 6.5), rather than the user location (Table 6.4), there is a slightly more varied relationship between distance travelled and centre location. While users of centres in better-off areas tend to travel further, those in the least deprived deciles (6-10) only travel a little over the average distance. This suggests that there are a small number of Phase 1 and Phase 2 centres physically located in better-off areas that seem to draw a proportion of their users from the same type of better-off areas.

Table 6.5. Mean distance travelled in metres by users to centre by IDACI (IMD 2010) deciles of centre location

Centre Location on the IDACI measure in deciles	Mean distance travelled by users	N	Std. Deviation
1 Most deprived	1019.73	4456	963.1
2	968.34	3902	992.1
3	1138.75	2508	1241.3
4	1370.89	1593	1258.6
5	1894.95	678	1921.2
6-10 Least deprived	1242.72	892	1237.1
Total	1123.06	14029	1160.0

Note: users more than 10km excluded.

6.1.5 Conclusions

Data issues

- 1) This is a preliminary analysis based on postcode data collected to conduct the Strand 2 survey (Maisey et al., 2012). At the next stage of the research, further postcode data will be collected on children's centre users on which more extensive analysis will be conducted. This was deferred to avoid overloading centres and others with further data collection demands.
- 2) This exercise demonstrates that good quality postcode data can be collected from centres.
- 3) The postcode data supplied by the centres, as noted in the text, contained no information on usage. Information on usage was collected via the Strand 2 User Survey (Maisey et al., 2012).
- 4) Also lacking is any information about 'non-users' living in the neighbourhood, particularly those using other neighbouring children's centres. Without this information, testing fully the 'reach' of the centre in its locality is not really possible. This issue will be addressed in the next stage of analysis.

Data coverage

- 1) The overall distribution of centres in terms of region and local authority area type gives reasonable coverage of all types of areas, though two regions and some districts appear to be under-represented, judged against a national benchmark group of Phase 1 and 2 centres.

Targeting the disadvantaged

- 1) In terms of targeting, the actual *location* of centres was predominantly (76%) in areas in the most disadvantaged three deciles of the IDACI measure of child income deprivation, though there were a few centres in less disadvantaged areas. The IDACI measure was one of the main criteria for allocating children's centres in early phases of the programme.
- 2) The majority (59%) of users/potential users also came from the most deprived three deciles on the IDACI measure, but there were some users from better-off areas – nearly 22 per cent of users were from less deprived areas (IDACI deciles 6-10). A few centres located in less deprived areas seemed largely to serve populations that were also not from disadvantaged areas (though they may serve other categories of children in need).
- 3) Centres physically located in the most disadvantaged areas (IDACI decile 1) were predominantly (75%) likely to serve users from the 30 per cent most deprived areas on the IDACI measure.

Home to centre distances

- 1) In terms of distance travelled, most users lived quite close to their centres – particularly those living in highly disadvantaged neighbourhoods. The median ('crow flies') distance travelled was 800 metres. Thirty per cent of all users were

less than 500 metres from the centre, 61 per cent less than 1km, and 78 per cent less than 1.5km.

- 2) Users living in the most disadvantaged 10 per cent of areas travelled only half as far to their centres (average 750 metres) as users living in the least disadvantaged areas (>1500 metres on average).
- 3) The few centres (8.6%) serving less deprived neighbourhoods seemed to be partly serving populations in similarly less deprived areas with the travelling distance about the average for all areas.

6.2 Structural configurations of children's centres

6.2.1 Introduction

Children's centres have been moving through an intense period of change. In 2011, the ring-fencing for Sure Start Children's Centre funding was removed. Local authorities have been challenged to reassess their provision for the Early Years in order to support cost-cutting exercises and target the needs of the most disadvantaged. Reconfiguration of children's centre provision has occurred over the last few years, with two particular new 'structural configurations' of children's centres emerging: clusters and hub-and-spoke models. Sharp, Lord, Handscomb, Macleod, Southcott, George and Jeffes (2012) established definitions for the two models which had become evident during their research:

Cluster model: *'a group of two or more children's centres collaborate. This may be on an informal basis, or more formally as a designated locality cluster... usually located in the same geographical area. Centres each have their own centre leaders but leaders (and other staff) agree to collaborate on specific areas of work, or one centre may lead a specific piece of work which is then shared across the cluster'.*

Hub-and-spoke model: *'a hub centre has responsibility for co-ordinating services across one or more satellite or 'spoke' children's centres. Hub centres have their own leaders, and spokes may or may not be led by an individual centre manager (or deputy). The hub may provide core services that are not available in spoke centres'.*

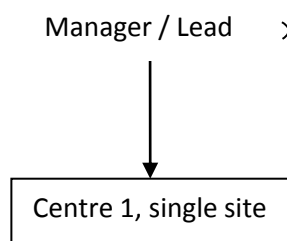
Sharp et al. (2012: 15-17)

As part of this study, configurations of children's centres became evident that extend the definitions proposed by Sharp et al. (2012), and potentially blur the boundaries between clusters and hub-and-spoke models. The fieldwork staff carrying out visits to the centres widely reported a range of centre configurations, and a subsequent report for the ECCE study aims to provide evidence for this quantitatively. It is, however, important to document these initial on-the-ground qualitative observations as they provide additional contextual information for the quantitative data explored earlier (in Chapters 3, 4 and 5). Only those configurations emerging during this

period of fieldwork will be explored within this report.⁸⁰ In particular, it is important to take account of the structural configurations of centres as these may differentiate between the impacts of centres upon outcomes (e.g. impacts may differ between single-site centres and those that are part of a cluster). These structural configurations were developed independently of the four ‘Typologies of Provision’ identified from Strand 1 baseline data, which intended to capture key aspects of centre management and leadership, user take-up, provision of services, and form and structure (Tanner et al., 2012, also discussed in Chapter 4). Other reports for the ECCE project (Tanner et al., 2012; and Maisey et al., 2012) consider configurations related to children’s centre usage and processes. For a definition of the terminology used within this section, see Appendix E2.

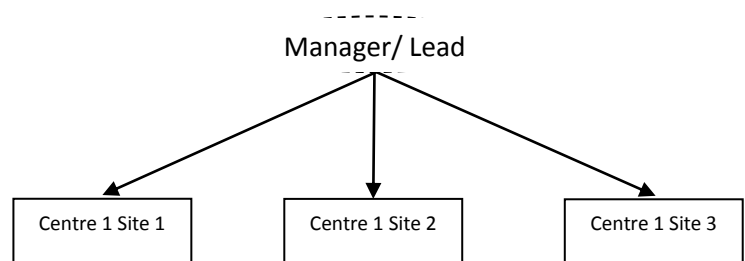
In the earlier parts of the study, a number of ‘core’ configurations were reported by fieldworkers as detailed in Figures 6.2-6.4. These configurations might be described as ‘one centre units’ where a single manager or lead is responsible for delivery of services across one or more sites (which work as a ‘one centre unit’). Figures 6.2 and 6.4 present a main centre which organises the services within the locality. In comparison, Figure 6.3 does not have a main centre from which to organise services, but services are delivered equally across all sites.

Figure 6.2. Single centre configuration



In this setup a single centre on one site is managed by a manager or lead. Whilst these setups used to be common, there appears to be a trend of moving from this single centre towards varying types of a cluster setup.

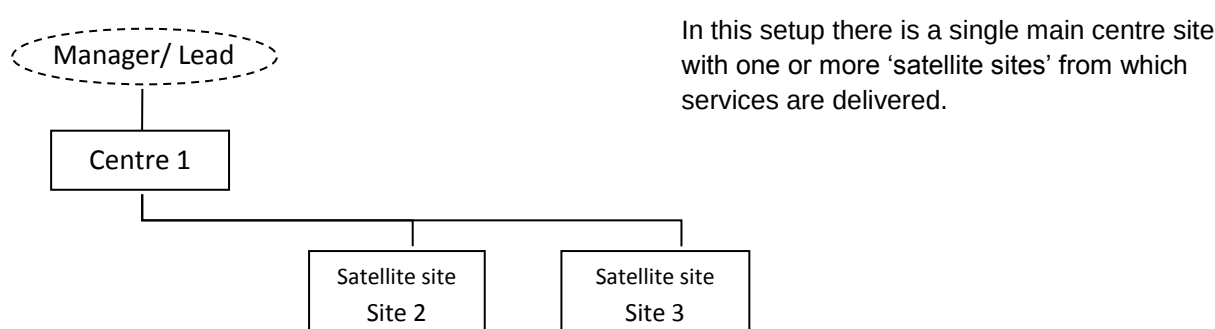
Figure 6.3. Multiple main sites configuration



This setup reflects a single centre managed by one manager (similarly to Figure 6.2). The difference however, is that this configuration is categorised by more than one main site for the children’s centre (for example, there might be multiple centres with duplicated core services over a large rural reach area, or a duplicated centre in a more disadvantaged area of centre reach).

⁸⁰ Note: it is not to quantify the information in Sections 6.2 and 6.3 of this chapter due to the method of data collection. Instead Sections 6.2 and 6.3 present information volunteered by the fieldwork staff during their visits to centres. Further fieldwork in 2013 will investigate the emerging themes in further detail.

Figure 6.4. Main site with satellite sites



6.2.2 Reconfiguration of core setups

As discussed later within this chapter, local authorities and lead agencies have been looking at ways of reconfiguring children's centre services in order to retain the core purpose while improving efficiency of the services. As a result, the research team noticed alterations in the 'core one centre unit' structural configurations previously mentioned, especially where designated Sure Start Children's Centres have lost their status or become subsumed by another main centre. In some cases, restructuring has meant that former 'single centre configurations' (as in Figure 6.2) have moved towards a 'multiple main sites' or 'main sites with satellites' configuration (Figures 6.3 and 6.4). This might be true for example, where the former children's centre has merged with one or more other centres and taken on the name of a 'main' centre; or is renamed to form a new configuration. In most cases, mergers will be categorised by a single manager or lead for the configuration.

Restructuring towards a 'multiple main site' reconfiguration (Figure 6.3) allows each of the former centres to retain the majority of their services, essentially duplicating children's centre work in different localities. Figure E6.1 within Appendix E2 shows an example of where the original centre (Apple Hills Children's Centre⁸¹) has now been reconfigured or merged into a 'multiple main sites' configuration, taking on the name of the 'main' centre (Flower Valley Children's Centre). In comparison, a reconfiguration of a former centre into a 'main sites with satellites' setup (Figure 6.4), could mean that the former centre would likely lose administrative/staff capacity within the centre and possibly run a reduced set of services (running as a new 'satellite site') or be tasked to roll out particular services as required by the new lead (running as a 'service delivery site'). Figures E6.2 and E6.3 within Appendix E2 present further reconfigurations of a de-designated or former children's centre (Apple Hills Children's Centre) that have now become part of a 'main sites with satellites' setup.

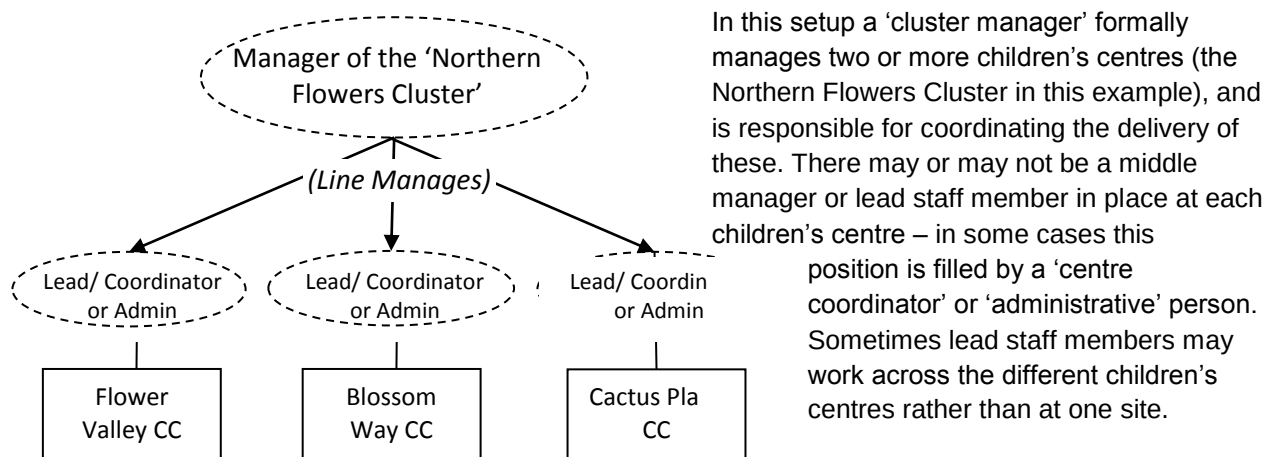
⁸¹ Note: centre names have been replaced with pseudonyms throughout all examples and do not reflect any specific centres within this sample.

6.2.3 Clustering of children's centres

Sharp et al. (2012) described a new configuration which involved the restructuring of centres into 'clusters'. The 'core one centre units' described in 6.2.1 and 6.2.2 highlighted ways that a main centre unit may choose to deliver services (i.e. through satellite sites). A number of 'core one centre units' may wish to coordinate delivery across one or more other 'core one centre units', thus working as a 'cluster' of centres. A number of different layers of 'clustering' became apparent during Strand 3 visits, including formal clustering (where the structuring of the leadership allows the centres to work in collaboration) and more informal clustering (where centres work collaboratively to offer services across a locality whilst retaining separate leadership). As discussed within Chapter 3, half of all interviewed managers reported that their centre was either part of a multi-site centre or operated as a cluster of centres. Importantly, this research has revealed that the centres within a cluster do not always have their own leadership as proposed by Sharp et al. In some cases, centre restructuring can lead to removal of middle management positions (discussed in further detail later within this chapter); where a single cluster manager might provide overall leadership (with centre coordinators or administrative teams in charge of centres on a more daily basis). These staff may work as flexible lead's across the cluster, or be designated as the coordinator for a particular centre. Of those managers listed in Chapter 3 who report that their centre is part of a cluster or multi-site centre, only 47 per cent claimed to be the *overall* manager, leading between one and eight centres. Sixty-two per cent of those same managers suggested that deputy coordinators were present at the other centres or sites (see Chapter 3 for further details).

