A BASELINE STUDY OF OUTCOME INDICATORS FOR EARLY YEARS POLICIES IN SCOTLAND

FINAL REPORT

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SUMMARY

INTRODUCTION

1. In Scotland a range of policies aimed at improving children's health, development, and ability to learn, and to support and strengthen families and communities have been introduced. The focus of these policies for the early years is to give children under 5 the best start in life, with an emphasis on reaching the most vulnerable. Since 2002, there has been a move towards an integrated approach to policy and service planning and delivery.

2. This study by the Centre for Research on Families and Relationships and the National Centre for Social Research followed up from a previous evaluation feasibility study and aimed to explore the effectiveness of these early years' policies through two approaches. An indicator study looked at the extent to which the impact of early years polices can be measured, whilst a case study of two contrasting local authority areas explored ways in which policies have been interpreted and integrated at a local authority level.

INDICATOR STUDY

3. The indicator study involved analysis of data on a range of 'indicators' identified in a previous feasibility study as relevant to the early years' policy objectives.

4. A number of indicators related to health and pre-school education were identified. However, data were not available on family functioning, parents' ability to find employment or issues of capacity and working practices within the systems of service provision. The absence of such data implies that we cannot use existing indicators to assess if early years policies have met their objectives in relation to these issues.

5. Analysis reveals that there have been some small improvements in health indicators since 1999 – including increased rates of breastfeeding and reduced maternal smoking. Encouragingly, these health gains appear to have been greatest among those in the most deprived groups – on which many early years' initiatives are focused. Rates of primary immunisations have increased among the most deprived groups, while experiencing no overall change.

6. There has been no real change in levels of infant mortality, accidental injuries or deaths, dental decay and low birth weight babies. It is too early to tell whether there have been changes in levels of obesity or under-nutrition. There has been a notable decline in rates of MMR immunisation.

7. There has been a dramatic increase in children attending pre-school provision since 1999 and an increase in staff numbers associated with this. The highest rates of pre-school provision at age 3, are among those in the most deprived areas. A rise in attendance at Family Centres is particularly evident among those in more deprived areas, where some of these facilities have been targeted.

CASE STUDIES

Development of services

8. The two areas, Highland and Dundee, took contrasting approaches to the re-organisation required for delivering integrated children's services, one evolutionary and incremental, the other innovative and ambitious. This reflects the contrasting starting points of the two authorities in relation to existing levels of service provision and the existing shape of planning structures.

Inter and intra-agency working

9. The benefits of working closer together across agencies were seen as positive by many respondents in this study with a high level of commitment to improving service delivery through collaboration. Although there were contrasting approaches in the two areas, many of the same issues arose. These include difficulties in defining boundaries between professional groups and lack of time and support for workers in achieving effective collaboration. Tensions between strategic planning, management and service delivery also existed in both areas with collaborative working being driven in different ways, at different speeds and having different consequences at each level.

Targeting

10. In both areas, targeting service to the most vulnerable has been within a framework offering more universal services, which play a role in identifying families in need of additional support. This approach is seen as allowing maximum flexibility, to be less stigmatising and to be inclusive in terms of meeting the needs of diverse groups. In Highland, services have been targeted at vulnerable families, wherever they may be, with no specific specialist services due to the spread of population. In Dundee, over and above generalist services for vulnerable children and families, specialist services have been targeted at children with special educational needs, ethnic minorities and families where a parent has a mental health problem.

Funding

11. The move towards integrated service delivery has led to increased integration of funding streams in both areas. Integrated funding may lead to a blurring of professional boundaries, the development of integrated services and posts. For these reasons it is increasingly difficult to tie specific outcomes to specific funding streams or policies.

Monitoring and evaluation

12. A range of monitoring and evaluation is being carried out, most often relating to individual services including feedback from individual families. It focuses on short term goals and service delivery, rather than being tied into planning. There is no baseline data for service

delivery at a planning level, and further work is needed to establish mechanisms for defining and measuring outcomes.

Parents' views

13. Parents found benefit from accessing services, whether this was attending groups themselves, having a child-care place provided, outreach help or a combination of such services. Similar outcomes were reported by parents in both areas relating to children social, emotional and educational development and parents own needs for leisure or training, and the value of support workers in providing information and access to services.

CONCLUSION

14. We broadly adopted a theory of change approach to this evaluation, along with a consideration of specific indicators available from national data sources. Early years' policies should be considered complex interventions, with their broad and multiple objectives, cutting across sectors, and allowing for local diversity in implementation. This approach helps evaluators to address complex interventions by focusing on processes and systems and to explore the relationship between context, activities and outcomes. We have only been able to take the theory of change approach to its first stages, as the processes under investigation are themselves fairly new and the intermediate and longer term policy objectives are yet to be identified locally and embedded in planning, delivery and outcome evaluation at community, institutional, family and individual levels.

The indicator study

15. One way in which we have tried to assess the effectiveness of the first few years of early years policies has been to measure change from 1998 to 2002 across a range of agreed and available indicators. Some indicators were analysed with respect to deprivation and rural/urban dimensions in order to ascertain whether targeted groups are being particularly well served.

16. The results of the indicator study are, on the whole, disappointing in terms of what they can tell us about the effectiveness of early years' policies. Since early years' policies are recent, need time to bed in and develop, and the indicators themselves are broad measurements, this is not surprising. However, small change in a positive direction was noted for some indicators, and more importantly, there was some evidence that the greatest change had taken place amongst the most deprived categories. Both of these suggest that early health related interventions might be having some effect, especially an enhanced health visitor role. A large increase in the proportion of three year olds receiving pre-school education was found, with a smaller rise among those aged four from a higher baseline in 1998, with higher provision in more deprived areas. The number of children attending family centres has also increased, although overall numbers are small.

