Origins, purpose and future of Sure Start children’s centres

The United States led the way in setting up successful early intervention programmes and England followed suit in an effort to give every child the best start in life. Laura Camps and Tony Long evaluate the outcomes of a service now under threat.

Abstract
Sure Start began in England under the UK’s former Labour government as an intervention for families with young children, particularly targeting the most deprived in society. More than a decade later the service is under threat in many parts of the country as local councils face financial difficulties. This article considers the origins, purpose and future of the service.

Keywords
Children’s services, health visiting, local authorities, social services

Origins and purpose
Sure Start local programmes were introduced in 1999 following evidence from longitudinal research about the extensive success of early intervention programmes, such as Head Start and Early Head Start, in the United States (Vinovskis 2005). These results had been analysed for compatibility with the different health and social care systems in England in a comprehensive spending review (HM Treasury 1998). Considering the messages to be taken from the American experience for health care in England, Gray and Francis (2007) noted that those early intervention programmes made a tangible difference to children’s life chances by positively affecting parents and key developmental indicators in children. These concerns were relevant and applicable to the situation in Britain, and were desirable outcomes to be pursued in England through Sure Start.

Sure Start became SSCCs in 2004 to contribute to achieving the outcomes of the Every Child Matters (ECM) policy (Department for Children, Schools and Families (DCSF) 2004). The five primary outcomes of ECM were for every child to:

- Be healthy.
- Stay safe.
- Enjoy and achieve.
- Make a positive contribution.
- Achieve economic wellbeing.

Before May 2010 there were about 3,500 Sure Start children’s centres (SSCCs) in England providing services to 2.5 million children (Thompson 2010). The aim of Sure Start, as noted in a House of Commons report (2008), was to reduce child poverty, overcome inequalities and give every child the best start in life. However, there is controversy surrounding the efficacy of Sure Start and whether strategic outcomes are being achieved (Fitzpatrick 2010).

There is further debate over the future of Sure Start children’s centres amid ongoing funding cuts in England, with contradictory messages over the intended funding source for the centres.

The government has given reassurances that Sure Start would be protected and enhanced. However, a survey completed by the shadow children’s minister Sharon Hodgson showed that, of 152 local authorities in England, of those that responded, 80 per cent had already cut funding for children’s centres and more were planning to reduce funding in 2012. At least 47 children’s centres had already been closed or were planned to be closed (Richardson 2011).
However, a change in government in 2010 resulted in the immediate dissolution of the DCSF and reference to ECM was equally quickly eradiated. While every child still appears to matter, this initiative has been subsumed into the Early Support programme (Department for Education (DfE) 2010).

To achieve the outcomes of ECM, Sure Start offers family support services and high quality early years’ provision to all preschool children (Thompson 2010). Recent guidance demands that every SCCS must offer child and family health services, such as breastfeeding support, high quality childcare and early learning provision, and advice on issues such as parenting, healthy eating, employment and money management (HM Government 2011).

Additional services are offered at some SSCCs, including parenting classes and smoking cessation. Within the principle of universal provision, Sure Start’s purpose has always been to engage with the most disadvantaged children and families. Many would argue that this provision, and the need to target disadvantaged families, is being challenged by threats to funding and likely closure of children’s centres.

Positive outcomes evaluation

The Office for Standards in Education, Children’s Services and Skills (Ofsted) (2009) reported a significant lack of data evaluating SSCCs. However, a large evaluation with more than 9,000 families in 150 areas for the National Evaluation of Sure Start found that SSCCs were exerting a positive effect on the health and wellbeing of children and families (Melhuish et al 2008). Seven out of 14 outcomes for children living in Sure Start areas showed improvement.

Positive outcomes included:
- Improved home learning environment.
- Improved social behaviour.
- Enhanced child independence and self-regulation.
- Increased uptake of immunisations.
- Fewer accidents and positive parenting.

A small-scale evaluation by Ofsted (2009) also reported improved outcomes.

Negative outcomes evaluation

No improvements were made involving fathers, maternal smoking, life satisfaction, family service use, language development or reducing obesity (Melhuish et al 2008). The last of these, in particular, is known to incur lifelong risks of developing diabetes, cancer and heart disease (Swain and Sacher 2009). Obese children are more likely to suffer from low self-esteem and have a poorer quality of life (Department for Education and Skills 2006).

Some common targets, such as smoking cessation and reversal of obesity trends, can be criticised for being unrealistic, particularly in the time frames applied to initiatives. Against a complex backdrop of problems with housing, children’s school attendance, finance, domestic violence and antisocial behaviour, smoking cessation is likely to be the last item prioritised by parents (Ravey et al 2008), and the selection of benchmarks for success may require further thought. However, there is no sign of such targets being changed. Indeed, whereas the outcome sought from substance misuse services has for some time been referral to and maintenance in treatment, current trends are for the target to be actual cessation of the misuse (National Treatment Agency for Substance Misuse 2010).