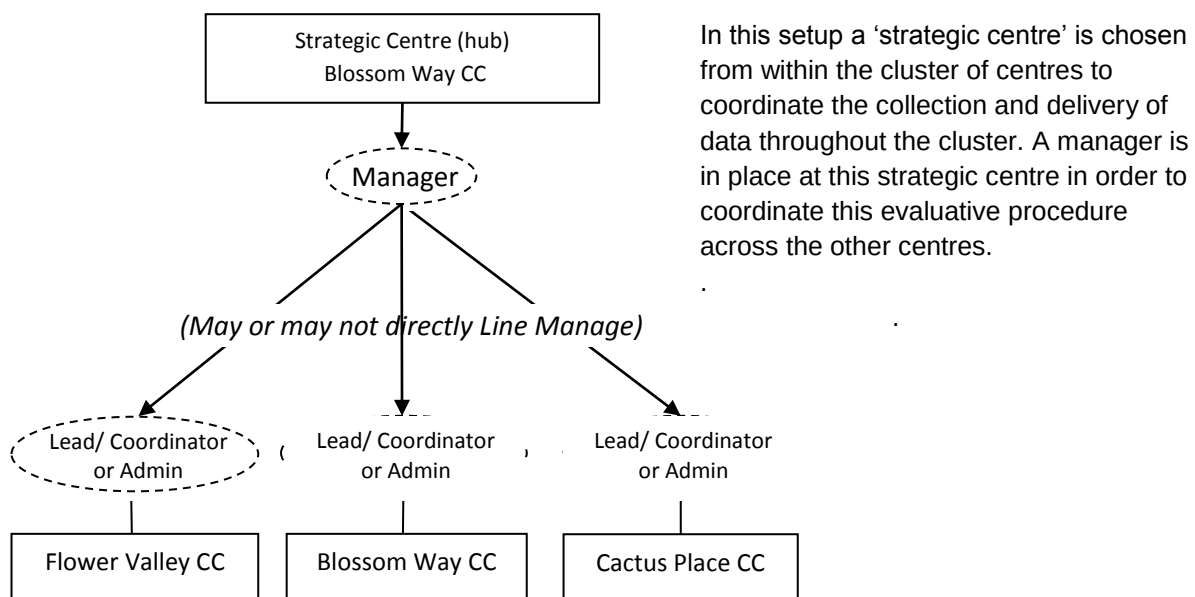
Centres within a 'cluster' might be renamed to clarify the nature of the new clustering (for example, one name might be the 'Northern Flowers cluster'), but essentially the centres remain independent 'core one centre units' and often retain their designated names. More detail is now presented in the examples shown in Figures 6.5 and Figure E6.4 in Appendix E2 on the types of formal clustering witnessed within the evaluation. Whilst not detailed within the diagrams, any of the named children's centres which are shown to cluster in Figure 6.5 and Figure E6.4 can also work across a number of satellite sites (i.e. their 'core one centre unit' as demonstrated in Figure 6.4).

Figure 6.5. An example of a cluster with a formal structure



The research from this study suggests that the 'hub-and-spoke' model described by Sharp et al. (2012) may in fact present a more complex form of clustering. Figure E6.4 in Appendix E, for example, illustrates a manager of one centre with overall line-management of the other two centres in the cluster; they are thus responsible for the coordination of services across the cluster. The centre currently led by the cluster manager might be designated a 'hub' centre from which services are compared and evaluated against. Figure 6.6 details another example of a 'hub-and-spoke' configuration, where one centre within the cluster has been designated as the 'strategic centre' and is responsible for the coordination and delivery of data relating to work carried out within the cluster. In the particular model detailed in Figure 6.6, the strategic centre may or may not directly line manage the other 'spoke' centres, but will be designated overall responsibility for the delivery of some service across the cluster.

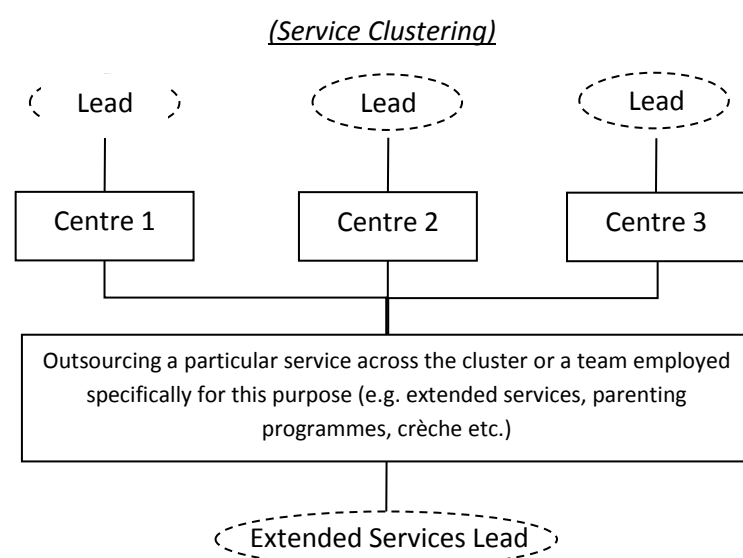
Figure 6.6. Example of a hub-and-spoke cluster (with a strategic centre lead)



Hub-and-spoke configurations such as those presented in Figures 6.5 and 6.6 are examples of methods which allow provision to be sufficiently targeted across centres. Strand 3 fieldworkers noticed that some centres demonstrated working across more ‘informal clusters’ to coordinate the delivery of services. In ‘informal cluster’ configurations, centres (or ‘core one centre units’) can still be very much independent in terms of their own leads, centre aims, and outcomes, but the services might instead be delivered or outsourced to another team either by organising the delivery of a service in one particular centre and alternating this throughout the year, or by training an expert ‘team’ of individuals who work across the cluster to deliver a particular session. Two services that were commonly found to ‘cluster’ across centres were ‘extended services’ (which include outreach and/or family support staff) and ‘parenting teams’ (who roll out parenting and/or evidence-based programmes across the centres).

There are a number of potential benefits to the clustering of services. The sharing of extended services work across centres might reduce the opportunity for duplicated work with families (for example, when a family attends more than one centre) and can ensure that family support and outreach workers are trained to the same standard. The sharing of a ‘parenting services’ team across a group of centres might allow a specific team of individuals to be trained to deliver evidence-based programmes with fidelity, and to receive relevant support and supervision (thus reducing the cost of training and support for each centre) and increasing their likelihood of higher quality delivery. Other services that were also discussed as being outsourced across an informal cluster of centres included crèche workers, and teams that work with disabled families. Figure 6.7 shows an example of service clustering across children’s centres.

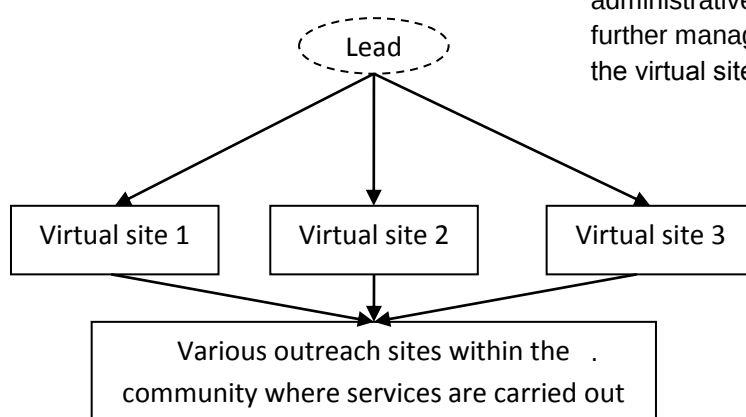
Figure 6.7. Clustering of services



This setup does not necessarily require a formal clustering of centres (in terms of a joint leadership) but the centres work collaboratively to share a joint service across the ‘informal cluster’. This joint service or team might alternate the centres in which the service is provided (and thus the centre might be required to signpost or transport their families to the centre which is currently running the service) or the team/service might run concurrently at each centre, on different days.

One final configuration that was witnessed by researchers in a few centres within the Strand 3 sample is that of a ‘virtual children’s centre’. In this type of centre, outreach work within the community is prioritised without the presence of an administrative children’s centre ‘base’ (where core services would be carried out). Instead, the address of the children’s centre might be that of a school, but all services are coordinated throughout the local community. Figure 6.8 presents a virtual centre configuration.

Figure 6.8. ‘Virtual centre’ configuration



The purpose of the virtual site is to provide an administrative base/address. There might be a further manager above the lead, especially when the virtual sites are ‘schools’ (in which case the top manager would be the head teacher). It does not however have an actual centre site, although it may have a room in a community site where administrative staff can work (for example, a school room).

The restructuring of children’s centres has by no means been clear cut, and a number of the previously discussed configurations can be witnessed to some extent as a result of the restructuring acknowledged by researchers within Strand 3. Whilst researchers did encounter single stand-alone centres, clustering with other children’s centres was common; for example, some local authorities were implementing locality model arrangements⁸². Hub-and-spoke models were emerging, however even these models functioned in different ways: in one particular centre, a manager leading a hub did not consider the group to be working as a cluster, but rather as a group with a hub centre and outreach sites. A couple of centres within one local authority were following a strategic cluster model. The researchers visited examples of both strategic centres and their satellites, all of which retained their own centre manager. Over the course of the evaluation, it is likely that centres within the sample will evolve toward the configurations detailed within this chapter. The second wave of fieldwork in 2013 aims to document further changes to the structure of children’s centres. The following Section 6.3 will now explain in more detail some of the reflections ‘on the ground’.

⁸² *Locality model* working might include clustering of children’s centres according to their geographical location, and linking centre services with other provision and multi-agency partners within the region in order to ensure that the locality as a whole provides a continuum of services for children from 0-19 years; this might also involve integrated working with social care, access teams and family support teams across the locality.

6.3 Qualitative reflections on an evolving service

This section reflects upon the fieldwork experiences within children's centres, as reported by the researchers 'on the ground'. It suggests possible reasons for findings within the report, and contextualises these in terms of qualitative observations made by researchers. It is important to reflect back upon the circumstances surrounding the fieldwork to enable a clearer understanding of the landscape in which centres were tasked to deliver services to families.

Staff in a number of the 121 children's centres visited as part of the Strand 3 fieldwork reported altering their ways of working in order to adjust to a challenging pace of change. Whilst centre staff expressed concerns about future reorganisation, staffing, multi-agency working and the impact that changes may have upon families, they were also enlisting strategies to ensure that any impact was minimal on both centre staff and the families. While a majority of centre managers interviewed about service delivery and multi-agency working reported funding cuts and loss of staff due to reorganisation and reconfiguration, and a shift from 'stand alone' centres to 'clusters' (see Chapter 3), some spoke positively of this challenge as an opportunity to refocus their procedures and generally 'sharpen up' their ways of operating. Despite these challenges, the list of services delivered is impressive, both for the range and the detail. Services and activities were run by both centre staff and partner agency staff, often in tandem with a considerable number operating at weekends and in the evenings as well.

Whilst the centres visited as part of this study may be considered as more established given that they were sampled from Phase 1 and Phase 2 children's centres, the extent of reorganisation and flux, reduction in funding, or changes to other agencies has meant that some of the previously strong links to multi-agency partners have been weakened. Multi-agency collaboration, (while thought to be under threat if partner agencies had to withdraw further due to cuts to staff) was apparently surviving, with centre managers reporting a high level of shared vision or ethos, shared formal arrangements for referrals and plenty of informal contact for keeping in touch with partners.

6.3.1 Nature of centre management

Researchers were required to talk with a person of managerial capacity at the centre. In reality, a variety of different managers were encountered with differing categories of line management over the children's centre. A few 'acting' managers were interviewed during periods when managers were on maternity leave; or were working within a *caretaking* or *interim* capacity when the current manager was tied up with other responsibilities, or a new manager was being appointed. Acting managers typically held a senior position at the centre such as a deputy position, senior family support worker or senior early years practitioner. A number of the

interviewed centre managers were Heads of Nursery or Primary schools, or led the childcare provision if it was based on the same site as the children's centre; in such cases, researchers often met with 'deputy managers', 'extended services managers' or those in a more day-to-day coordinator capacity. Researchers encountered some centre managers who were officially line-managed by a 'Head of Centre' (e.g. leading a nursery or primary school, or childcare provision), and others who also held a leadership role within another on-site provision (e.g. Special Educational Needs Co-ordinator [SENCO] or the lead of the Early Years).

Centre managers were known by a variety of terms including 'Lead Centre Officer', 'Centre Coordinator' or 'Head of Centre'. Definitions of these varied across the centres— in one site, a centre manager might lead multiple centres, yet in another they might lead a single centre within a cluster; centre managers may play only an administrative day to day role at the centre or they may have hands-on management over a number of centres within a neighbourhood. It was fairly common for the centre manager taking part in this study to lead more than one children's centre, with just under half of the Strand 3 sample reporting that they led more than one centre (n=57 centres).

6.3.2 Centre configuration

Cluster models varied greatly in management: whilst some were effectively working as one integrated centre through the sharing of service timetables, family support, outreach staff and even names, others retained separate names and were required by Ofsted to demonstrate separate planning and self evaluation⁸³. There were examples of working across a locality without 'formal clustering'; for example through the introduction of 'locality' or 'early intervention' teams, or through the sharing of services such as dedicated outreach teams or crèche facilities. The core staff teams thus varied greatly across the sample from the very small (i.e. one manager, one part time receptionist and one part time crèche worker, with other staff working across the locality) to larger teams (some of over 70 staff including business managers, extended services managers, outreach teams etc).

A number of different terms were used for describing the area from which a centre serves families, including (although not limited to): cluster area, reach area, locality, footprint, project, quadrant, catchment area, geographical area and community. Whilst some clustered centres were clearly within walking distance of each other and could easily divide out services across different sites, a few centres had been set up to facilitate serving a larger (often more rural) area. These centres might serve a

⁸³ Note that the 2013 Framework for Ofsted Inspection now includes the capacity to be inspected as a children's centre group: 'a children's centre group has shared leadership and management and integrated services; although it will consist of several centres, it will be inspected as one children's centre,' Ofsted, (2013).

distance of many miles, interspersed with satellites sites, to ensure that duplicated outreach services were brought into the community to reduce difficulties caused by rurality or poor transportation links. Staff often acknowledged that families would choose to attend particular centres due to distances to other sites, boundaries such as main roads or rivers, or cultural or religious differences.

6.3.3 Reconfiguration of centres and leadership

In 2012, 4Children reported that 20 per cent of children's centres were run by the voluntary sector, 76 per cent by local authorities (sometimes in conjunction with schools), one per cent by the health sector and two per cent by private organisations. Over the last year of the 4Children census, the management of 90 per cent of the centres had not changed (although 4 per cent of the centres had transferred from local authority to voluntary sector: 4Children, 2012). Within this Strand 3 sample, researchers reported that at least 10 per cent of the centres had recently moved to a new lead body or agency (or the change was imminent). In a large number of cases, charities such as Action for Children, Barnardo's or Spurgeons were taking over the lead of the centres, although a couple of centres saw leadership taken over by the local authority (whether Borough Council, District Council or County Council); or children's hospital. The retendering process often brought about a reorganisation of centre management and structure. Some centres could see benefits to reorganisation in terms of working as a network with other centres, and sharing the target of particular priorities. Restructuring was also noted by a couple of centres as being important for enhancing leadership and management, particularly where it was felt that the centre was struggling.

A number of managers stated their apprehensions about future roles within the centre. In some cases, reorganisation had led to a reduction of 'middle management' posts (i.e. managers responsible for specific centres) in favour of higher level positions. Some centre staff spontaneously referred to the '*deletion*' of management posts; others were required to reapply for their post or adopt responsibility over other children's centres; and not all managers were successful. In a few cases, higher-level staff (for example, Integrated Family Support Service staff or Children's Services managers), were taking more direct oversight over the centre. A centre coordinator could also be appointed as a day-to-day contact responsible for operational leadership and management of support staff, but key responsibilities often remained with the higher lead. A couple of managers who had been promoted into the role (some temporarily) were demoted back to a senior staffing role, or offered the choice of voluntary redundancy. Concerns were voiced regarding the impact that staffing restructure might have on families attending the centre, particularly with regards to the consistency of staff, and hiring individuals who were unfamiliar with local families and their hidden needs.