The Case Studies: System Capacity

17. Both case study areas of Highland and Dundee can be considered 'success' stories in managing nationally driven but locally enacted early years' policies. Starting from very different levels of existing provision and using different approaches to change (incremental in Dundee and radical in Highland), both areas, in a short time, have increased capacity in provision and created organisational structures to promote integration and collaboration at both planning and service delivery level.

18. This expansion of system capacity can be seen in a variety of ways such as an increase in overall provision, increasing integration of universal services with provision to meet the needs of minorities and vulnerable groups, and enormous energy and commitment from service providers to developing provision to meet the new early years' agenda. Nevertheless some difficulties and barriers remain.

19. A complex picture emerged of the relationship between targeted and universal provision. A commitment to provide increasingly targeted provision within a context of a universal service was present in both areas, and a distinction made between universal provision and universal access. Universal access to services, even if they are aimed at meeting the needs of particularly vulnerable groups was described as one way of removing the stigma of accessing targeted services, especially if they were social work based. Vulnerable families are thought to derive benefit from universal services, and both areas used funding streams as a way of supporting an imaginative mix of services on a universal/targeted continuum.

20. Changes in organisational structures took place to promote integration and collaboration in both areas. In both, challenges and barriers to collaboration and integration were identified and in their different ways, integration and collaboration were taken seriously. Although few interviewees spoke explicitly about early years' policy objectives and services did not seem to develop with specific outcomes in mind, those wide objectives clearly underpinned approaches to service development. In other words, services were not criterion based in their approach.

The Case Studies: Service Users' Views

21. Our small sample of service users' views provides illustrative material suggesting that it is important to consider impacts on child, parent and wider family and community. Parents were particularly well able to identify short term change in their child's behaviour as well as in themselves and reported how others had perceived changes in their children. On the whole, they seemed more concerned with the development of social skills in their children than educational attainment, although preparedness for school was also important. Health visitors and development workers were seen as important in providing information on and access to services. Service users in this study did not talk about integrated services or collaboration between agencies. This could suggest seamless delivery, but further investigation is required.

The Case Studies: Service Planning and Delivery

22. In both areas there is no doubt that there has been a rapid expansion in system capacity and range of early years provision. Early years policies have resulted in considerable change in the planning and delivery of services in both areas. In Highland this change has been intensive and rapid, suggesting a maximalist approach to change, driven by policy objectives, funding streams and historical context. The picture of early education and childcare and family support is very different today compared with the mid 90's. In Dundee, the changes have also been substantial within a context of restructuring that has been incremental rather than maximalist, reflecting the area's higher baseline level of early years provision. A central planning structure has been modified in parallel with the development of a more integrated approach to new posts, synchronised funding periods and joint bids.

23. It seems that an integrated approach is currently most effective at the top planning level (through new planning groups and structures) and at service delivery level (through joint bids/projects and good co-operation across staff and sectors), but that more can be done at the middle management/operational level.

24. A significant barrier to developing effective services is staffing, where high turnover or difficulties in recruitment are likely to affect quality of service, joint working practices, morale and workload. These system issues could be more closely monitored as a possible dimension of effectiveness, but also demand specific attention in terms of training, pay and job satisfaction in order to ensure that expanded capacity is indeed achieved consistently across areas and over time. Short term funding can also limit the development of services.

25. Measuring the impact and effectiveness of early years' policies is impeded by the absence of baseline data when they were introduced to measure the change that would ensue. To have comparable data across councils would require a database which would count in a consistent manner different types of provision, centres of provision, capacity in terms of places and uptake in terms of service users.

26. Although we identified local internal and external evaluation studies, further work is needed to establish mechanisms for defining and measuring outcomes. Additionally training in evaluation techniques need to be rolled out to include service providers who are currently trying to incorporate feedback into their own working practices around service delivery.

27. Integrating funding streams is one indicator of the success of joint planning. However, it also means that is has become difficult to link particular funding streams with particular interventions or outcomes.

Meeting policy objectives

28. In terms of the broad policy objectives of the early years' policies, our case studies have identified activities and impacts across all of them:

To improve children's health

29. The indicator study suggested small improvements in levels of breast feeding and maternal smoking during pregnancy, but not in other health related indicators. The case studies identified examples of initiatives across early education and childcare and family support provisions. Service users in the study did not, on the whole, report specific health related changes in their children.

To improve children's social and emotional development

30. A range of services have been developed which meet this aim – from centre based and outreach work as well as pre-school nursery provision. The indicator study gives evidence of a marked increase in the numbers of children attending family centres as well as the number of staff in pre-school education. Soft indicators of improvements in children's social and educational well-being were reported by parents, suggesting the short term benefits are quickly perceived and felt.

To improve children's ability to learn

31. The expansion of pre-school education is the clearest example of rapid change. There is not direct evidence to support improvement in children's ability to learn, but this is likely to be the case where such a universal service is provided. Learning to play was considered as important as ability to learn and should feature as an indicator in any future evaluation.

To strengthen families and communities

32. The range of centre and outreach services, especially groups and initiatives that involve parents in shaping and delivering services could all be considered to strengthen families and communities. Our qualitative evidence is limited. The indicator study can only be suggestive here through measures of increased capacity.