A large number of children’s centre users report less use of health services due to lack of awareness (Long et al 2008, DCSF 2009). Only 26 per cent of Sure Start users knew about services through their health visitor, compared with 33 per cent who heard by word of mouth (DCSF 2009). However, the pattern of factors involved is likely to be complex, and the positioning of SSCCs in the midst of communities in specific areas of deprivation may rely on varied means of contact for success (Long et al 2008).

The need for extensive evaluation

Most SSCCs have failed to evaluate the impact of their services (Ofsted 2009), so positive results may remain unidentified. This is unfortunate, since evaluation is crucial to the optimisation of services, highlighting positive facets that need to be maintained and built on, and identifying areas of weakness or ineffectiveness that can then be addressed (Gray and Francis 2007). Continued funding depends on evidence of efficacy and efficiency, while eliciting and responding to service user perspectives is vital for promoting sustained access and exploitation of such services by target groups.

An evaluation form for Sure Start centres has been introduced to gather data for future evaluations (Ofsted 2009). The Centre for Longitudinal Studies (2005) millennium cohort study will be analysed in 2012 and may be useful in appraising government initiatives such as Sure Start.

One Sure Start aim was to reach the most deprived in society and improve outcomes. Coe et al (2008)
identified some ‘hard to reach’ populations as teenage parents, fathers, travelling families and lone parents. However, the notion of being hard to reach requires deeper investigation, since many vulnerable families are more accurately ‘service-resistant’ and subject to self-exclusion.

Previous research (Doherty et al 2004) indicates that minorities are often under-represented, marginalised, disadvantaged and socially excluded, and that these groups may be distinguished from service resistant groups, which are often overlooked, invisible and unable to articulate their needs. A third group may be made up of those who slip through the net: perhaps the over-targeted and disappointed, ‘known’ families, and those who are wary, suspicious or distrustful. Engaging with these groups requires persistence, skill and resources.

Evaluation of Sure Start up to 2005 (Belsky et al 2006) showed limited achievement in the target groups and there was evidence in some areas that those with the greatest need and who were hardest to reach were receiving the fewest services. A later evaluation showed that altered strategies were exerting the required effect.

Surveying 1,496 parents to quantify the reach, satisfaction and use of SSCCs, DCSF (2009) reported that reach in the target group was good and no sub-groups were failing to use the service. In addition, 78 per cent of people were aware of the centres and 45 per cent attended. The survey was restricted to centres that were fully established by 2006 since Melhuish et al (2005) recommended a period of at least three years in commission before evaluation. Only 800 children’s centres were established by 2006 (House of Commons 2010), so the survey was in some ways incomplete, but the trajectory of change was evident nonetheless.

Coe et al (2008) found that a significant proportion of the intended clientele was not accessing Sure Start services. Similarly, at least half of 30 children’s centres visited by Ofsted (2009) reported problems in engaging the most vulnerable families – and fathers in particular. Despite improvements generally, problems remain with access.

Barriers to families attending SSCCs have included lack of information, poor accessibility and social isolation (Coe et al 2008), as well as cost, timing and flexibility of service delivery, and inadequate public transport (Long et al 2008). However, purposefully prioritising vulnerable families can have unexpected and unintended effects. Such an approach may stigmatise the targeted group, leading to failure to access the service. While making strenuous efforts to make inclusion of target groups easier, the maintenance of a universal service may be a vital factor (Cornish 2010).

**Budget cuts and the future**

Plans for SSCCs under the new coalition government are yet to be revealed. The Department for Education (2010) states only that: ‘The Department for Education and the Department of Health will be publishing a policy statement on the Early Years later in the year, setting out our vision for reform.’ However, concern has been expressed at all levels about the future of such services.

Conservative Party plans to refocus SSCC services on the most disadvantaged and dysfunctional families are explicit (Conservatives 2011). The coalition government has confirmed this by stating, in June 2011, that: ‘The Early Intervention Grant [EIG] … contains enough money to maintain a network of children’s centres so they are accessible to all, and supporting families in greatest need’ (DfE 2010). The same policy expresses the intention to increase the degree of voluntary and community sector involvement in children’s centre provision through local authority commissioning.

However, SSCCs face cuts in some areas because of a lack of funding. It has been suggested that every council in England is likely to close at least one SSCC because of funding cuts (Richardson 2011). One Conservative council has already withdrawn funding for nine of its 15 SSCCs (BBC News London 2011). Each month more examples are reported either of closures or of drastic reductions in funding in which centres are not closed but the services that are offered are reduced greatly. The EIG replaces previous funding for SSCCs and is spent at the discretion of local authorities. However, the EIG provides 10.9 per cent less capital than previous funding (Puffet 2010). Furthermore, councils have to make budget savings. For example, Manchester City Council has to save £109 million in 2012, rising to £170 million in 2013. With such large savings targets, councils across the country will be unable to fund SSCCs to the same extent as previously.