New centre structures were emerging, resulting from '*federations*', '*collaborations*', '*mergers*' or '*amalgamations*' with other children's centres. During the fieldwork, a couple of centres were de-designated or listed as satellite sites for other main centres. Restructuring was often in the earlier stages, with staff unclear as to how changes would affect their work and whether there would be an impact upon families. There were fears that new roles under a new lead agency might be largely undefined, and worries about there being little opportunity to contribute to any decision-making regarding the future of the centre and the families. Budgets for the following year had sometimes not been set and tensions were evident amongst those centres who were about to reorganise, particularly with regards to protecting current services and staff.

6.3.4 Impact of centre reconfiguration

Immediate issues emerged during what was referred to as '*turmoil*' or '*restructure paralysis*'. When describing the reorganisation, staff gave examples of the suspension of particular services and an inability to develop or maintain services and practices, for example the closure of universal services during school holiday periods. Staff also talked about reduced partnership working due to agencies returning to their core business, and feeling increased pressure on current resources; or agencies feeling the effects of reduced funding and being unable to support referrals from children's centres, thus pushing workload back into the centre. In one example, a centre reported that the cluster had reduced opening hours to less than half of the days per week that they were open in 2010; in other centres, staff reported that the number of families using the centre had significantly dropped due to fewer groups running or services being suspended or reduced. However, in comparison, another centre noted that workers across the locality were working extended hours in order to provide services across the area. Chapter 3 describes in more detail the changes due to the reconfiguration of centres and funding restrictions.

A couple of centres reported difficulties in maintaining current staff. As a result of the Government reform of early education (DfE, 2010), qualified professionals were no longer required in centres and thus examples were given of difficulties keeping Qualified Teachers or Early Years Professional Status staff; or the inability to replace them with similarly qualified individuals if they left for maternity leave. Centres also reported losing senior staff such as senior outreach workers or family services coordinators. Whilst several new staff were being drafted in to children's centres, a few centres were facing a freeze on recruitment; or were unable to hire their own permanent staff for positions such as administration.

6.3.5 Following a new core purpose

Centre reconfiguration and restructuring appeared to be related to the revised *Core Purpose* (DfE, 2012, as discussed in Chapter 1) which emphasised identifying, reaching and helping those families '*in greatest need of support*'. A move away from universal services was apparent across a couple of the centres, who reported beginning to run less universal groups. There were reports of centres seeing more acute cases of social care work due to changes in familial circumstance; difficulties in showing families meet the 'high' threshold of need to be referred into the social care system; and systems becoming more efficient at picking up family issues at an earlier stage. Some centre staff suggested that priorities for work were moving away from early intervention towards acute cases of child protection and social intervention. Whilst a few centres raised concerns about the higher workload and the lower skill-set of staff required to deal with these more complex cases, a couple of centres talked about their intentional 'up-skilling' of the workforce in order to meet those in greatest need; of putting more resources into areas of poverty, multiple deprivation and the most disadvantaged families; of employing a clinical supervision service for staff; and of providing targeted outreach support to focus on the most disadvantaged families.

In order to meet higher family needs, some centres reported that multi-agency responses worked well (for example, a 'Team Around the Family' type-approach, multi-agency 0-19 teams, one team working etc.) There were examples of Integrated Family Support Services managing centres in order to ease the transition for acute child protection cases; local authorities sharing postcode details of child protection families in order to join up support; social care placing resources into children's centres (such as Speech and Language Therapists); employment of dedicated individuals to work as a link to social care, or to focus on the most disadvantaged families in order to ease the referral process; and examples of linked social workers who can strengthen the link to social care and ensure that the centre is kept aware of policy updates.

This section underlines the range of excellent work that was evident from Strand 3 visits. There were clearly concerns about the future and much inevitable anxiety about changes in activity and organisation to meet the new emphasis on the most disadvantaged families. Whilst the sample of centres did however display a range of good work, challenges were clearly being faced in some centres. This kind of disruption is inevitable during a time of such reorganisation and refocusing.

7 Summary and Conclusions [Kathy Sylva and Teresa Smith]

Children's centres are changing – this report is a snapshot of the situation in 2012 but it is clear they will continue to change. This report has delved deep into the organisation of children's centres, the activities they run with parents, their meetings with partner agencies, the ways they welcome new families and the means they have for evaluating their own work. The prototype five years ago of a 'one stop shop' within pram-pushing distance for parents has shifted dramatically to one of networks and clusters. Instead of dropping into the local centre for stay and play sessions several times a week, parents in 2013 might find themselves participating in a parent group some distance across town, attending *Baby Massage* at the centre nearest them, and seeing a health visitor on a single occasion in the 'Spoke' of their local centre's 'Hub'.

The shift from one single, stand-alone centre has had some benefits. Centres do not think having services on one site is the key factor in centre ethos, contrary to previous assumptions about multi-agency working and partnerships focusing on providing services in the same place. Other factors, such as having workers willing to make contact with other services on behalf of families, were more important; and focusing on services rather than venues will allow scarce resources to be more widely distributed.

Staff everywhere were committed to their work and energetic in the face of time pressures. However, fewer staff appeared to be doing more things: in one centre the weekly visit from JobCentre Plus has been replaced by a noticeboard, and some guidance from the (now) part-time receptionist on how to use the computer in the lobby to access information on jobs. More importantly, the centre manager who used to manage one centre has been 'promoted' to managing three, at almost the same salary. She regrets not having time to talk with her new staff about training opportunities or even to chat about their own families at home.

This research on the ground has drawn a picture of the effects of financial cuts on services for families. Like all public services, pruning was necessary and this required hard decisions about staff deployment and priorities. One casualty was the time needed for meetings with partner agencies. More business was relegated to email and some services reduced their weekly offer. Other services had to reduce their 'universal' offer, in favour of targeted services for the most vulnerable.

There is great variation in the management of centres, especially in relation to their configuration, and the skills and qualifications of the staff. The highest leadership and management quality score was in the '*Staff Training and Qualifications*' but the highest score was derived from qualification amongst the front-line staff, not of the

managers. The lowest quality domain was in '*Centre Organisation and Management*' (scoring in the midst of the *adequate* range), probably due to the continual reorganisation in response to funding cuts.

The analysis of reach, using administrative data, showed that the vast majority of centres focus on the most disadvantaged areas and attract their users from these areas. Although about 10 per cent of centres are located in less disadvantaged areas, the user base in the sample was still disadvantaged according to several criteria.

Is it possible to take stock? On the plus side, few children's centres have actually closed, but many are struggling on short rations with staff feeling the stress of too much to do, with too little time to do it. In keeping with government policy, most have prioritised their work with the more vulnerable families. If the infrastructure survives until funding increases, the universal services and rich offerings of their heyday (before the recession really began to bite) may thrive again. Another plus is the agreement amongst all players that evidence-based practice should be followed. There is serious confusion at centre level as to the standards of evidence required for effective practice. The majority of centres implement at least one programme from the Allen list (2011) of programmes showing the highest standards of evaluation research; these reach few users however, with the typical centre running two groups for parents each year, each reaching approximately eight to twelve parents. However, centres also use programmes that were not present on Allen's list, some of which demonstrate a growing research base on effectiveness. Many of the 'non Allen' programmes reach more users as they are less expensive. The programmes on Allen's list attract more referrals, so are more targeted; almost all report using a manual, but few can manage to implement with full fidelity. This is a highly contentious topic, with disagreements as to whether expertise should be considered evidence alongside randomised control trials.

Researchers on the Strand 3 team ran hard to keep up with an evolving service. In their nine months of fieldwork they observed committed teamwork, open relationships with parents and agency partners, and a serious effort to improve practice. At a time when all public services were having to trim down, children's centres would do well to concentrate on those activities and relationships that have beneficial effects. Ineffective but popular services may need to go by the board and be replaced with innovative but *effective* ones that improve outcomes. Social science and practice must join forces in the invention of new and useable metrics of success. Bean counting is never the aim - but demonstrating improvement in life chances is. In carrying out Strand 3 work it was necessary to re-think interviewing and invent new assessment instruments. The work of children's centres is so complex, on so many levels, that the standard tools of social sciences were stretched to their limits.

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⁸⁴ The database of children's centres was maintained by Together for Children at the time of sampling. Together for Children's contract ended on 31 March 2011 (and the database was passed to EC Harris).

APPENDIX A: Introduction

Figure A1.1. Letter inviting participation to the study



Dear xxxxx,

Evaluation of Children's Centres in England: Visit to your children's centre

Thank you for your continued participation in the Evaluation of Children's Centres in England (ECCE) commissioned by the Department for Education. This evaluation is being conducted by the National Centre for Social Research (NatCen) in collaboration with the University of Oxford and Frontier Economics. In particular, thank you for taking the time to carry out the 2011 online/telephone survey and for providing a list of parents with young children who use your children's centre.

We are now writing to you for your help with the University of Oxford part of the study which looks at the services provided by children's centres, leadership practices, and the use of intervention and parenting programmes. **This part of the research is crucial to the evaluation as it links the experiences of centre users with the different elements of children's centre provision. With your help, we aim to show how the work of children's centres affects the lives of different families.**

To help us gather this information, a member of our Oxford University research team would very much like to visit your children's centre for a two day period at some point over the next few months and meet with yourself and your staff in order to learn about your work. **Of course, we will ensure that these visits are as unobtrusive as possible, and our experienced researchers will work closely with you to find the most convenient dates and times.** The information you and colleagues provide will be treated in confidence. Please find further information about this visit overleaf.

We appreciate the commitment of your time involved in helping us with this. However it is only by working with you and learning about the work being carried out in your centre that we can reliably demonstrate what is *actually happening* in Sure Start Children's Centres and give an account of how much they *benefit the families they serve*.

A member of the Oxford University research team will shortly be contacting you by telephone to discuss your participation in this vital element of the evaluation. If you have any queries or concerns, please do not hesitate to contact the Evaluation of Children's Centres in England research team on (01865 284096) or by email at ecce.oxford@gmail.com. **Please have your eight digit reference number to hand when you call or email (shown at the top of this letter).**

Many thanks again for your valuable help. We look forward to hearing from you.

What will I need to do during this visit?

Our researcher would like to speak with you, as centre manager, for a few hours on both days to learn about the services that your centre provides, your multi-agency working practices, and your leadership and management practices. We would also like to spend time talking with the member of staff most familiar with the interventions or programmes that you run with parents, children and families at the centre, and also with a member of your senior team who leads either family support or outreach work.

During these two days, the researcher will also ask to review a few key documents to help us to understand the procedures at your children's centre. These might include 'development plans' or 'self evaluation forms'. We will suggest a number of key documents in advance that you may wish to have to hand on the day, but you will not need to carry out any special preparation for this. Finally, there are also a couple of questionnaires that we hope can be filled out by key members of your team, preferably in advance so as to minimise the time required by our visit.

What will happen to the information that I/colleagues provide?

At no point is the ECCE project identifying or reporting on any individual children's centre. Any information that is collected on an individual centre will be reported in an amalgamated way across all children's centres in the sample, and used to describe the forms and practices of children's centres across England.

We can reassure you that any information that we collect regarding your children's centre will be kept securely, confidentially, and used only for research purposes. Moreover, all the information we collect will remain completely anonymous and will be destroyed once all research has ceased. We can offer you two further reassurances: First, that ECCE has received informed ethical clearance from the University of Oxford's Research Ethics Committee; Second, that ECCE is carried out in accordance with both the Freedom of Information and Data Protection Acts.

APPENDIX B: Evidence-Based Practice

B1 - Evidence-Based Practice Appendix

Table B1.1. Further detail regarding implementation of the three most commonly used well-evidenced programmes as featured in Allen's (2011) list of 19 programmes

Well-evidenced programmes most used within the children's centre sample	Currently Implementing (n) ¹			Ready to Implement (n) ¹	
	1. Followed in full	2. Substantially followed	3. Inspired or based upon	4. Trained to use, but not currently using	5. Planned to start running with six months
Incredible Years	41	7	1	11	2
Triple P	39	5	0	7	2
Family Nurse Partnership	18	3	2	1	1

¹ Centres might have ticked multiple options regarding the type of implementation as appropriate to their use of the programme. For example, a centre may have ticked 'trained to use' as well as 'planned to start running'.

Table B1.2. Further detail regarding the implementation of the seven most commonly used ‘other’ named programmes, strategies or interventions (i.e. those not listed as well-evidenced within the Allen Report, 2011)

Well-evidenced programmes most used within the children’s centre sample	Currently Implementing (n) ¹			Ready to Implement (n) ¹	
	1. Followed in full	2. Substantially followed	3. Inspired or based upon	4. Trained to use, but not currently using	5. Planned to start running with six months
Infant/ Baby Massage	76	8	1	2	1
Every Child a Talker (ECAT)	34	17	15	5	1
Solihull Approach /Programme	16	8	6	10	2
Family Links Nurturing Programme	25	0	0	1	1
Early Support programme	9	8	2	5	0
ICAN	10	5	4	2	2
PEEP	13	2	4	5	0

¹ Centres might have ticked multiple options regarding the type of implementation’ as appropriate to their use of the programme. For example, a centre may have ticked ‘trained to use’ as well as ‘planned to start running’.

Table B1.3. Comparison of researcher scores on the ‘Fidelity to programme’ *Programme Implementation Scale* against staff-reported implementation for Incredible Years, Triple P, Baby Massage, Family Links and PEEP

Programme	Number of centres where staff-reported the programme is ‘followed in full’	Total n for which comparison data was available	Number of centres scoring ‘good’ on the researcher-rated ‘fidelity to programme’ scale
Incredible Years	28	34	7
Triple P	27	33	1
Baby Massage	53	58	1
Family Links	20	21	1
PEEP	12	14	0

Table B1.4. Comparison of researcher scores on the 'Manual Use' *Programme Implementation Scale* against staff-reported implementation for Incredible Years, Triple P, Baby Massage, Family Links and PEEP

Programme	Number of centres where staff-reported the programme is 'followed in full'	Total n for which comparison data was available	Number of centres scoring 'good' on the researcher-rated 'manual use' scale
Incredible Years	28	34	28
Triple P	27	33	25
Baby Massage	53	58	43
Family Links	20	21	20
PEEP	12	14	8

Table B1.5. Comparison of researcher scores on the 'Feedback and Evaluation' *Programme Implementation Scale* against staff-reported implementation for Incredible Years, Triple P, Baby Massage, Family Links and PEEP

Programme	Number of centres where staff-reported the programme is 'followed in full'	Total n for which comparison data was available	Number of centres scoring 'good' on the researcher-rated 'feedback and evaluation' scale
Incredible Years	32	39	21
Triple P	29	35	18
Baby Massage	55	60	12
Family Links	20	21	19
PEEP	12	14	3

B2 - Evidence-Based Practice Material Development

Questionnaire (Section 5.2 of Main Report)

Each children's centre was sent a short questionnaire for self-completion⁸⁵ by a member of staff with appropriate knowledge regarding work with families. This questionnaire was designed to assess the range of programmes, strategies or interventions used with families at the centre. The questionnaire provided a list of the well-evidenced programmes mentioned in the Allen Review (2011), along with a list of a further 38 programmes, strategies or interventions that had come to the attention of the team through relevant literature, expert opinion, recommendations, or during visits to children's centres. Respondents were also given the opportunity to include details of other programmes that were being used during the fieldwork period.