To reduce barriers to unemployment especially for lone parents and to reduce number of children living in workless households

33. Expansion of childcare and education services can help support parents into and in employment, although wider economic trends continue to define accessibility of labour markets. We had limited evidence that paid work outside the home was not necessarily the best option for all parents with young children. Provision should allow real choices for parents about whether or not work would improve their situation and parenting capacity.

RECOMMENDATIONS

34. There is a need to have in place a robust set of indicators and reporting mechanisms that are consistent and fit for purpose. Current reviews of the CHSP-PS may result in improvements in this area as would the commissioning of a longitudinal study with additional cross-sectional surveys.

35. The case studies highlighted a number of issues that could be developed into indicators relevant to the evaluation of early years that can still take into account local variation in organisation and delivery.

36. We suggest that some standardised template is developed for use by service providers in order to provide robust and relevant information on service provision; service use; where on the continuum of universal/targeted the services lies; who is served; nature of the workforce and the extent of joint working.

37. The transition record may provide a useful intermediate measure relating to children's social, emotional and educational development. The transition record is a report by a child's nursery to their primary school at the point of transition. While it does not follow a standard format, it will make reference to a range of early years educational and developmental targets. A standardised set of measures is required for these dimensions for all children. It is important that measures also take into account the parent's perspective as they are often able to observe short term behavioural change. Indicators could be developed that tie into service use and employed at intervals during and after an intervention.

38. Involvement in training, work or other formal and informal activities could also provide a measure of success of some of the parent centred interventions. Measures of parental self-esteem, self-reported change in parenting behaviour, self-reported change in relationships, self-confidence and community involvement could also be developed.

39. System capacity could be mapped through the use of the templates above at strategic level to identify structures and planning processes. The provision and uptake of joint training, the provision for joint posts and the extent of joint bids could all be used as measures of degree of implementation irrespective of local authority structures.

40. However, all providers spoke of the limits of hard measures and any programme of evaluation should incorporate the perceptions of those working on the ground and the clients they do or hope to serve.

41. Mapping service development, provision and use across all local authorities would be a long task. It would, however, provide a detailed picture of the implementation of early years' policies across the country. Geographical information systems could be used to analyse this information and present it in an accessible format. Service use needs to be monitored locally, with nationally defined, but locally agreed, criteria. Future research could support the creation of a monitoring and evaluation framework to meet local and national needs, and support training in evaluation at local level.

CHAPTER ONE INTRODUCTION

1.1 This Chapter outlines the structure and content of the report. It then reviews the early years' policy context at national (Scottish) level.

BACKGROUND TO THE STUDY: PHASE 1 OF EVALUATION

1.2 The present study is the second stage of a study of the feasibility of evaluating the impacts of recent early years' policies in Scotland. It developed from the recommendations of the first phase, which was conducted by CRFR and the National Centre for Social Research Scotland from March to May 2003.

1.3 The first phase feasibility study developed the rationale for the present study and put forward a draft evaluation framework. The aim of such an evaluation framework was to enable gaps to be identified and for recommendations to be made to fill those gaps. The framework identified a range of indicators to measure the different types of impact at the national level and proposed utilising area-based case studies to explore in more detail the impact on different target groups, of these policies.

The rationale for the chosen approach

1.4 The overall rationale for the chosen approach to evaluation in this second stage was based on the conclusions in the feasibility study that the requirements for an experimental approach to evaluation could not be satisfied since only limited baseline data were available prior to the introduction of the policies, and that there were no evaluation frameworks put into place at the beginning of the implementation period. Furthermore, the relationships between policy objectives and measurable outcomes had not been made clear in the original policy formulation. The feasibility report suggested that while policy evaluation using experimental methods was not feasible, a limited and indirect policy evaluation was possible that could monitor outcomes over time using a limited suite of indicators providing measures in areas likely to be affected by early years' policies, supplemented by qualitative case study evidence in areas to fill gaps where evidence from indicators was weak. These areas include 'families and communities' and 'system capacity'.

1.5 System capacity includes mapping implementation from planning to delivery, identifying degrees of partnership working and service integration. Case study evidence on families and communities can provide evidence of the direct experience of a small number of families, and the impact they perceive of early years' policies on their community and quality of life. Complementing the perspectives of service users are those of service providers across sectors, which are sought to provide evidence on how objectives on social and emotional well-being, health and education are being met. Where the policy environment is both complex and devolved, the way in which local factors influence implementation, especially in the areas of partnership working and integration of services is especially important to understand. Since early years' policies have both a targeted and universal element, a case study approach will need to address the experiences of vulnerable groups, such as minority ethnic children or children with disabilities.

1.6 The choice of case study areas was guided by the desire to reflect contrasting contexts: rural/urban, different socio-economic circumstances, different implementation frameworks, and the requirement of being able to complete fieldwork and reporting within the short timescale of the project. The two case study areas selected were the Highland and Dundee City local authorities.

1.7 Case study evidence is not only useful in its own right, but can also be used to develop indicators and evaluation frameworks for future use and improve our understanding of the processes and contexts in which early years' policies were implemented at local level, and how these are experienced by a range of stakeholders including service users. As such, these studies can also complement quantitative indicator data and consultation initiatives.