4Children (2011a) reports that, since Sure Start funding is no longer ring-fenced, local authority spending on SSCCs can be selective. Surveying 150 local authorities, 4Children asked: ‘Are you able to give a commitment to keeping all your existing children’s centres open in 2011-12?’ Only
39 per cent of local authorities confirmed that no centres would close. Furthermore, 4Children (2011b) surveyed SSCC managers and found that, in the next 12 months, 3,100 SSCCs would experience funding cuts, 250 were expected to close and a further 2,000 would provide reduced services.

SSCCs must continue to provide the services outlined in their core offer (HM Government 2011). However, local authorities have already begun to reduce budgets. Manchester City Council (2011) announced that it would withdraw from its role as provider of services and encourage independent and voluntary sector organisations to run SSCCs. This proposal has encountered fierce opposition and there is public opposition to the foreseen reduction in SSCCs.

Reduction in local authority budgets has already led to reduced funding for SSCCs. Naomi Eisenstadt, who led the initiation of Sure Start was reported as saying, in November 2011, that the cut in resources for SSCCs was having a drastic impact, with gross limitations on the service and a consequent negative effect on the families for whose benefit Sure Start was designed (McVeigh 2011).

While third-sector providers can offer services at lower cost, this is achieved by paying lower wages and employing a less well qualified workforce, factors identified by Melhuish et al (2008) as contributing to the early poor results of Sure Start. Even this approach, however, still requires funding to undertake the commissions.

Concurrent initiatives
The Family Nurse Partnership (FNP) programme, which offers intensive home visiting from early pregnancy until the child is two years of age, is aimed at young, first-time mothers (DH 2011a).

It aims to improve:
- Pregnancy outcomes.
- Child health and development.
- Parents’ economic self-sufficiency.

An interim evaluation reports: ‘The outcomes for the young mothers themselves and their children look promising’ (DH 2011b). The government’s plan is to increase the number of FNP places to 13,000 by 2015. At the same time, the government has undertaken to provide an additional 4,200 health visitors to take forward its Early Support Programme.

The FNP is often delivered through SSCCs, partly with a view to moving the families on to SSCC services when the FNP finishes at two years, and mothers in the evaluation expressed their concerns about the level of support that might be available from SSCCs. Given the long-term uncertainty of SSCCs, linking FNPs to them could also be in question. Furthermore, the funding to provide for the increase in health visitors to 4,200 is still under question (Calkin 2011), while the training programme for this will be sorely tried in meeting the target. A fall in health visitor numbers was reported in the eight months since the government set the target (Unite 2011).

Cuts to SSCCs could have a negative effect on child and family health. Sure Start has reported improvements in these areas, but, with a reduced service and fewer centres, families may not benefit as much. The Day Care Trust (2011) carried out research with mothers who accessed SSCCs to measure the impact that reduced or withdrawn access to SSCCs would have on families. A total of 35 per cent of mothers reported that they would feel isolated with less access to SSCCs. Twenty-eight per cent felt their child’s development would suffer, and 32 per cent would find it more difficult to meet, and receive advice from, their midwife or health visitor.

These factors ought to raise concerns about health (for example, feeding patterns and nutrition), wellbeing (developmental progress and stimulation) and the safety of young children (parenting inadequacy and physical safety).

There could be direct consequences for children’s nurses. Sure Start is intended to prevent later problems with health and wellbeing. If this effort fails, whether from lack of funding or strategic decisions, the outcome might be expected to be increased illness, enduring health problems, more accidental and non-accidental injuries, perhaps epidemics of communicable diseases, and the overall pernicious effects of deprivation and disadvantage. It could bring about a reversal in policy and practice to focusing on treating illness, rather than promoting health – arguably a huge leap backwards for children’s nursing and children’s services.

Conclusion
Sure Start children’s centres were intended to benefit children’s health and wellbeing, and to contribute to achieving the outcomes of the Every Child Matters policy. Improvements have not been evidenced in some outcomes, notably in reducing obesity, though overall there has been a general improvement in key.
Community services

Factors since 2006. Further longitudinal research could highlight additional positive outcomes on child and family health. More time is needed to evaluate some outcomes and to raise awareness of health services offered at SSCCs. However, more work needs to be done to overcome inequalities and to make Sure Start services more accessible for the most deprived in society. The future looks bleak for SSCCs, with many centres expected to close and many more services offered at SSCCs. However, more time is needed to evaluate possible demise.

References


4Children (2011b) 250 Sure Start Children's Centres Face Closure within a Year. www.4children.org.uk/News/Detail/250-Sure-Start-Childrens-Centres (Last accessed: January 19 2012.)