For each programme, the respondent was asked to indicate whether this was run by (or accessed through) the centre and to provide further detail as to how programmes were *currently implemented* (i.e. followed in full, substantially followed, or inspired by or based upon). Respondents were also given the opportunity to note whether they were *ready to implement* the approach – even if not currently doing so (i.e. trained to use the approach but not currently using it, or planning to start running the approach within six months). Finally, further detail was collected on *how the programme was being run* (i.e. by children's centre staff, by staff from a linked or clustered centre, staff employed by the cluster specifically for this purpose, staff from another agency or from an unrelated children's centre).

Seven experts provided both verbal and written feedback during the initial development exercise for content validation. All comments and feedback from experts, ECCE team members and the DfE were considered and the tools were finalised in September 2011. The resulting questionnaire describes well-evidenced programmes as defined by Allen (2011) along with a list of other well-known programmes. Overall, 119 of the 121 children's centres visited as part of the fieldwork provided detail on the programmes, strategies and interventions that they were currently running with families.

Interview (Section 5.3 of Main Report)

Aside from the questionnaire which was used to scope the range of programmes, interventions and strategies implemented across the sample, respondents were also asked to provide further detail on up to three of their most well-attended and currently implemented programmes. A '*focus programme*' selection procedure was

⁸⁵ If not completed before the fieldwork visit, this was completed as a self-report in the presence of the researcher.

defined, which took into account which staff were available to interview during the visit.

Researchers spent 30 minutes with respondents, discussing up to three 'focus' programmes in more detail (as defined using the 'Focus Programme' selection criteria).⁸⁶ The detailed discussion gathered information on the programme; implementation; common outcomes; reasons for choice; feedback and evaluation; documentation and manual use; training, and planning and supervision. Three scales were devised to assess the rigour of *programme implementation*; 'Feedback and Evaluation', 'Manual Use', and 'Ensuring Fidelity to Programme'. Scores for these three scales were created using the median average, taken from a number of three-point ordinal scale questions which were scored 'inadequate', 'satisfactory' or 'good' (see Figure B2.1 in Appendix B for details).

It is important to remember that levels of implementation were developed from the research literature regarding how well-evidenced programmes are run. Levels have not been validated against other scales or quality ratings, but are used here as a means to compare programmes in terms of the rigour of their implementation. A complementary section of the questionnaire was devised so that staff could indicate their knowledge of the programme when they were unable to discuss implementation. On average, centres were able to discuss the maximum number of three focus programmes (both modal and median average, n=86). Of the 121 children's centres visited, 118 returned details on at least one focus programme.

⁸⁶ *'Focus programme' selection procedure:* After completing the questionnaire (see Section 5.2) researchers asked centre staff to give further detail on up to three of the 'well-evidenced programmes' that were currently implemented at or by the centre. If more than three well-evidenced programmes were implemented, the respondent was asked to choose those which were 'most attended' by families using the centre. If less than three well-evidenced programmes were implemented, remaining programmes were chosen by firstly prioritising up to three of the other named programmes, strategies or interventions programmes that were pre-listed in the questionnaire, and then concluding with any other programmes reported by the respondent.

In all cases, a focus was on programmes that were 'most attended' by families at the centre. Where possible, researchers interviewed the individuals responsible for running the programmes. After initial trials of the research instrument, two programmes were excluded from those asked in detail due to lower quality of the data gathered and a lack of respondent knowledge regarding programme implementation: *Family Nurse Partnerships (FNP)*, and *Every Child a Talker (ECAT)*.

Figure B2.1. The creation of three scales to assess the rigour of programme implementation: three ordinal scales from 11 scores. Note: rating values have not been validated against other scales and should therefore be used only as a guide

The median of five questions was taken to comprise the 'Feedback and Evaluation' score:

1. *Nature of feedback score*
 0. [*Inadequate*] Nothing or other
 1. [*Satisfactory*] Only qualitative
 2. [*Good*] Any quantitative
2. *Frequency of feedback score*
 0. [*Inadequate*] Feedback never collected
 1. [*Satisfactory*] Feedback (any type) collected at the end of programme or after two or more sessions only
 2. [*Good*] Feedback (any type) collected after every session
3. *Formal evaluation score*
 0. [*Inadequate*] No formal evaluation
 1. [*Satisfactory*] Centre-created evaluations or other types of evaluation not from programme creator
 2. [*Good*] Evaluation from programme creator
4. *Type of evaluation score*
 0. [*Inadequate*] Other type or no type listed
 1. [*Satisfactory*] Case study, parent contribution, staff contribution, or child contribution
 2. [*Good*] Measuring change in families from beginning to end and measuring change in children from beginning to end
5. *Independent formal evaluation score*
 0. [*Inadequate*] No independent evaluation
 1. [*Satisfactory*] Other person or form of independent evaluation
 2. [*Good*] Certified individual from the programme

The median of three questions was taken to comprise the 'Manual Use' score:

1. *Documentation score*
 0. [*Inadequate*] No documentation
 1. [*Satisfactory*] Created by children's centre
 2. [*Good*] Created by programme creator
2. *Frequency of manual use score*
 0. [*Inadequate*] Manual never referred to, or no manual
 1. [*Satisfactory*] Manual referred to rarely or 'other' time period
 2. [*Good*] Manual referred to every session or once a month
3. *Use of session plans score*
 0. [*Inadequate*] Session plans never used
 1. [*Satisfactory*] Session plans used partly
 2. [*Good*] Session plans used fully

Figure B2.1. [Continued]

The median of three questions was taken to comprise the 'Ensuring Fidelity to Programme' score:

1. *Use of checklist score*
 0. [*Inadequate*] Checklist never referred to, or no checklist
 1. [*Satisfactory*] Checklist referred to rarely or 'other' time period
 2. [*Good*] Checklist referred to every session or once a month
2. *Supervision frequency score*
 0. [*Inadequate*] Supervision occurs never referred to, or no checklist
 1. [*Satisfactory*] Supervision occurs rarely, once a month, at the end of the programme only
 2. [*Good*] Supervision occurs every session or once a fortnight
3. *External fidelity check*
 0. [*Inadequate*] External fidelity checks never occur
 1. [*Satisfactory*] External fidelity checks occur once only, once every three years, or 'other' time period
 2. [*Good*] External fidelity checks occur once a month when the session is running, once every time the session is rolled out, or once a year

B3 - Implementation of Six Particular Programmes

A. Incredible Years (IY)

Thirty nine children's centres chose to report in detail on the implementation of the *Incredible Years (IY)* programme⁸⁷ (see Table B4.10 in Appendix B). The majority of the staff running the programme understood *IY* to be used internationally (n=38), as a programme that focuses upon parents and children (n=33), and a programme that was most commonly delivered solely through their own children's centre staff (n=13) or a mix of organisations (n=20). Considering potential outcomes, children's centres viewed *IY* as being most beneficial for 'parenting skills for behaviour' (n=33), 'attachment between parent and child' (n=30), and 'child's social and emotional development' (n=23).

Most commonly, the local authority (n=23) or children's centre staff (n=21) were responsible for choosing to implement the *IY* programme at the centre. Staff reported a broad range of reasons for selection of this particular programme, including that it falls on a list of recommended programmes (n=33), there is substantive evaluative research (n=30), research has shown a measurable impact on families (n=29), it suits the needs of families (n=27) and it is well known (n=26). There were a wide range of methods for recruitment of families into the programme, but most popular for this programme were 'targeting specific families within the centre' (n=38) and 'taking referrals from other agencies' (n=37). Centres also recruited families through 'advertising within the centre and local community' (n=28), and consulting with other partners over 'which current non-centre users would most benefit' (n=26).

All 39 children's centres delivered *IY* as a time-bound programme, the majority of which took place through weekly sessions (n=37) within the children's centre (n=38). All 39 centres who reported on *IY* ran this within groups, most commonly once (n=12) or twice a year (n=14): eight centres reported running this three times in the last financial year. Centres reported an average of 22 families participating in *IY* programmes over the course of a year (ranging between 16-60 families). Mothers were said to participate in all 39 roll outs of the programme, and fathers were the next most likely family member to participate in the programme (in 29 centres). Dropout from families attending *IY* was most commonly expected to lie within the 11-20% range (n=19). Considering programme implementation, centres most commonly scored the highest marks on *feedback and evaluation* (over half of the centres scoring 'good' using the rating scales⁸⁸ [n=23], with the remainder scoring

⁸⁷ A further six centres answered questions regarding their input when it was delivered for them by another organisation, see Table B4.11, Appendix B4.

⁸⁸ The *Programme Implementation Scale* was used to rate the responses of the respondent, and scales were applied post-interview by researchers. Levels of implementation were based on the research literature regarding how well-evidenced programmes are run. Levels have not been

‘satisfactory’ [n=16]), and *manual use* (over three quarters of centres scoring ‘good’ [n=33])⁸⁹. Centres scored less highly when it came to ensuring *fidelity to the programme* (a third of centres scoring ‘satisfactory’ [n=13], a third scoring ‘inadequate’ [n=13], and only seven scoring ‘good’).

B. Triple P (Positive Parenting Programme)

Staff running the *Triple P* programme at 35 children’s centres chose to report on the programme in detail (see Table B4.12 in Appendix B4). A further three⁹⁰ children’s centres discussed their involvement in the roll out of *Triple P* via other organisations (see Table B4.13 in Appendix B4). As with *IY*, the majority of staff running the programme understood *Triple P* to be used internationally (n=29) and as a programme that focuses upon parents and children (n=26). *Triple P* was slightly more likely to be delivered solely through children’s centre staff (n=17, compared to n=13 of *IY* programmes) or a mix of organisations (n=14). In terms of outcomes, *Triple P* was reported as being most beneficial for ‘parenting skills for behaviour’ (n=33), ‘attachment between parent and child’ (n=23) and ‘child social and emotional development’ (n=16): these incidentally are the same three top outcomes as listed for the *IY* programme.

Triple P was most commonly chosen for implementation by the local authority (n=26), and then by children’s centre staff (n=14). Reasons for choosing this programme included that it is well known (n=25), research has shown a measurable impact on families (n=23), it falls into the list of evidence-based programmes (n=22) and there is substantive evaluative research behind the programme (n=21). Staff running the programme reported that all of the centres running *Triple P* took referrals from other agencies into the programme. A mixture of other recruitment procedures were also used for this programme including: ‘targeting specific families within the centre’ (n=31), ‘advertising within the centre and local community’ (n=29) and consulting with other partners over ‘which current non-centre users would most benefit’ (n=22).

All 35 children’s centres delivered *Triple P* as a time-bound programme, the majority of which took place through weekly sessions (n=33) both within the children’s centre (n=32) and homes (n=24). The programme was run in groups (n=31) and through one-to-one work (n=27). *Triple P* was most commonly run three times a year (n=9), although this figure was equally varied (8 centres ran this twice a year, 6 ran it once, and 5 ran it more than five times). Similar numbers of families to *IY* (n=23) were

validated against other scales or quality ratings, but are used here as a means to compare programmes in terms of the rigour of their implementation.

⁸⁹ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

⁹⁰ As so few centres (n=3) reported in detail on use of *Triple P* when run by another organisation, this is not discussed within the report.

reported as participating in the course over a year (ranging between 5 and 74). Mothers and fathers were most likely to participate in the programme (n=34 and n=27 centres respectively) and dropout was most commonly expected in the ranges 0-10 per cent (ten centres) or 11-20 per cent (nine centres).

When looking at scores on the programme implementation scales⁹¹, *Triple P* scored highly on *feedback and evaluation* (over half of the centres scoring 'good' [n=20], a little over a quarter scoring 'satisfactory' [n=10], and a small number scoring 'inadequate' [n=3]) and *manual use* (over three quarters of centres scoring 'good' [n=30], and a small number scoring 'satisfactory' [n=3]). In a similar manner to *IY*, centres scored lowly on ensuring *fidelity to the programme* (nearly half of centres scoring 'satisfactory' [n=17], a similar number scoring 'inadequate' [n=15], and only one centre scoring 'good').

C. Family Nurse Partnership

Staff members from five centres chose to report on questions regarding the direct running of the *Family Nurse Partnership (FNP)* programme, and thus the following descriptions are unlikely to be generalisable (see Table B4.14 in Appendix B). A further four⁹² children's centres discussed their involvement in the roll out of *FNP* via other organisations (see Table B4.15 in Appendix B). Of the five centres directly running *FNP*, three believed the programme to be used nationally, and all believed that parents and children were the focus of the programme. None of the five centres indicated that it was solely run by centre staff, but rather that it was run by staff from another organisation (n=3) or a mixture of organisations (n=2). The three most commonly reported outcomes for *FNP* were 'parental mental health' (n=3), 'attachment between parent and child' (n=3) and 'parenting skills for behaviour' (n=2). Two of these outcomes matched the top three listed for the *IY* and *Triple P* programmes.

Health services were most commonly reported as being responsible for choosing the programme (n=4) for reasons such as it suited the needs of families (n=4), it was recommended by another organisation e.g. NHS/Child and Adolescent Mental Health Service (CAMHS: n=3), research has shown a measurable impact on families (n=3) and it falls into a list of evidence-based programmes (n=3). Families were recruited via a mixture of referrals from other agencies (n=3) and advertising within the centre (n=3).

⁹¹ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

⁹² As so few centres (n=4) reported in detail on use of *FNP* when run by another organisation, this is not discussed within the report.

All five children's centres reported delivering *FNP* as a time-bound programme, on either a weekly (n=2) or fortnightly (n=2) basis. It was always run as a one-to-one programme within homes, but for two out of the five centres was also carried out within the children's centre itself; and for one centre within a group setting. *FNP* was either reported as being run continuously (n=3) or once a year (n=2). For those centres claiming to run the programme once, dropout was estimated to be low at between 0-10 per cent. All *FNP* programmes were aimed specifically at mothers, although two centres noted participation from fathers, and between 10 and 25 families were reached via *FNP* over the course of a year. In terms of the programme implementation scales⁹³, *FNP* scored lower than *IY* and *Triple P*, perhaps because due to the staff knowing less about the implementation of the programme: *feedback and evaluation* (two centres scoring 'satisfactory', two centres scoring 'inadequate to satisfactory' and the final centre scoring 'inadequate'); *manual use* (one centre scoring a 'good' and one centre scoring 'inadequate') and *ensuring fidelity to the programme* (two centres scoring 'inadequate').⁹⁴

D. Infant/Baby Massage

When comparing the extent of implementation for all well-evidenced programmes (section 5.2.1, Table 5.2) and all additionally listed programmes (section 5.2.2, Table 5.3), *Infant/Baby Massage* (hereon referred to as *Baby Massage*) was most extensively run throughout the sample. It is of little surprise therefore that this programme was chosen to be reported on in detail by the most centres (60 centres delivering this programme through their own staff, and two further centres through another organisation⁹⁵: see Table B4.16 and B4.17 in Appendix B4).