SCOPE AND APPROACH OF THE RESEARCH

1.8 The feasibility study recommended that the second phase of research, to be carried out over a 6 month period, should consist of two parts:

Part 1. Measuring impact through a suite of indicators across policy objectives

1.9 Using 1998/1999 as a baseline, the feasibility study identified a suite of relevant and potentially accessible indicators from a range of data sources, comprising a total of 27 indicators across 8 datasets. It observed that baseline information was needed, to allow for comparison with outcomes for subsequent years. Although the report identified data gaps that would make some objectives harder to assess than others, it concluded that in some areas, primarily outcomes relating to health and education, key impacts could be measured with some disaggregation for specific groups (disadvantaged/ non-disadvantaged; rural-urban). It observed that measures of children's social and emotional development were notably weaker.

Part 2. A case study approach to evaluation

1.10 The feasibility study recommended that two case studies be conducted, in one rural and one urban area, to provide an in- depth analysis of the operation of early years' policies in these two contrasting contexts. It was to involve a number of stages, as outlined below.

1.11 Based on these recommendations, the Research, Economic and Corporate Strategy Unit of the Scottish Executive commissioned the Centre for Research on Families and Relationships in July 2003 to carry out the second phase of the evaluation research programme. The research was carried out over a 5 month period from the end of July to the end of December 2003.

AIMS AND OBJECTIVES OF THE RESEARCH

1.12 The broad aim of this research project is to evaluate the effectiveness of the range of early years' policies operating in Scotland in mid 2003 against their core objectives. This has been done in two parts by measuring their impacts at both national and in two case study areas.

1.13 Part 1 comprised the recommended indicator study, expanded to include the following stages:

- Obtaining agreement from relevant data holders to provide the data
- Specifying precisely which data were required for which years, and broken down in specified ways,
- In a few cases, where it was necessary, meeting with analytic staff and conducting scoping work with the data,
- Checking data for form, accuracy, consistency, and querying and resolving any anomalies
- Assessing and presenting data in the required format for reporting
- Interpreting the data, identifying any trends
- Recommending a system to allow for an update of the data in subsequent years, if needed.

1.14 Part 2 comprised two case studies as recommended. The chosen areas were Highland and Dundee City as noted above.

- Policy analysis that identified the approaches used across sectors in relation to early years' policies and their implementation, common aims and areas of conflict. This consisted of a review of documents, at least 5 interviews with stakeholders across sectors, and at least 2 focus groups of existing partnerships or planning groups. It draws on a theory of change approach.
- Mapping service development and implementation of early years' policies
- Reviewing current monitoring data at local level and any existing evaluations, using information supplied by service providers
- Interviews (25) with a range of service providers across health, education and social work sectors, with the potential to explore specific issues in more detail in additional focus groups,
- Interviews (25) with a range of parents of young children, including representatives from target groups (minority ethnic parents, young parents, lone parents, parents of children with disabilities, parents living in deprived areas, in remote rural areas, with the potential to explore specific issues in more detail in additional focus groups,
- Limited observation of service delivery including children's perspectives.

A theory of change approach and the evaluation of early years' policies

1.15 A theory of change approach has informed this evaluation of early years' policies. This approach has also informed other policy evaluations in Scotland, such as the external evaluation of Starting Well. In this case, as described in its interim report, the approach was chosen to better understand why and in what circumstances stakeholders consider particular interventions will lead to specific outcomes.

1.16 A theory of change approach was developed notably by Connell and Kubisch (1998) and the Aspen Institute in the US to overcome problems that arise in the use of traditional experimental and quasi-experimental evaluation methods to evaluate complex area based initiatives promoting change at an individual, family and community level. It was developed to address the complexity of comprehensive interventions in community initiatives by identifying underlying assumptions, focusing on processes and systems within communities. Connell and Kubisch define a theory of change approach to evaluating complex community

initiatives (CCIs) as "a systematic and cumulative study of the links between activities, outcomes, and contexts of the initiative".[1]

1.17 The early years' policies that are the focus of this research share many features with complex community initiatives. They have broad and multiple goals which are related to organisational issues, child health and wellbeing, and educational training. Goals are locally determined, and therefore geographically variable. Since policy requirements at a national level change over time it is difficult to achieve an approach that is consistent over the life of projects. Activities and intended outcomes are difficult to measure using traditional methods since the units of measurement are complex, the variables influencing behaviour and outcomes cannot be controlled, and are related in multiple and often unknown ways. If interventions permeate communities, experimental designs cannot be achieved since the selection of a treatment and control group or community is not possible. Many of the outcomes expected for early years' policies will take much longer to become evident than a timescale usual for an evaluation, since many of them will only become evident later in the lifecourse, such as educational attainment, and employment and family life history.

OUTLINE OF THE REPORT STRUCTURE AND CONTENT

1.18 The remainder of this report is organised as follows.

1.19 Chapter 2 focuses on the national indicator study. It presents evidence measuring outcomes in early years and considers the potential for measuring future change. This chapter forms the main substantial report of the indicator study, with material presented at a national level, and with commentary on data coverage and quality.

1.20 Chapter 3 presents the two case study areas, Dundee City and Highland, with reference to their particular local contextual features, traditions and issues for policy provision. The overall policy, agency structure and funding backgrounds are described. Previous agency structures are illustrated with organisational diagrams, highlighting where any recent reorganisation has resulted in significant differences. It draws on material sourced locally, supplemented by information from interviews. The chapter concludes by comparing and contrasting the two areas, in relation to historical context, rurality, patterns of women's labour market participation, and the political context.

1.21 The next chapters present findings organised along thematic lines from the case study areas of Highland and Dundee City.