Considering those 60 centres where staff reported direct delivery of *Baby Massage*, the majority understood this to be an internationally used programme (n=46) which focuses on both parents and children (n=58), and is most commonly delivered solely through centre staff (n=49). All 60 children's centres viewed *Baby Massage* as beneficial for 'attachment between parent and child', with some centres additionally suggesting that the programme benefits: 'child physical health' (n=33), 'parental mental health' (n=28) and 'child social and emotional development' (n=24).

⁹³ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

⁹⁴ The lower scores on the *FNP* programme should not be generalised beyond the very small sample reporting on the programme (n=5). These lower scores for *FNP* may be easily explainable given that the staff answering the questions were often bystanders to the actual programme (which was run by a mixture of organisations) and were therefore unlikely to have information regarding how nurses evaluated the programme, and how frequently nurses made reference to a manual. Scores for *FNP* therefore should not be seen as reflective of the programme as a whole.

⁹⁵ As so few centres (n=2) reported in detail on use of *Baby Massage* when run by another organisation, this is not discussed within the report.

Across the 60 centres directly delivering the programme, staff were most commonly reported to have chosen the programme for use at the centre (n=46) although they gave a broad range of reasons for the selection of this programme including that it is well known (n=55), it suited the needs of families (n=51), positive outcomes have been witnessed in other centres that have ran the programme (n=44), research has shown a measurable impact (n=44) and that it falls into a recommended list of evidence-based programmes (n=30). There were also a broad range of means to recruiting families, including advertising within the centre and local community (which proved most popular; n=55), targeting specific families within the centre (n=54), taking referrals from other agencies (n=53), and consulting with partners over which non-centre users would most benefit (n=42).

In all 60 children's centres *Baby Massage* was carried out in a time-bound fashion, while the majority did so out of the children's centre itself (n=59) via weekly sessions (n=56). All programmes were run within groups, although one-to-one work was also possible in over half of the centres (n=33). *Baby Massage* was most commonly run either five or more times a year (n=24) or continuously (n=19). An average of 47 families participated in *Baby Massage* programmes across these 60 centres over the course of a year (ranging from 6-200 families per year). As might be expected, mothers and children were the family members most likely to participate in the programme; while dropout was most commonly expected to lie within the 0-10 per cent range (n=39). In terms of programme implementation, centres were more likely to score highly⁹⁶ when it came to their use of a programme *manual* (three quarters of centres scoring 'good' [n=45], nine centres scoring 'satisfactory' and two centres scoring 'inadequate'), than on their use of *feedback and evaluation* (three fifths of centres scoring 'satisfactory' [n=36], one fifth scoring 'good' [n=12], and one tenth scoring 'inadequate' [n=6]) and *ensuring fidelity to the programme* (nearly three quarters of centres scoring 'inadequate' [n=43], one fifth scoring 'satisfactory' [n=13], and only one centre scoring 'good').

E. Family Links Nurturing Programme (Parenting Puzzle)

The next programme to be considered for discussion is the *Family Links* Programme, due to the large numbers of staff reporting in detail (21 centres in total, B4.18 in Appendix B4). No centres running *Family Links* reported on the questions related to programme carried out by other organisations. Of the 21 centres running *Family Links*, the majority regarded the programme as internationally used (n=12) focused on both parents and children (n=19) and delivered both through children's centre staff (n=11) or a mixture of organisations (n=9). A number of outcomes were listed as important for the programme, including 'parenting skills for behaviour'

⁹⁶ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

(n=18), 'attachment between parent and child' (n=14), 'child social and emotional development' (n=12) and 'parental mental health' (n=10). The top three outcomes exactly match those of two of the well-evidenced programmes (*IY* and *Triple P*).

The local authority and children's centre staff were reported as being almost equally responsible for the choice of this programme (14 and 13 centres respectively). A varied set of reasons were given for choosing this programme across the centres, including more commonly that research has shown a measurable impact (n=17) and that it falls into a recommended list of evidence-based programmes (n=17). Other reasons included that positive outcomes have been witnessed in other centres that have ran the programme (n=15), there has been substantive evaluative research (n=15) and it suited the needs of families within the reach area (n=14). All centres noted that they recruit families through targeting in the centre and taking referrals from other agencies.

In all 21 children's centres, *Family Links* was carried out in a time-bound fashion within the children's centre itself, and all programmes took place via weekly sessions (or more frequently). The majority of programmes were run within groups (n=20) although over half of the centres noted that one-to-one sessions were also carried out (n=13). *Family Links* was most commonly run either three (n=8) or two (n=6) times per year. An average of 30 families participated in the *Family Links* programme within the centres over the course of a year (ranging from 9-100 families per year). Mothers were the dominant attendees in all the centres, although a large number of fathers did also take part (in 16 centres). The dropout rate was most commonly expected to be slightly higher than *Baby Massage*, at the 11-20 per cent range (n=9). With regards to the three programme implementation scales, all 21 centres scored 'good'⁹⁷ on their use of a programme *manual*, and very highly on their use of *feedback and evaluation* (with nearly all centres scoring 'good' [n=20] and only one centre scoring 'satisfactory'). Similarly (although marginally better) to *Baby Massage* however, centres scored less well on the scale measuring *fidelity to the programme* (over half of centres scoring 'inadequate' [n=12], just over a third scoring 'satisfactory' [n=8], and only one centre scoring 'good').

F. Peers Early Education Partnership (PEEP) Learning Together Programme

The last programme to be considered for discussion is the *Peers Early Education Partnership* programme (*PEEP*: now called *Parents Early Education Partnership*), as this was also largely chosen for discussion throughout the focus interviews (by 14 programme roll outs across 13 centres, see Table B4.19 in Appendix B4). Again, no

⁹⁷ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

centres running *PEEP* reported on the questions related to programmes carried out by other organisations.

Staff involved in all 14 roll outs of *PEEP* regarded the programme as nationally used, and all stated that the programme's focus was on both parents and children. For the majority of centres, this was delivered through children's centre staff (n=9). Two main outcomes were listed as being important for the programme, which were 'child development in language and cognition' (n=12) and 'child social and emotional development' (n=12). The local authority and children's centre staff were reported as being fairly equally responsible for the choice of this programme (within 5 and 7 roll outs respectively). A variety of reasons were given for choosing this programme across the centres; including positive outcomes witnessed in other centres running the programme (n=13), it suited the needs of families within the reach area (n=11), research has shown a measurable impact (n=11) and it falls into a recommended list of evidence-based programmes (n=10).

All centres noted that they recruit families through targeting in the centre and the majority also advertised within the centre (n=13) and took referrals from other agencies (n=10). Just over half of the roll outs were run in a time bound manner (n=8), and half of the programmes were instead run continuously (n=7). Of those programmes run in a time-bound manner, there was great variety in terms of the number of times it occurred per year (ranging from one to five times or more, see Table B4.19 in Appendix B4 for further details). An average of 104 families participated in *PEEP* within centres over the course of a year (ranging from 10-962 families per year), confirming the drop-in nature of a number of the programmes. Whilst all programmes were attended by mothers, a range of other family members also attended this programme including children (n=10), fathers (n=7), and grandparents (n=6). The drop out rate was not applicable to those running the programme as a continuous drop-in session, but was generally expected to be low (between 0-10%).

With regards to measuring programme implementation, the 14 programmes scored highest⁹⁸ on their use of a programme *manual* (over three quarters of centres scored 'good' [n=10], and nearly a quarter scored 'satisfactory' [n=3]). Scores were not so high regarding their use of *feedback and evaluation* (with nearly three quarters scoring 'satisfactory' [n=9], just over a quarter scoring 'good' [n=4], and one centre scoring 'inadequate to satisfactory'), and scores were lowest on *ensuring fidelity to the programme* (over three quarters of centres scoring 'inadequate' [n=11], and the remainder of centres scoring 'satisfactory' [n=3]).

⁹⁸ From three point ordinal scales ranging from 0-2 and scoring inadequate, satisfactory or good: see Figure B2.1 in Appendix B2.

B4 - Technical Appendix for Evidence-Based Practice

Appendix B4 is available on the Department of Education, University of Oxford website (<http://www.education.ox.ac.uk/research/fell/research/>). The appendix contains the following.

Table B4.1. Details of all the listed programmes within the supplementary information section of the questionnaire during Strand 3 baseline fieldwork (centres could report up to seven programmes, strategies or interventions that were in addition to those shown in Chapter 5, Tables 5.2 and 5.3)

Table B4.2. Most common responses given by centres on 18 measures (when discussing up to three 'focus' programmes, strategies or interventions)

Table B4.3. Full set of responses given by centres on 18 measures (when discussing up to three programmes, strategies or interventions). (n=118 centres providing data on at least one programme)

Table B4.4. Responses on the programmes, strategies or interventions discussed with staff who do not run these i.e. where they were commissioned out to be run by another agency, or other arrangement. (n=118 centres providing data on at least one programme)

Table B4.5. The 87 focus programmes that children's centres provided detailed information on during Phase 1 of the Strand 3 fieldwork (up to three reported by each children's centre, but each programme reported only once per centre)

Table B4.6. Responses on the programmes, strategies or interventions discussed with staff who run these. Scores from the 13 programmes, strategies or interventions discussed in depth by four or more children's centres

Table B4.7. Responses on the programmes, strategies or interventions discussed with staff who do not run these (i.e. where they were commissioned out to be run by another agency, or other arrangement). Median scores from the 13 programmes, strategies or interventions discussed in depth by four or more children's centres

Table B4.8. Responses on the programmes, strategies or interventions discussed with staff who run these. Scores from the 87 programmes, strategies or interventions discussed in depth by four or more children's centres

Table B4.9. Responses on the programmes, strategies or interventions discussed with staff who do not run these (i.e. where they were commissioned out to be run by another agency, or other arrangement). Median scores from the 87 programmes, strategies or interventions discussed in depth by four or more children's centres

Table B4.10. Responses on the Incredible Years (well-evidenced programme) as discussed by staff who ran the programme. (n=39 centres personally running the Incredible Years programme)

Table B4.11. Responses on the Incredible Years (well-evidenced programme) as discussed by staff who did not run the programme i.e. where the programmes were commissioned out to be run by another agency, or other arrangement. (n=6 centres commissioning out or running via another agency the Incredible Years programme)

Table B4.12. Responses on the Triple P (well-evidenced programme) as discussed by staff who ran the programme. (n=35 centres personally running the Triple P programme)

Table B4.13. Responses on the Triple P (well-evidenced programme) as discussed by staff who did not run the programme i.e. where the programmes were commissioned out to be run by another agency, or other arrangement. (n=3 centres commissioning out or running via another agency the Triple P programme)

Table B4.14. Responses on the Family Nurse Partnership (well-evidenced programme) as discussed by staff who ran the programme. (n=5 centres personally running the Family Nurse Partnership programme)

Table B4.15. Responses on the Family Nurse Partnership (well-evidenced programme) as discussed by staff who did not run the programme i.e. where the programmes were commissioned out to be run by another agency, or other arrangement. (n=4 centres commissioning out or running via another agency the Family Nurse Partnership programme)

Table B4.16. Responses on the Infant/Baby Massage programme as discussed by staff who ran the programme. (n=60 centres personally running the Infant/Baby Massage programme)

Table B4.17. Responses on the Infant/Baby Massage programme as discussed by staff who did not run the programme i.e. where the programmes were commissioned out to be run by another agency, or other arrangement. (n=2 centres commissioning out or running via another agency the Infant/Baby Massage programme)

Table B4.18. Responses on the Family Links Nurturing programme as discussed by staff who ran the programme. (n=21 centres personally running the Family Links Nurturing programme)

Table B4.19. Responses on the PEEP programme as discussed by staff who ran the programme. (n=14 programme roll outs across 13 centres personally running the PEEP programme)

Figure B4.1. Four standards of evidence criteria for early intervention programmes, as defined by Allen (2011)

APPENDIX C: Service Delivery, Multi-agency Working and Integration

C1 – Definitions of the terms used in Chapter 3

There has been little clarity in the language used to refer to service integration and multi-agency working (Siraj-Blatchford and Siraj-Blatchford, 2009)⁹⁹. The definitions adopted in this part of the investigation are set out here, together with some examples of the questions used to ‘unpick’ actual practice in the children’s centres:

Service delivery: the services offered by children’s centres, where and by whom.

- **What services do children’s centres offer, and in what combinations?**
For example, some centres focus on health and health-related services, others on child development. Some centres concentrate on services for parents, others on children. Some centres do more outreach work than others, with families or local community groups. What is the balance between different services?
- **Where are services delivered?** Services may be delivered in one central building (the children’s centre), in other buildings which are part of the centre, or part of a cluster of centres, or on other sites which may be more accessible to some neighbourhoods in the catchment area – a local church, health clinic, library, corner shop or supermarket, Travellers’ site, or a combination of all of these.
- **Who delivers the services?** Services may be delivered by staff employed and managed by the children’s centre, or staff employed and managed by partner agencies and deployed for some part of the week on children’s centre services, or a combination of both.

Multi-agency working and partnerships: the involvement of other organisations in providing services in children’s centres, and the extent to which priorities and ethos are shared¹⁰⁰

- **What other organisations provide services for parents and children using children’s centres?**

⁹⁹ Iram Siraj-Blatchford and John Siraj-Blatchford argue that ‘service integration’ might best be understood as an ecological ‘Integrated Children’s System’ that is ‘centred on the child and their family, served through service coordination, and supported through integrated organisations and agencies’.

¹⁰⁰ Multi-agency partnership working may operate at the strategic level of planning by local authorities, health authorities, or the private and voluntary and independent sector (PVI): Children’s Trusts are one example. This strategic level, however, was not included in the final ECCE research design agreed by the DfE.

- **What other organisations do children's centre managers and staff see as partners?** This may be other statutory bodies, voluntary organisations, community groups, all the organisations that a centre works with or only a sub-set. Partnership may be seen as formal (partnership agreements to provide/use services) or informal ('we work with them').
- **Do centres set priorities for their work together with partners?** If so, this may be done formally (e.g. through advisory boards) or informally.
- **Do centres and their partners share working practices?** For example, data may be shared about potential users (birth data held by the health authority) or information about families using the centre, either formally (information-sharing protocols with Children's Services, for instance) or informally.

Integration: the extent of integration, collaboration, or coordination evident in philosophy (vision) or practice (service delivery and management).

This may be evidenced at different levels:

- **Philosophy and vision:** to what extent is there a shared vision or ethos between centres and their partners? How is this demonstrated? How is it reached?
- **Service delivery on the ground:** do workers from the centre and their partners work together in providing a service? Is there a common timetable? Who has authority to make changes to the timetable?
- **Management:** who do workers report to? Do workers from the centres' partners also report to, or discuss their work with, the centre manager? Who has authority to make changes to workers' responsibilities or workload?

If we think of integration as a continuum, it may be possible to plot different configurations of service delivery, management style or multi-agency partnerships at different points along the continuum. Here is one way of characterising centres:

- **Co-location:** Here services for young children and their parents are brought together in one centre. The advantage for families is that they can get access to services under one roof (the concept of 'one open door'). But there may be different philosophies underpinning the different services, and possibly different eligibility criteria; workers will be managed separately, and the head of centre may have little overall power or control.
- **Co-ordination:** As before, families can get access to services under one roof. There may be moves to bring the services together into a more consistent whole, with common timetables, some common reporting and management, and development of common priorities and vision. But when 'the chips are down' (for example, when retrenchment and reorganisation begins to take effect) there will be separate management systems and overall strategic planning systems in operation, and no overall control by the head of centre of the operation or of planning.

- **Integration:** Here there is an integrated shared philosophy and practice throughout the centre's operation and planning. This is characterised by aspects such as common timetables, agreed protocols for data-sharing and information-sharing, common reporting systems, common management systems with agreed arrangements for funding and employment or secondment and service delivery, and strong overall control by the head of centre.

C2 – A comparison of the services offered by children's centres in 2011 and 2012

Table C2.1. Change in the 11 categories of services offered by children's centres between 2011 and 2012 (in n=121 children's centres)

Categories of Services (n=how many individual services are summarised within the category)		Centres offering these categories of services in 2011 - out of a longitudinal max. n=121		Centres offering these categories of services in 2012 - out of a longitudinal max. n=121		Statistical comparison of the change in offered categories of services between 2011 and 2012			
		No. of Centres offering	% out of max. n=121	No. of Centres offering	% out of max. n=121	Overall Δ No. (2012 – 2011)	Statistic (Wilcoxon rank test: Z)	Effect Size, r: $Z/(n^{1/2})$	p
1	Childcare and early years education (n=1)	99	82	110	91	+11	Z=2.3	0.21	.022
2	Before/after school care for older children (n=2)	27	22	34	28	+7	Z=1.5	0.14	.127
3	Opportunities for parents and children to play and take part in activities together (n=4)	118	98	121	100	+3	Z=1.7	0.15	.083
4	Childminder development and support (n=3)	103	85	100	83	-3	Z=0.7	0.06	.491
5	Health-related services (n=9)	117	97	121	100	+4	Z=2.0	0.18	.046
6	Employment and benefits services or advice (n=8)	111	92	115	95	+4	Z=1.3	0.12	.206
7	Other advice and information services (n=2)	88	73	97	80	+9	Z=1.6	0.15	.106
8	Adult education for parents (n=4)	106	88	112	93	+6	Z=1.5	0.14	.134
9	Family and parenting support(n=7)	116	96	119	98	+3	Z=1.1	0.10	.257
10	Outreach or home-based services (n=3)	114	94	114	94	No change			
11	Other Services (n=4)	110	91	120	99	+10	Z=2.9	0.26	.004

Note: Effect sizes are interpreted as: 0.1 small; 0.3 medium; 0.5 large

Table C2.2. Change in the services offered by children's centres between 2011 and 2012 (n=121 children's centres)

Services			Centres offering these services in 2011 - out of a longitudinal max. n=121		Centres offering these services in 2012 - out of a longitudinal max. n=121		Statistical comparison of the change in offered services between 2011 and 2012			
Categories	Individual Services		No. of Centres offering	% out of max. n=121	No. of Centres offering	% out of max. n=121	Overall Δ No. (2012 – 2011)	Statistic (Wilcoxon rank test: Z)	Effect Size, r: $Z/(n^{1/2})$	p
Childcare and early years education	1	Early learning and childcare	99	82	110	91	+11	Z=2.3	0.21	.022
	2	Before school care for older children	17	14	20	17	+3	Z=0.7	0.06	.467
Before/after school care for older children	3	After school care for older children	24	20	32	26	+8	Z=1.7	0.15	.088
	4	Stay and play	118	98	119	98	+1	Z=0.4	0.04	.655
Opportunities for parents and children to play and take part in activities together	5	Thematic stay and play (music classes/art classes)	97	80	93	77	-4	Z=0.8	0.07	.433
	6	Play and learn (stay and play for older children)	58	48	41	34	-17	Z=2.6	0.24	.010
	7	Weekend activities	75	62	77	64	+2	Z=0.4	0.04	.724
Childminder development and support	8	Childminder development (training and support)	82	68	86	71	+4	Z=0.7	0.06	.465
	9	Childminder drop-ins	94	78	79	65	-15	Z=2.7	0.25	.007
	10	Childminders play and learn	41	34	40	33	-1	Z=0.2	0.02	.869
Health-related services	11	Health watch	10	8	4	3	-6	Z=1.6	0.15	.109
	12	Speech and Language Therapy (SALT)	91	75	92	76	+1	Z=0.2	0.02	.847
	13	Breast feeding support	109	90	109	90	No change			
	14	Midwife clinic	88	73	86	71	-2	Z=0.4	0.04	.683
	15	Health visitor clinic	95	79	92	76	-3	Z=0.7	0.06	.491
	16	Sports and exercise for babies and children	92	76	88	73	-4	Z=0.6	0.05	.537
	17	Sport and exercise for parents	48	40	61	50	+13	Z=2.5	0.23	.012
	18	Specialist clinic	34	28	47	39	+13	Z=1.9	0.17	.053
	19	Clinical psychology services	31	26	34	28	+3	Z=0.5	0.05	.631
Employment and benefits services or advice	20	Benefits and tax credits advice	89	74	97	80	+8	Z=1.5	0.14	.131
	21	JobCentre plus (drop-in and pc terminal)	37	31	44	36	+7	Z=1.2	0.11	.223
	22	JobCentre plus (back to work advice)	47	39	56	46	+9	Z=1.5	0.14	.139
	23	JobCentre plus (appointment only sessions)	35	29	36	30	+1	Z=0.2	0.02	.857
	24	Next steps (employment support)	47	39	35	29	-12	Z=2.0	0.18	.046
	25	Teenage parents - get into work or training	65	54	60	50	-5	Z=0.7	0.06	.456
	26	Women's back to work support	46	38	38	31	-8	Z=1.2	0.11	.238
	27	Basic IT and job skill course	62	51	52	43	-10	Z=1.7	0.15	.096
Other advice and information services	28	Housing advice or information	73	60	81	67	+8	Z=1.3	0.12	.182
	29	Debt advice (e.g. From citizen's advice bureau)	77	64	80	66	+3	Z=0.5	0.05	.612

Table C2.2. [Continued]

Services			Centres offering these services in 2011 - out of a longitudinal max. n=121		Centres offering these services in 2012 - out of a longitudinal max. n=121		Statistical comparison of the change in offered services between 2011 and 2012			
Categories	Individual Services		No. of Centres offering	% out of max. n=121	No. of Centres offering	% out of max. n=121	Overall Δ No. (2012 – 2011)	Statistic (Wilcoxon rank test: Z)	Effect Size, r: Z/(n ^{1/2})	p
Adult education for parents	30	Adult learning	96	79	105	87	+9	Z=1.9	0.17	.061
	31	Further education	40	33	39	32	-1	Z=0.2	0.02	.876
	32	English for Speakers of Other Language Classes (ESOL)	62	51	55	45	-7	Z=1.1	0.10	.274
	33	Life coaching	27	22	19	16	-8	Z=1.6	0.15	.102
Family and parenting support	34	Ante natal classes	80	66	78	64	-2	Z=0.3	0.03	.752
	35	Post natal classes	56	46	58	48	+2	Z=0.3	0.03	.773
	36	Peers and family support/ parenting classes/ relationship support	107	88	107	88	No change			
	37	Peer support	100	83	39	32	-61	Z=7.0	0.64	<.000
	38	Activities and hobbies for parents	65	54	52	43	-13	Z=2.0	0.18	.042
	39	Evidence- based parenting programmes	103	85	112	93	+9	Z=2.1	0.19	.039
	40	Other specialist support	81	67	41	34	-40	Z=5.0	0.45	<.000
Outreach or home-based services	41	Home-based services ¹	75	62	98	81	+23	Z=3.2	0.29	.002
	42	Home-based outreach services ²	108	89	102	84	-6	Z=1.3	0.12	.201
	43	Other outreach services ³	44	36	83	69	+39	Z=5.1	0.46	<.000
Other Services	44	Toy library	57	47	60	50	+3	Z=0.7	0.06	.513
	45	Book Start Baby Bags/My treasure box	85	70	104	86	+19	Z=3.3	0.30	.001
	46	Sure Start resource library	34	28	38	31	+4	Z=0.7	0.06	.465
	47	Parent forum	98	81	108	89	+10	Z=2.0	0.18	.050

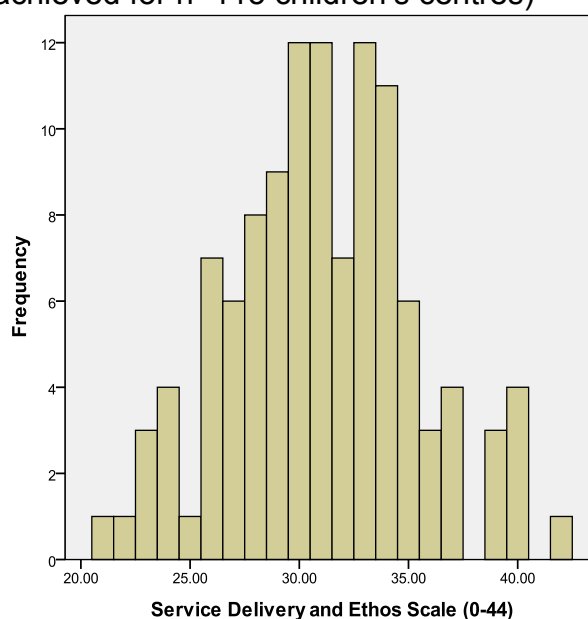
Notes: ¹ Merely home visits; ² As Home-based services but also to deliver a service; ³ Services that are not Home-based. Effect sizes are interpreted as: 0.1 small; 0.3 medium; 0.5 large

C3 – Multi-agency working and integration

Table C3.1 The variety of professional backgrounds characterising the children's centre managers who were interviewed about multi-agency working and the delivery of integrated services during Wave 1 of Strand 3 fieldwork in 2012 (answers given by all n=121 managers interviewed)

Voluntary sector	Health (physical, mental)	Social work/ social care/ community work	Education	
			No	Yes
No	No	No	6	39
		Yes	21	12
	Yes	No	9	2
		Yes	1	2
Yes	No	No	6	7
		Yes	4	8
	Yes	Yes	1	3

Figure C3.1. The *Service Delivery and Ethos Scale*. Created from the summation of 11 questions that asked managers to rate the importance of 11 aspects of centre working when attempting to make services accessible for children and families (median=31; scores achieved for n=115 children's centres)



C4 – Disagreements and lack of sharing

Examples:

- “There is a lack of understanding of what the children’s centre provides.”
- “The midwives have a particular way of speaking.”
- “There is a lack of joint working, as the delivery of health services is not integrated.”
- “There is no support from the JobCentre. There are threshold issues with social care about children we think need attention.”
- “Health and social services have problems sharing information.”
- “Health has a different vision, a different ethos; they do not understand multi-agency working; they think that children’s centre staff are not properly trained in health procedures.”
- Other services “have unrealistic expectations of children’s centres, and they do not know or understand the area.”
- “It has taken years to develop solid links with health. The expectation from social care is that it can be done overnight.”
- “Health colleagues are hardest to engage with, different working ethos. Schools are a challenge, again a different working ethos. Nurses see the children’s centre as competition.”
- “Schools see children’s centres just as family support and pastoral care.” “Schools are preoccupied with their own policy.” “Headteachers have different perceptions about what children’s centres can offer families.”
- “Midwives are hard to engage – lack of time and understanding; the school likes to do things in-house and in isolation; the JobCentre does not know about the service; there are issues over thresholds with children’s services.”
- “Partner agencies do not realise that children’s centres offer universal as well as targeted services.”

C5 – The importance of open access and a welcoming atmosphere for making services accessible

Examples:

- “The first impression is vital.” “It has to be a friendly and welcoming centre open to all.”
- “The centre should look and feel welcoming: the visual display should be clean and tidy.”
- “Welcoming, visually appealing, approachable, comfortable.” “Quick and easy access.”
- “We need to be flexible and make changes for the better.”
- “We never turn anyone away.”
- “Show the community that centres are inclusive: it’s a female-dominated environment but has to be accessible also to men.”
- “Ensure ethnic groups have equal opportunities to access services.”
- “Listen to what people want.”
- “You have to know the community, the needs of the community.” “Local knowledge.” “Staff who speak the community’s languages.” “Translation services.”

C6 – Technical Appendix for Service Delivery, Multi-agency Working and Integration

Appendix C6 is available on the Department of Education, University of Oxford website (<http://www.education.ox.ac.uk/research/fell/research/>). The appendix contains the following.

Table C6.1. The location of sites for service delivery other than the main children’s centre, including ‘satellite sites’ run by the main centre, and ‘non-satellite sites’ not run by the centre but rented perhaps for a few hours a week

Table C6.2. Quantifying the priorities of children’s centres in the context of shared visions with partner agencies during Wave 1 of Strand 3 fieldwork in 2012

Table C6.3. Responses to the 11 named aspects of children’s centres that centre managers were asked to rate as important (or otherwise) in their attempts to make centre services accessible for families and children

Table C6.4. Responses to the six questions about children’s centres’ collaborative working arrangements with partner agencies and organisations that were asked of centre managers who were interviewed during Wave 1 of Strand 3 fieldwork

APPENDIX D: Leadership and Management

D1 – Children’s Centre Leadership and Management Rating Scale (CCLMRS)

Figure D1.1 Introducing the Children’s Centre Leadership and Management Rating Scale (CCLMRS)

Introducing the CCLMRS:

The CCLMRS is an interview and document-based assessment that measures the quality of management-level practices within a children’s centre. The CCLMRS focuses on the processes of leadership and management that take place within children’s centres, as evidenced by documentation and interview. The scale is administered by a trained researcher who rates the centre on a set of indicators which form an incline of quality. Items are made up of a collection of indicators, and are interrogated through structured interview and review of documentation to assure the researcher of score accuracy. The variety of literature that one might review during this process includes: centre timetables, staff organisational charts, centre development plans or documents detailing centre aims and future plans, self evaluations (e.g. the Self Evaluation Form: [SEF]), staff qualifications and work experience (including those within childcare), staff induction literature, meeting agendas and minutes, training manuals, centre policies, evaluation/assessment tools (including those used within particular programmes, as discussed in Chapter 5), and handbooks for programmes. The CCLMRS consists of 20 items, grouped under five subscales. Items are rated on a 6-point scale from ‘0= *Inadequate*’ to ‘1 = *Adequate*’ to ‘3 = *Good*’ to ‘5 = *Outstanding*’. Scoring is an additive process as all lower indicators need to score ‘yes’ before proceeding onto the higher ratings; in this sense, each item constitutes an incline of leadership and management quality. For further information on the scale, see Sylva et al. (2012). The outline of the scale is detailed in Figure D1.1a. Whilst the CCLMRS was validated through expert review and detailed research into relevant literature and policy, it is important to note that the scale has not yet been validated against other assessment instruments and therefore the incline/levels of quality may need further research. Ratings should therefore not be considered as validated against other assessment instruments, but used as a method to compare centres in terms of their leadership and management.