1.22 Chapter 4 looks at the agency structure and organisational framework for integrated early years services. It provides information obtained from documentary sources and interviews and presents evidence about the following: the rationale for the current organisational structure, how they developed and changed, and the influence of previous structures and organisation on the current arrangements. It considers the extent to which the

[1] Connell, J. P., & Kubisch, A. C. (1998). Applying a theory of change approach to the evaluation of comprehensive community initiatives: Progress, prospects, and problems. In K. Fulbright-Anderson, A. C. Kubisch, & J. P. Connell (Eds.), New approaches to evaluating community initiatives, Volume 2: Theory, measurement, and analysis (pp. 15–44). Washington DC: The Aspen Institute.
Also at http://www.aspenroundtable.org/vol2/connell.htm

present organisational framework facilitates or impedes in the development and delivery of early years provision.

1.23 In Chapter 5 intra-agency and inter-agency collaboration is considered. It begins with a descriptive account of the mechanisms and processes of collaboration at top, middle and grass roots levels. It then presents an analysis of issues that arise in the course of interagency collaboration such as managing different professional languages, perceptions of the impact of collaboration on professional roles, the degree of consultation and involvement at different levels about organisational change, different administrative boundaries. Examples of good collaborative practice are highlighted.

1.24 Chapter 6 discusses early year's services development. It draws on evidence obtained from interviews and focus groups and presents an account of service development, including rationales for what services, where located, and to whom targeted (e.g. universal or towards vulnerable or disadvantaged social groups). The influence of the financial framework and funding streams on the development and delivery of services is considered.

1.25 Chapter 7 looks at the service users' perspectives, drawing on interview material with a small group of parents within both case study areas. The influence of different contexts is examined as well as what service users' value about the services they access. Also discussed is the nature and extent of user involvement/participation and consultation in service development, including attempts to consult or include the views of 0 to 5 children. It includes information about the following.

- The extent to which new services embody continuity and/or change
- Access and take-up of services
- To whom are services targeted (and whether targeting is on target)
- Parents'/users' and grass roots providers' perspectives on services
- Perceived outcomes/impacts of service delivery
- The extent to which perceived outcomes of service delivery are compatible with quantitative impacts measured by indicators discussed in chapter 3

1.26 Chapter 8 is the concluding chapter that integrates findings across the two case study areas with the indicator study. The extent to which early years service development is explicitly linked to the aims of early years' policies is considered. It presents observations about lessons from early implementation of early years' policies and about the areas in which the monitoring and evaluation of the impacts of early years provision are well covered, and where there are gaps. This covers the extent to which new services embody continuity and/or change, access and take-up of services, targeting, users and providers' perspectives, perceived impacts and outcomes, relationship between perceived outcomes and quantitative indicators. The chapter concludes with a discussion on the need for replication of this research at intervals to gain greater insight into how early years provision is 'bedding in' at a more mature stage of policy implementation and how early years provision is influenced not only by the particular policies known as 'early years policies' but also by the wider policy environment. Recommendations for how further monitoring and evaluation could be carried out are made.

1.27 Appendix 1. This methodology appendix describes the case study design, including the design and administration of the data collection instruments, negotiation of access to data sources, sample description and data analysis.

BACKGROUND TO THE STUDY: POLICY CONTEXT IN SCOTLAND

1.28 A central plank of the Government's social inclusion, anti-poverty and welfare to work agendas has been to close the opportunity gap and ensure that every child has the best possible start in life. It is committed to abolishing child poverty over 20 years and tackling the inequalities that prevent all children from achieving their potential. Using research that identifies early years interventions as the most effective in bringing about improved outcomes for vulnerable children, a key element of its *Closing the Gap* policy agenda has been to introduce a range of early years' policies that aim to deliver better outcomes particularly for children from the most vulnerable and deprived families.

1.29 In Scotland since 1998/1999 there has been a range of early years policy initiatives, principally

- Sure Start Scotland
- Childcare Strategy for Scotland
- Pre-school Education
- The early years component of the Heath Improvement Fund (HIF)
- The National Health Demonstration Project, Starting Well, based in Glasgow

1.30 The broad aims of these policies are as the Government agenda suggests. They have substantially expanded support for families and young children well beyond the health visitor role through both universal and targeted programmes.

1.31 The core objectives of these early years' policies are:

- To improve children's health
- To improve children's social and emotional development
- To improve children's ability to learn
- To strengthen families and communities
- To reduce barriers to employment, especially for lone parents
- To reduce the number of children living in workless households

1.32 The policy objectives were to be addressed in a targeted way through working intensively with vulnerable families, as in Sure Start Scotland, but also in a universal way, as in the provision of free part time pre-school education for all 3 and 4 year olds and the development of childcare provision. Specific early years funding streams were introduced and these are intended to be used in conjunction with mainstream funding to achieve change. The policies are cross-sectoral, involve health, social work and education, and agencies were clearly instructed to work towards integrating education and childcare. Health (mental and physical) was a theme cross-cutting all policies. They required integrated planning and service delivery. The range of early years policies, their different styles and degrees of implementation along with their common and disparate objectives raise particular challenges for evaluation. However, some policies and associated programmes and projects have been subject to evaluation, for example the Starting Well Demonstration Project is being independently evaluated as one of the National Demonstration Projects. Others have been rolled out prior to rigorous evaluation being put into place, although the policies themselves may be evidence based.

1.33 These policies operate in a fluid and evolving policy environment. They are built on a foundation of mainstream provision in early years, such as health visitor services, which

themselves evolve. Other policies relevant to early years' provision had been introduced over the period, such as *the Curriculum Framework for Children 3 to 5* (Learning and Teaching Scotland 1999), which gives guidance on young children's learning and development needs, and *Protecting Children-a Shared Responsibility: Guidance on Inter-Agency Co-operation* (1998). They are also influenced by reviews, for example *For Scotland's Children: Better integrated children's services* (2001) which requires integrated planning of children's services through Children's Service Plans, the report of the Child Protection Review *It's Everyone's job to make sure I'm Alright* (2002) and *Growing Support: review of services for vulnerable families with children aged 0-3 years* (2002).

1.34 In addition, since the suite of early years' policies were introduced, other policies have been put forward such as *The Child at the Centre* (2000), setting out early education and childcare standards, the *National Programme for Improving Mental Health and Well-Being Action Plan 2003-2006*, published in September 2003, and most recently, the consultation document *Care and Learning for Children Birth to Three*- the equivalent for younger children of the Curriculum Framework for children 3 to 5, from Learning Teaching Scotland, which applies to childcare settings. These will also have an influence on the context in which early years' policies operate. The regulation, monitoring and inspection of childcare have also been affected since April 2002 by the creation of the Scottish Commission for the Regulation of Care (the Care Commission). Further policy development is underway on an Early Years Workforce Strategy and an Early Years National Learning Network (a learning network to support the dissemination of lessons from Starting Well and related early years issues). The Executive aims to use the findings from this study, where relevant, to support the implementation of the Integrated Strategy for the Early Years.

1.35 The Executive has also reported regularly on progress against its social justice milestones, which includes some early years' elements. Some of the milestones relate to children generally, and are not disaggregated by age group, and others are specific to this age group, and their parents. Each of the milestones is assessed by a set of indicators. In the most recent report on indicators of progress, *Social Justice -- a Scotland where everyone matters: Indicators of Progress* (2003), there are six milestones relating to children (p. vi):

1. 'Reducing the proportion of our children living in workless households,
2. Reducing the proportion of our children living in low income households,
3. Increasing the proportions of our children who attain the appropriate levels in reading, writing and maths by the end of Primary 2 and Primary 7,
4. All of our children will have access to quality care and early learning before entering school,
5. Improving the well-being of our young children through reductions in the proportion of women smoking during pregnancy, reductions in the percentage of low birth-weight babies, reductions in dental decay among 5 year olds, and by increasing the proportion of women breastfeeding,
6. Reducing the number of households, and particularly families with children, living in temporary accommodation.'

1.36 Of these six milestones, progress is reported for the first four, no change for the fifth and a regress in the sixth. A variety of data sources is used, including national cross sectional and longitudinal surveys, HBAI statistics from the Department of Work and Pensions, census data, vital statistics collected by the General Register Office for Scotland and administrative data sources, such as the Scottish Executive National 5 to 14 attainment levels, its pre-school and day care census and data from the NHS Scotland Information and Statistics Division.

1.37 Policy is formulated not only at a national level, but, as would be expected, is mirrored and taken forward at local level. For example, Highland local policies reflect national policies to a fairly high degree perhaps because of their willingness to participate and be involved in shaping these policies. Starting with the Well Being Alliance, Sure Start, The Childcare Strategy, HIF and Curriculum development for 3-5; followed by For Scotland's Children, Changing Children's Services Fund, Community planning and NCSA; they have each been taken and carefully woven, with the complexity of a Tartan, into a visionary integrated pan-Highland policy framework for the delivery of Children and Family services (For Highland's Children New Community Schools Approach Guidance, 2003), although the complexity of the weave can at times be problematic.

1.38 National policy documents have provided a framework for local planning policy, such as the use of *The Child at the Centre* as a quality framework for the planning of pre-school activities, which will be included in Dundee's Children's Services Plan from 2004. See chapter 4 for a more detailed account of local policy.

1.39 The Scottish Executive has not only put forward a suite of policies but has also explicitly aimed to bring them together in an integrated strategy. A consultation paper on an *Integrated Strategy for the Early Years* was published in 2003 in which the broad objectives of a 'joined-up' integrated early years' strategy are set out, as follows.

- *"to improve children's health;*
- *to improve children's social and emotional development;*
- *to improve children's ability to learn;*
- *to strengthen families and communities;*
- *to reduce barriers to employment, especially for lone parents, since work is the best route out of poverty.*" (para 12, p. 6)

1.40 The Strategy then outlines five building blocks for meeting these objectives, which are to:

1. *"align Executive policies across Departments to enable a coordinated and coherent framework for promotion of the health and wellbeing of children in their early years, and that of their families*
2. *create greater coherence in relevant Executive funding to enable fully integrated early years services delivery*
3. *propose a set of clear outcomes for local partners, targeting health improvement and narrowing the opportunity gap for children in vulnerable and disadvantaged families*
4. *support joint planning, commissioning and single system service delivery of early years services in local authorities and NHS Boards and Trusts*
5. *provide a framework to monitor and evaluate impact drawing on analysis of Children's Services Plans, the NHS Performance Assessment Framework and commissioned research.*"
   (paragraph 3, p. 4)

1.41 The paper invited comment about how to measure outcomes, specifically whether the proposed outcomes were the right ones, whether others should be added, whether they comprised the right mix of 'hard' quantifiable indicators and 'softer' qualitative data, and whether these outcomes would measure if agencies were successfully targeting the needs of

vulnerable and deprived children and families. Further comment was invited about frameworks for monitoring and evaluation (p. 20).

1.42 Responses to the consultation paper welcomed plans to introduce an integrated strategy and the final strategy is anticipated in early summer 2004.