Figure D1.1a. Breakdown of items and subscales within the CCLMRS

A. Vision and Mission 1. Vision and Strategic Planning 2. Performance Management 3. Achieving Positive Outcomes for Families and/ or Children 4. Safeguarding Children B. Staff Recruitment and Employment 1. Recruitment and Induction of New Staff 2. Line Management 3. Professional Development of Staff C. Staff Training and Qualifications 1. Qualifications and Experience of Senior Staff 2. Qualifications and Experience of Other Centre Staff	D. Service Delivery 1. Child Learning 2. Parenting and Family Support 3. Outreach and Home Visits 4. Multi-agency Partnerships 5. Parent Consultation and Community Engagement E. Centre Organisation and Management 1. Financial Management 2. Staff Timetables and Ratios 3. Space and Equipment 4. Centre Health and Safety 5. Staff Meetings and Consultation 6. Branding and Publicity
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Table D1.1. Mean subscale scores for all five of the Children's Centre Leadership and Management Rating Scale (CCLMRS) subscales, and for the total mean CCLMRS score

	Vision and Mission subscale	Staff Recruitment and Employment	Staff Training and Qualifications	Service Delivery	Centre Organisation and Management	Total CCLMRS
No. centres providing data	115	115	116	112	111	107
Mean	2.0935	2.6609	3.2716	2.0089	1.6877	2.1785
Median	2.0000	2.6667	3.5000	2.2000	1.6667	2.1000
Std. Deviation	.92626	.95919	.90504	.91174	.88965	.71123
Minimum	.00	1.00	.00	.00	.00	.50
Maximum	4.25	5.00	5.00	4.80	4.17	4.05

Table D1.2. Mean item scores across the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=119 centres providing data on at least one item on the scale)

Subscale	Item	No. centres	Min	Max	Mean Score	S.D.
Vision and Mission	Vision and Strategic Planning	115	.00	5.00	1.4435	1.37133
	Performance Management	115	.00	5.00	2.9130	1.46038
	Achieving Positive Outcomes	115	.00	5.00	2.2174	1.22677
	Safeguarding Children	115	.00	5.00	1.8000	1.33902
Staff Recruitment and Employment	Recruitment and Induction of New Staff	115	.00	5.00	2.2261	1.52212
	Line Management	115	.00	5.00	2.0783	1.35820
	Professional Development of Staff	115	.00	5.00	3.6783	1.30147
Staff Training and Qualifications	Qualifications and Experience of Senior Staff	119	.00	5.00	2.0168	1.42009
	Qualifications and Experience of Other Staff	116	.00	5.00	4.5345	1.00806
Service Delivery	Child Learning	115	.00	5.00	2.7130	1.71047
	Parenting and Family Support	114	.00	5.00	1.9298	1.20998
	Outreach and Home Visits	113	.00	5.00	2.4248	1.39390
	Multi-agency Partnerships	115	.00	5.00	1.3739	1.20278
	Parent Consultation and Community Engagement	115	.00	5.00	1.6087	1.42469
Centre Organisation and Management	Financial Management	112	.00	5.00	1.5893	1.76836
	Staff Timetables and Ratios	116	.00	5.00	1.9224	1.27280
	Space and Equipment	116	.00	5.00	2.2845	1.37560
	Centre Health and Safety	116	.00	5.00	1.5259	1.62299
	Staff Meetings and Consultation	115	.00	4.00	.9652	1.30405
	Branding and Publicity	115	.00	5.00	1.7826	1.78582

Figure D1.2 Describing the five subscales (or 'domains of quality')

The Vision and Mission subscale:

This subscale of the CCLMRS contains four items. Centres are rated on their *vision and strategic planning*, in terms of who contributed to the initial vision/mission statement and its content, how it is made known to others and how often it is reviewed. For *performance management*, interviewees are asked about: self evaluation, collection of additional data and usage, monitoring trends and user satisfaction, and data manipulation. Regarding *achieving positive outcomes*, respondents are asked about particular family outcomes (health, safety, child and parent learning, and economic security) including targeted services; and monitoring of success and evidence of improvement. Lastly, *safeguarding children* covers: child protection/awareness and training, safe recruitment of staff volunteers and contractors, and safety procedures.

The Staff Recruitment and Employment subscale:

This subscale of the CCLMRS incorporates three items. *Recruitment and induction of new staff* assesses the format and structure for inducting new staff, and advertising procedures for new vacancies. Within *line management*, interviewees are asked about staff supervision arrangements (including frequency) and procedures for staff appraisal. This item also covers job descriptions (for staff and volunteers), and the handling of complaints and grievances. The final item within this subscale, *professional development of staff*, interrogates the opportunities and processes for staff of different seniority to undertake professional development, and procedures regarding outcomes from the training.

The Staff Training and Qualifications subscale:

This subscale is made up of two items assessing the training and qualifications of senior and non-senior staff at the centre. *The qualifications and experience of senior staff* item covers relevant work experience and qualifications of those in senior roles (i.e. those managing the setting, leading the Early Years, or leading family and parenting support services). *Qualifications and experience of other centre staff* assesses the percentage of childcare and family support staff who are qualified at NVQ Level 3 or above, and have at least two years relevant work experience.

The Service Delivery subscale:

This subscale contains five items which assess the range of services integrated into the working of the children's centre. The *child learning* item covers the management processes behind provision for children's learning, such as planning and review (Early Years Foundation Stage [EYFS] skills and interests of children); monitoring and evaluation; and protocols for assessing and supporting children with additional learning needs. *Parenting and family support* is a more wide-ranging item that assesses provision of support and evidence-based parenting programmes; collaborative working arrangements with specialists; protocols for working with families of children with additional physical and/or mental needs; parental involvement within centre management; and provision for fathers and male carers. *Outreach and home visits* covers birth visits to newborn babies and access to databases of live births within the locality; procedures for engaging vulnerable families; management of home visits and outreach work including staff training and policies, and protocols covering staff personal safety.

Figure D1.2 [Continued]

The Service Delivery subscale [continued]:

The *multi-agency partnerships* item assesses partnerships with health services, childminder networks, primary schools, employment-related agencies (particularly JobCentre Plus), and Health and Social Care. This item particularly focuses on signposting and referral procedures, the co-location of staff, and close collaboration amongst agencies. The last item within this subscale is *parent consultation and community engagement* which covers feedback from families; parental support within the governance of the centre (e.g. governing or advisory boards, parent forums); and consultations with parents who do not currently use children's centre services.

The Centre Organisation and Management subscale:

This subscale contains six items covering a wide variety of centre management processes. *Financial management* incorporates: the centre budget and monitoring processes, the development plan, financial policies and securing additional income. The *space and equipment* item looks at the provision of rooms with particular focus on privacy issues and access to relevant facilities (including ICT equipment and educational reading) for staff and families. The *centre health and safety* item focuses on: risk assessment procedures, training for staff, fire evacuation protocols, paediatric first aid, and child health needs. *Staff meetings and consultation* looks into: procedures for staff meetings (including attendees and arrangements), and methods for consultation with staff about services and working conditions at the centre. The last item is *branding and publicity*, which assesses: the production of the advertisement materials, branding for the centre (including outside of the building), distribution of publicity materials, and recording enquiries.

D2 – Leadership Questionnaires

Figure D2.1 Introducing the Leadership Questionnaires

Introducing the Leadership Questionnaires:

In addition to the development of a quality rating scale (see Section 4.1), the first wave of Strand 3 fieldwork also studied centre leadership and management with a questionnaire that was designed to investigate staff perceptions and experiences. The questionnaire was developed to assess the quality and effectiveness of leadership in children's centres from the perspective of both managers and key centre staff. It was primarily a research tool developed for ECCE, but it also has the potential to be used as a self-reflective tool by the leaders of children's centres for the purpose of self evaluation (Sammons, Smees, Good, Sylva and Hall., 2011a and 2011b; Sylva, Good and Sammons, 2011). For further information on the development of the questionnaire, see Appendix D5.

The structure of the questionnaire

The questionnaire was developed with two coordinating versions; one to be completed by centre managers, and one to be completed by key staff at the centre. The centre manager version contained 17 areas that were grouped under five sections. Questions were responded to on a six-point ordinal scale (see Figure D2.1a). Two types of question were responded to on these six-point scales: either extent of agreement with the statement (*Disagree strongly-Agree strongly*), or existence of a practice/activity within the centre (*Not at all – A great deal*).

Figure D2.1a. Breakdown of items and sections within the centre manager questionnaire

A. Vision and purpose within the Sure Start Children's Centre 1. Clarity of vision and focus 2. Standards and expectation B. Leadership of the Sure Start Children's Centre 3. Leadership practice 4. Leadership style C. Monitoring of services within the children's centre 5. Activities to improve centre practice 6. Use of data	D. Working with staff and stakeholders 7. Impact on staff 8. Working with centre staff 9. Continuing Professional Development 10. Relationship with staff 11. Other leaders within the centre 12. Relationship with Advisory board 13. Distributed or shared leadership E. Collaboration of staff and integration of services 14. Facilitation of staff collaboration 15. Integration and multi-agency working 16. Working with partner agencies 17. Parent and community involvement
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Figure D2.1 [Continued]

Where possible, the key staff version of the questionnaire contained questions that were adapted from the version designed for centre managers. The key staff version included 16 areas (one less than the centre manager version) that were grouped within five sections (see Figure D2.1b).

Figure D2.1b. Breakdown of items and sections within the key staff questionnaire

A. Vision and purpose 1. Clarity of vision and focus 2. Standards and expectation B. Leadership of the Sure Start Children's Centre 3. Leadership practice 4. Leadership style C. Monitoring of services within the children's centre 5. Activities to improve centre practice 6. Evaluation of centre performance 7. Use of data	D. Working with staff 8. Impact on staff 9. Continuing Professional Development 10. Relationship with centre manager 11. Other leaders within the centre 12. Distributed or shared leadership E. Collaboration of staff and integration of services 13. Facilitation of staff collaboration 14. Integration and multi-agency working 15. Working with partner agencies 16. Parent and community involvement
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Table D2.1. The statistically significant relationships between the views of centre managers and key staff

Q1. To what extent do you agree with the following statements in relation to your Sure Start Children's Centre.... <i>Vision and purpose</i>	Corr.	n
As yet we do not place a strong enough focus on the Early years Foundation Stage (EYFS)	0.35**	105
The multi-agency focus and partnership-working within our centre needs further development	0.32**	103
There is a strong focus on promoting parents'/carers' learning and development	0.29**	101
Staff and families are regularly involved in developing the vision of our centre and the centre provides services to match this vision	0.27**	105
Q2. To what extent do you agree with the following statements in relation to standards and expectations in your Sure Start Children's Centre....	Corr.	n
It is difficult to improve outcomes for the neediest children and families in the community served by our centre	0.24**	101
Q5. To what extent does the CM carry out the following activities to improve SSCC practice... <i>Monitoring of services</i>	Corr.	n
The CM observes interactions between children and adults during centre activities	0.40**	104
The CM screens to identify children and families 'at-risk' (e.g. CAF)	0.32**	98
The CM screens to identify children and families 'at-risk' (e.g. CAF)	0.32**	98
The CM observes interactions between staff and parents/carers during centre activities	0.27**	104
The CM uses research evidence to inform practice	0.24*	105
The CM encourages and support staff to use data effectively in planning for individual child or family needs	0.29**	104
Q6 (CM)/q7 (KS) To what extent do you use data to.....	Corr.	n
Measure progress in centre targets for staff, families, and children	0.37*	104
Act on weaknesses in achieving the highest quality learning and development outcomes for all children	0.24*	102
Enable the sharing of information between agencies	0.24*	103
Monitor progress in, act on, and set priorities for achieving the highest quality learning and development outcomes for all children	0.23*	104
Examine value for money in service planning and implementation	0.22*	103
Evaluate your centre's programme and its improvement	0.20*	104
Q7/Q8. Thinking about working with staff and stakeholders, to what extent to you believe your actions..... <i>Work with staff and stakeholders</i>	Corr.	n
The CM ensures wide staff participation in decisions about the improvement of services	0.37**	103
The CM encourages staff to think of broad outcomes for children and families (e.g. physical, educational, emotional and behavioural)	0.23*	103
Q9. To what extent do you agree with the following in relation to CPD and staff development in your SSCC....	Corr.	n
The CM rarely appraises staff performance to identify staff training areas including goals and targets	0.34**	104
Q11. Please indicate the extent to which centre leadership is provided by the following....	Corr.	n
Local Authority (LA)	0.38**	98
Governors/Advisory board/centre improvement partners	0.34**	99
Community groups/voluntary organisations	0.31**	98
Service Managers/Senior Leadership Team (SLT)	0.31**	100
Q12/13. Thinking about the way leadership responsibilities are distributed or shared, to what extent do you agree or disagree with the following....	Corr.	n
The full team collectively plan which individual or group(s) will carry out which leadership tasks (e.g. centre teacher leading education element)	0.34**	101
There are clear arrangements in place as to who should take responsibility when the centre manager is away/unavailable	0.24*	103
Q13/14. To what extent do you believe the leadership practice facilitates working collaborative with <i>Collaboration and integration</i>	Corr.	n
Other local childminders	0.46**	100
Local primary schools	0.40**	104
Managers of social care services	0.25*	103
Managers of Job Centre Plus	0.23*	102
Other local nurseries/pre-schools	0.23*	102
Q14/15. To what extent do you agree with the following in relation to your work with other people within your SSCC	Corr.	n
I include feedback from all stakeholders within our centre's self evaluation	0.36**	99
My leadership style has a positive impact on outcomes for children and families	0.34**	103
I encourage my staff to attend training to improve multi-agency working	0.24*	102

Table D2.1. [Continued]

Q15/16. To what extent do you agree with the following in relation to your work with partner agencies...	Corr.	n
I find it difficult to bring together partner agencies	0.21*	104
Q16/17. To what extent do you agree with the following in relation to parent & community involvement...	Corr.	n
Parents/carers have their own committee, group, or channel through which their views can be represented	0.39**	102
Parents/carers have too little involvement in the day to day provision of services within our centre	0.27**	102
Parents/carers are actively encouraged with service design	0.26**	101
I ensure effective outreach into the community so that the most disadvantaged families can access services	0.23*	102
Few parents/carers support our centre activities as volunteers	0.22*	101
Parents/carers have access to courses/sessions to develop their skills	0.20*	101
Our centre takes into account the cultural and child-rearing views of families using the services	0.20*	102

* $p < 0.05$

** $p < 0.01$ N/A not included in Q11.

D3 - Technical Appendix for Children's Centre Leadership and Management Rating Scale (CCLMRS)

Appendix D3 is available on the Department of Education, University of Oxford website (<http://www.education.ox.ac.uk/research/fell/research/>). The appendix contains the following.