1.43 In the *National Programme for Improving Mental Health and Well-Being Action Plan*, 'early years' is one of the priority areas, with the objectives to improve infant mental health and to integrate mental health in all work on early years. This report identifies key areas for action as ante-natal care, parenting programmes, early interventions for post-natal depression, targeted, intensive home visits and community led family centres. The *Health Improvement Challenge*[2] also includes a specific focus on early years. Thus the set of early years' policies that form the focus for this study is linked in its scope, priorities and objectives with other policies both at national and local level, indicating joined up policy-making across sectors and priority groups.

1.44 For example, the Government's early years' targets appear in other policy documents, such as its report, *Working Together for Scotland - A programme for Government*,[3] in which the Government points to its achievements in providing early support, such as

- More support through Sure Start Scotland
- Achieving free nursery places for all four year olds and most three year olds
- Launching a National Childcare Information Line
- Providing additional funds for childcare infrastructure and staff training
- Higher childcare allowances for parents in further education

That report sets out its early support targets, which include

- Achieving free nursery places for all three year olds by 2002
- Establishing in 2002 a fund combining resources for local government, health and the voluntary sector to promote integrated services for children and young people (p.16)

1.45 The Government is committed to a 'what works' approach to policy implementation and has therefore wished to assess the effectiveness of early years' policies in achieving their core objectives.

1.46 In 2002 the Scottish Executive Education Department commissioned research to evaluate Sure Start Scotland. The resulting report produced by CRFR, *Mapping Sure Start Scotland* (2002), mapped the development of services funded through Sure Start Scotland and found that Sure Start Scotland was seen as a major catalyst for change that has led to new and improved services for young children across all local authorities. That research also found that the Government's target of expanding support for families and very young children through family centres, with mobile and outreach services for at least 5000 additional children by 2002 had been exceeded.

1.47 There are, in effect, a range of current early years targets across Executive policies and brought together via the Integrated Strategy for the Early Years.

[2] Improving Health in Scotland – the Challenge, 2003 http://www.scotland.gov.uk/library5/health/ihis-00.asp
[3] Scottish Executive (2001) Working Together for Scotland - A programme for Government http://www.scotland.gov.uk/library3/government/pfg-00.asp

CHAPTER TWO MEASURING OUTCOMES IN EARLY YEARS AND POTENTIAL FOR MEASURING FUTURE CHANGE

INTRODUCTION

2.1 As part of the feasibility study looking at ways of evaluating Scotland's early years' policies, a number of indicators were identified, covering topics relevant to the policies being implemented, such as health, education and social care, and for which data were believed to be currently available. The full list of indicators developed at this time is shown in Table 2.1 below. More information on the processes by which the list below were compiled, is available in the report of the feasibility study.

Table 2.1 Suite of available indicators compiled in feasibility study

	Indicator	**Data source**
1	Rates of developmental delay at 21-24 months and 39-42 months	CHSP-PS*
2	Rates of speech and language problems at 21-24 months and 39-42 months	CHSP-PS*
3	Rates of all developmental problems at 21-24 months and 39-42 months	CHSP-PS
4	Infant mortality rates	
5	Immunisations at pre-school review	CHSP-PS*
6	% children breast-fed at 6-8 weeks	CHSP-PS*
7	Obesity at age 3-4	CHSP-PS*
8	Under-nutrition at age 3-4	CHSP-PS*
9	Presence of a smoker in the household**	CHSP-PS*
10	Special needs referrals**	CHSP-PS*
11	Maternal smoking during pregnancy	SMR-02
12	Dental decay at age 5	Dental epidemiological programme
13	Tooth-brushing at 8-9 months**	CHSP-PS*
14	Emergency hospital admissions of children: accidents under 1 year and 1-4 years	SMR-01
15	Emergency hospital admissions of children: accidental deaths under 1 year and 1-4 years	SMR-01
16	Problems with social skills and behaviour **	CHSP-PS*
17	% 0-4 year olds on child protection register	Child Protection statistics
18	% 0-4 year olds referred for child protection enquiries	Child Protection statistics
19	Total number of children attending pre-school education	Pre School education and day care census
20	Total number of children attending pre-school education	Social Justice Milestones
21	Number of full-time equivalent pre-school education places taken up by children	Pre-school education and day care census
22	Number of children attending family centres***	Pre-school education and day care census
23	P2 P3 assessment in reading, writing, maths****	Scottish Executive 5-14 attainment levels
24	Child: staff ratio in pre-school education*****	Pre-school education and day care census
25	Pre-school education providers offering: family support, parents' groups, home visiting, escort, outreach***	Pre-school education and day care census
26	Number of full time equivalent staff in pre-school education and day care centres (available by centre type)*****	Pre-school education and day care census
27	Uptake of childcare places	Pre-school education and day care census
28	% Pre-school children in workless households**	Labour Force Survey

* Analysis by deprivation category possible.
** Not confirmed data robust enough to use – will require testing
*** Only available since 2001

****Not required back to 1998 – should begin in 2001 and contain early years' policies cohort by 2003.
*****Data from 2001 missing

2.2 Following the feasibility study, work began on compiling the indicators listed in Table 2.1. Specifications were drawn up and meetings were held with data providers in the Scottish Executive and Information and Statistics Division (ISD) of NHS Health Scotland. Statisticians in these organisations, and at the University of Dundee, then supplied tables presenting the data requested, and offered 'health warnings' where appropriate.