Table D3.1. Mean total CCLMRS scores for each children's centre. (n=107 centres providing full data for the full scale)

Table D3.2. Mean subscale scores for each children's centre on the 'Vision and Mission' subscale of the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=115 centres providing full data for this subscale)

Table D3.3. Mean subscale scores for each children's centre on the 'Staff Recruitment and Employment' subscale of the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=115 centres providing full data for this subscale)

Table D3.4. Mean subscale scores for each children's centre on the 'Staff Training and Qualifications' subscale of the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=116 centres providing full data for this subscale)

Table D3.5. Mean subscale scores for each children's centre on the 'Service Delivery' subscale of the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=112 centres providing full data for this subscale)

Table D3.6. Mean subscale scores for each children's centre on the 'Centre Organisation and Management' subscale of the Children's Centre Leadership and Management Rating Scale (CCLMRS). (n=111 centres providing full data for this subscale)

D4 - Technical Appendix for Leadership Questionnaire

Appendix D4 is available on the Department of Education, University of Oxford website (<http://www.education.ox.ac.uk/research/fell/research/>). The appendix contains the following.

Table D4.1. The highly positive views of centre managers on aspects of the leadership and management of children's centres

Table D4.2. The less positive views of centre managers on various aspects of children's centre leadership

Table D4.3. The views of centre managers on the involvement of parents and the local community in the children's centre

Table D4.4. Statistically significant associations between the perspectives of centre managers and key staff

Table D4.5. Factors within the leadership "aspect" of collaboration and integration of services

Table D4.6. Mean scale scores for factors related to collaboration and integration of services

Table D4.7. Factors within the leadership "aspect" of monitoring, data use, and CPD

Table D4.8. Mean scale scores for factors related to monitoring, data use, and CPD

Table D4.9. Factors within the leadership "aspect" of vision and purpose

Table D4.10. Mean scale scores for factors related to vision and purpose

Table D4.11. Factors within the leadership "aspect" of distributed leadership and staff inclusion in decision making

Table D4.12. Mean scale scores for factors related to distributed leadership and staff inclusion in decision making

Table D4.13. Differences on CCLMRS leadership domains between centre managers of different ages

Table D4.14. The qualifications of centre managers

Table D4.15. The significant relationships between staff absence rates within children's centres and the ratings of centre leadership as reported by both centre managers and key staff

Table D4.16. The ratings of leadership (as reported by centre managers and key staff) by Strand 1 'Typologies of Provision'

Table D4.17. CCLMRS subscales (means) by Strand 1 'Typologies of Provision'

D5 - Development of Instruments to Measure Leadership and Management within Children's Centres

The leadership and management instruments both underwent expert validation and piloting before use in the field:

- During the initial development, 10 experts were invited to critique the instruments using a structured format. Seven provided written feedback for 'content validation' and the others provided verbal. Changes were made based upon their comments.
- Ten children's centres were invited to participate in a pilot study of the instruments and seven centres agreed to take part. These seven pilot centres were omitted from the main ECCE sample. Further revisions were made after discussions with the ECCE consortium (University of Oxford, NatCen Social Research and Frontier Economics) and the DfE, and the documents were finalised in September (2011).
- Whilst the CCLMRS was validated through expert review and detailed review of relevant literature and policy, it is important to note that the scale has not yet been validated against other assessment instruments and therefore the incline/levels of quality may need further research.

Development of the Children's Centre Leadership and Management Rating Scale (CCLMRS):

The CCLMRS (Sylva, Chan, Good and Sammons, 2012) is an interview and document-based assessment that measures the quality of management-level practices within a Sure Start Children's Centre. The CCLMRS was developed in 2010 as a research tool. It focuses on the core elements of children's centre practice (for example, integrated education and care, family services, reaching the disadvantaged) as well as specific leadership practices (for example, staff development) and management practices (for example, finances). Development of the CCLMRS was informed by a range of government documents¹⁰¹ and research literature¹⁰², as well as interviews with managers from seven children's centres. Ofsted evidence (2008 and 2009 a&b) was reviewed to explore common features of successful leadership and elements of children's centre provision earmarked as needing improvement. Key findings within the Ofsted literature included a need to improve the evaluation of child and family outcomes, and to develop better strategies to attract the hardest to reach families (Ofsted, 2008, 2009 a&b: cited in Sammons, Sylva, Chan and Smees, 2010). In addition, Ofsted (2009 a&b) reported that links to primary school provision could be improved. Well known rating scales such as the *Early Childhood Environmental Rating Scale* (ECERS-R) (Harms and Clifford, 1998)

¹⁰¹ Including *Every Child Matters* (DfES, 2003) and the *Children's Plan* (DCSF, 2007) as well as other documentation for example: DfES (2005), DfES (2006), DfES (2007), DCSF (2010).

¹⁰² For example, Leithwood et al. (2006a&b), Leithwood, et al. (2004), Day et al. (2009).

and the ECERS-E (Sylva, Siraj-Blatchford and Taggart, 2010), were also reviewed by the authors in the production of the CCLMRS, to provide ideas for the layout and quality incline for a new rating scale. The CCLMRS was designed with a six level quality incline based on ‘adequate’, ‘good’ and ‘outstanding’ practices. The American *Program Administration Scale* (PAS; Talan and Bloom, 2004) was also reviewed to provide a comprehensive overview of administrative practice in other early childhood programmes (specifically within a US context). In response, the CCLMRS was designed to assess the integrated approach to service delivery within children’s centres via the inclusion of items on outreach and home visits, service delivery, and multi-agency partnerships.

Development of the Leadership Questionnaire

Initial development work during early 2010¹⁰³ involved: informal discussions with children’s centre heads and key workers, an in-depth review of relevant literature and existing leadership instruments, and piloting of the instruments within a limited number of children’s centres (Chan et al., 2010; Sammons et al., 2010). The questionnaire was designed in line with the guidelines laid out in the Every Child Matters initiative (DfES, 2003), the Children’s Plan (DCSF, 2007), and in response to government documents that were related specifically to children’s centres and/or integrated working¹⁰⁴. Evidence from Ofsted on the important characteristics of successful children’s centres was reviewed (Ofsted 2008, 2009a and 2009b) as was evidence from Together for Children (TfC, 2009), the Children’s Workforce Development Council (CWDC, 2009), and recent research on leadership from within the Early Years as well as leadership support products (Siraj-Blatchford 2009; Siraj-Blatchford & Manni 2007).

Considering literature that was drawn upon in more specific ways, some of the items in the questionnaire were developed from a review of the literature on school leadership (Leithwood et al., 2006a; 2006b; Leithwood et al., 2004), with particular reference to the seven key successful leadership practices that have an impact on pupil learning (Leithwood et al., 2006b). The questionnaire also built on the research and analysis within *The Impact of School Leadership on Pupil Outcomes Project* (Day, Sammons, Hopkins, Harris, Leithwood, Gu, Brown, Ahtaridou, & Kington, 2009 and 2011; Sammons, Gu, Day and Ko, 2011), by adapting relevant questionnaire items that were originally targeted at primary heads. A small number of items were also adapted from the *Program Administration Scale* (PAS; Talan and Bloom, 2004) which measures management processes within early years settings.

¹⁰³ More accurately: between December 2009-February 2010 during which the staff from seven children’s centres were visited. These children’s centres were located within the Oxford Local Education Authority (LEA) and the Brighton and Hove LEA.

¹⁰⁴ For example, DfES (2005), DfES (2006), DfES (2007), DCSF (2009a), DCSF (2009b), DCSF (2009c) and DCSF (2010).

APPENDIX E: Reach and Structure of Children's Centres

E1 - Reach of Children's Centres

1) Administrative Data

There were 14486 postcodes supplied by the 128 centres, all but 10 of which flagged up to a valid area code in the 2012 Post Office Address File (PAF), reassuring evidence that centres maintain accurate user data with full 7-8 digit postcodes. As this part of the exercise did not collect information on *type* of use (the user survey collected this information *only* from those sampled and interviewed) they can be described as 'users/potential users'. One centre had a particularly large number of cases (more than 600) - more than twice its 'stated numbers' (which each centre was asked to provide). As these were all valid postcodes in its locality, this case has been down-weighted to its stated user base accordingly, so that it does not distort the overall results. These user postcodes and centre locations provide a preliminary analysis. Subsequently, fuller postcode data on users will be drawn on for more detailed analysis later in 2013 in the autumn Strand 3 report.

2) Tables referred to in main text

Table E6.1. Distribution of sampled centres and their users/potential users with national benchmark

Region	Sampled Centres		Users		Benchmark All Centres from TfC 2009	
	N	Per cent	N	Per cent		
East Midlands	7	5.5	734	5.2	7.5	
East of England	11	8.6	1259	8.9	8.6	
London	26	20.3	3476	24.5	15.3	
North East	5	3.9	667	4.7	7.7	
North West	17	13.3	1405	9.9	16.7	
South East	12	9.4	1391	9.8	10.4	
South West	15	11.7	1492	10.5	10.0	
West Midlands	22	17.2	2471	17.4	11.0	
Yorkshire and The Humber	13	10.2	1274	9.0	12.8	
Total	128	100.0	14169	100.0	N= 2079	100.0

Table E6.2. Distribution by local authority type of all centres that supplied postcodes

			Sampled Centres	Benchmark From TfC 2009
	London Borough	Count	26	
		%	20.3%	15.2%
	Other Metro District	Count	38	
		%	29.7%	28.2%
	Other Unitary	Count	24	
		%	18.8%	25.4%
	County	Count	40	
		%	31.3%	31.3%
Total		Count	128	2051

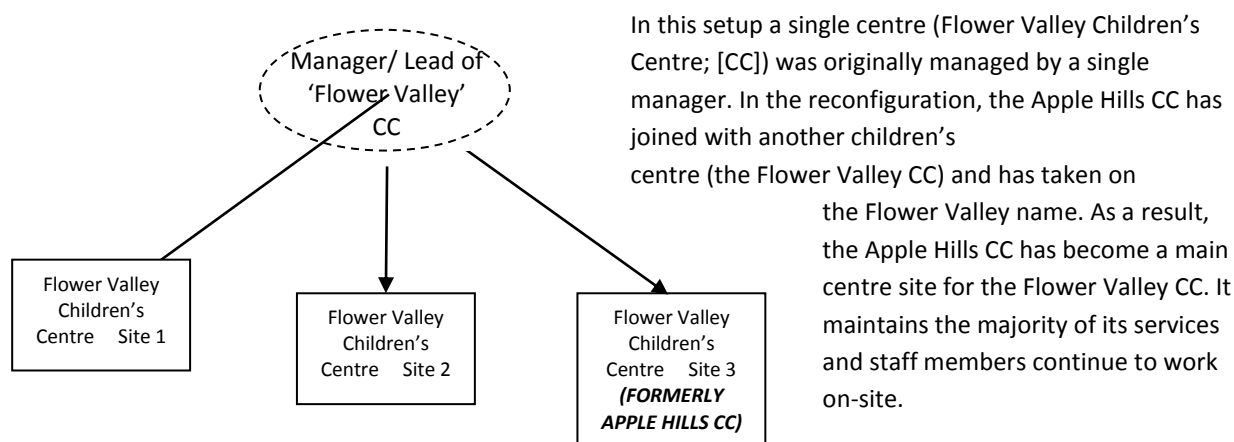
E2 - Terminology used within Section 6.2

Children's centre site/main site: Site where most of the activities take place and where the centre's leader and administration is based.

Children's centre satellite site: Sites which are considered part of the children's centre, often where some children's centre staff and activities are based. Satellite sites may be run by the children's centre (but are not the location where the centre manager or administration is located), for example a room solely run by the children's centre, in a local school. The satellite sites may also be locations where children's centre services are delivered but not run by the children's centre, for example a local church, library or school which may be rented for a few hours each week.

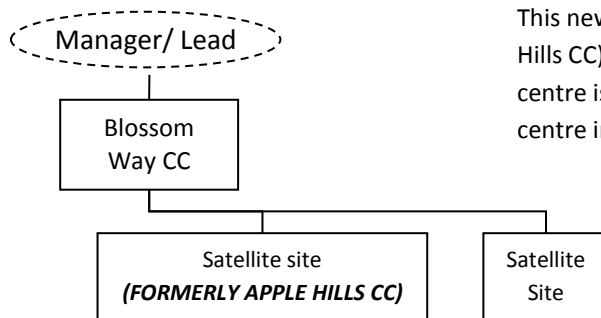
Service delivery sites: These might be sites which are not part of the children's centre but where a particular children's centre service is provided (for example childcare).

Figure E6.1. Multiple main sites configuration with a former independent children's centre now as a main site¹⁰⁵



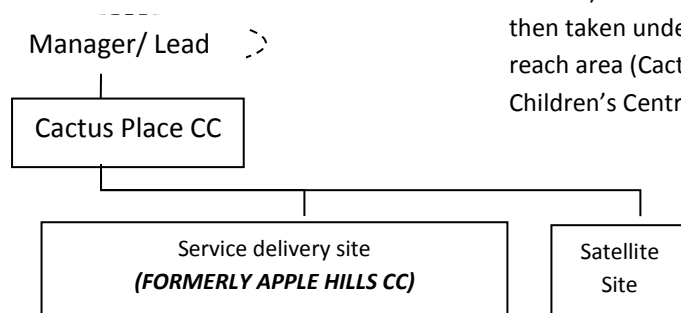
¹⁰⁵ Note: centre names have been replaced with pseudonyms throughout all examples and do not reflect any specific centres within this sample.

Figure E6.2. Main site with a former independent children's centre now as a satellite site. (Now a 'main site with satellite sites' configuration)



This new configuration sees the former children's centre (Apple Hills CC) lose its designated or Sure Start status. This former centre is then taken under the guise of another children's centre in the reach area (Blossom Way CC - which retains its Sure Start Children's Centre status). The de-designated centre (Apple Hills) thus becomes a satellite site run by the new main centre (Blossom Way), where a number of services can be delivered in a different area within the reach, and where staff might be based.

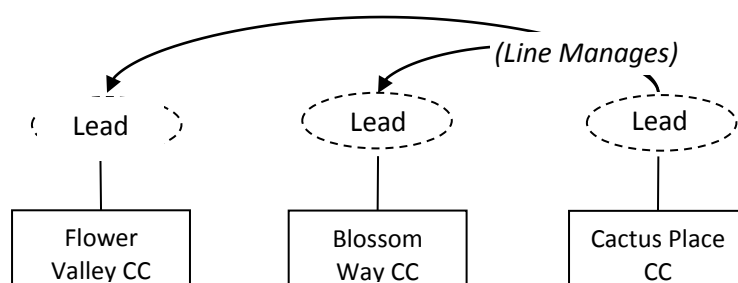
Figure E6.3. Main site with a former independent children's centre now as a service delivery site. (Now a 'main site with satellite sites' configuration)



This new configuration sees the former children's centre (Apple Hills CC) lose its designated or Sure Start status. This centre is then taken under the guise of another children's centre in the reach area (Cactus Place CC - which retains its Sure Start Children's Centre status).

The de-designated centre (Apple Hills) thus becomes a 'service delivery' site for the new main centre (Cactus Place), with the role of providing a single service (for example childcare). Staff are not often based at this delivery site unless running the sessions.

Figure E6.4. A second example of a cluster with a formal structure



In this setup, the lead from one of the 'clustered' centres formally manages two or more children's centres. This setup is characterised by the position of leads at each children's centre, managed by a lead at another children's centre.



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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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