2.3 This Chapter now presents the indicators for which it was possible to obtain data (in a number of cases, quality or non-availability issues arose which mean that not all the indicators in Table 1 are actually available). One new indicator, on 'low birth weight' was also added. Where possible, data have been graphed to aid in detection of trends, and are presented for Scotland as a whole, by the 7-category Carstairs Index of Deprivation, and by the 6-fold rural/ urban definition developed for the Scottish Household Survey. These indicators are postcode-based and thus can be added to datasets which have postcode information. More information on each, is provided below.

CARSTAIRS INDEX

2.4 This is a composite score created at a post code sector level, and based on four variables:

1. Unemployment - unemployed male residents over 16 as a proportion of all economically active male residents aged over 16.
2. Overcrowding - persons in households with 1 and more persons per room as a proportion of all residents in households.
3. Non car ownership - residents in households with no car as a proportion of all residents.
4. Low social class - residents in households with an economically active head of household in social class IV or V as a proportion of all residents in households.

All four variables are standardised using Z scores and the overall score for each ward is simply the unweighted combination of the scores. Final Carstairs scores range from 1-7, where 1 represents the most affluent areas, and 7 the most deprived areas4.

THE SHS RURAL/ URBAN DEFINITION

2.5 The area rural classification for use with the Scottish Household Survey[5] is based on postcode units, and distinguishes between both settlement size and remoteness, as follows:

- Settlement size
  The boundaries of settlements are based on the GROS postcode settlement index produced March 2000 (and updated subsequently). Settlements are divided into 4 sizes as follows:
  1. Large Urban areas (the four cities): settlements over 125,000
  2. Other urban areas: Settlements over 10,000 population and less than 125,000

4 More information is available from:Morris R, Carstairs V (1991) Which deprivation? A comparison of selected deprivation indexes. J Public Health Med 13:318-326.

5 This definition of rural was used in the first annual report on the Scottish Household Survey 'Scotland's people: results from the 1999 Scottish Household Survey: Volume 1' Scottish Executive 2000.

3. Small towns: Settlements of 3-10,000 population
4. Rural: Settlements less than 3,000 population

- Remoteness
  Drive time data and GIS are used to distinguish between accessible and more remote/peripheral rural areas using 30 minutes drive time from settlements of size 10,000 or more as the threshold, leading to a 2-fold definition of remoteness:
  1. Accessible: 30 minutes or less drive time from a settlement of 10,000
  2. Remote: more than a 30 minute drive time from a settlement of 10,000

2.6 Using these 2 criteria, a 6-fold area definition of rural Scotland is created, as set out below in Table 2.2:

Table 2.2 6-fold area definition of the population of Scotland

	Area type	Postcode units in
1	**'Large Cities'**	Settlements over 125,000 population (Aberdeen, Dundee, Glasgow and Edinburgh initially, and Inverness is now included.)
2	**'Other Urban'**	Other settlements over 10,000 population
3	**'Small, accessible towns'**	Settlements 3-10,000 population and within a 30 minute drive time of a settlement of 10,000 or more
4	**'Small, remote towns'**	Settlements 3-10,000 population and more than a 30 minute drive time of a settlement of 10,000 or more
5	**'Accessible rural'**	Settlements less than 3,000 population and within a 30 minute drive time of a settlement of 10,000 or more
6	**'Remote rural'**	Settlements less than 3,000 population and more than a 30 minute drive time of a settlement of 10,000 or more

Source: Scottish Household Survey

EXCLUDED INDICATORS

2.7 Some of the indicators for which it was anticipated data would be available, were examined in detail by the statisticians and found to be insufficiently robust to include. This was the case with the indicators looking at developmental problems and social skills and behaviour. Provisional analysis found large variation in rates across NHS Board. It was considered that such variation might be due to differences in recording practices rather than real variation, and thus the measures were excluded. More information on these measures and proposed changes which might allow them to be used in future, is found in Appendix 2. Data on special needs referrals were also withdrawn due to concerns about data quality.

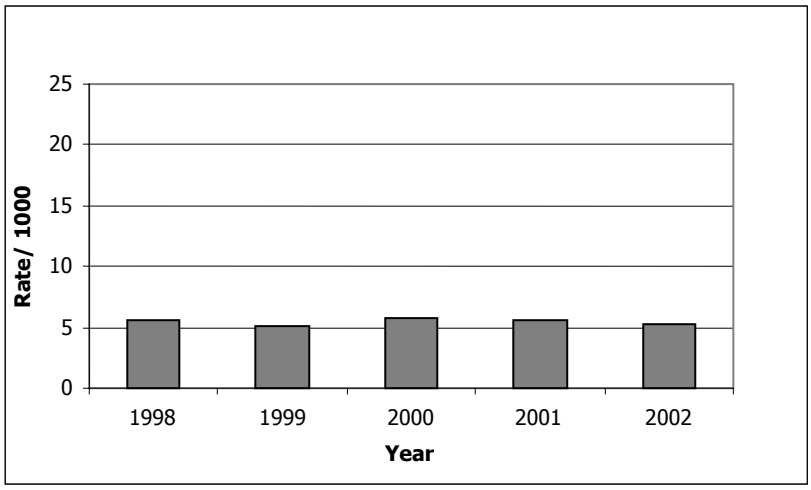
2.8 Another potential indicator was dropped since it was considered not to be sufficiently relevant to the impact of early years' policies on education (P3 assessment in reading, writing and maths). It was not possible to break down the Labour Force Survey data on children in workless households, to cover pre-school children only. Information is however available on the other indicators suggested in the Feasibility report.

THE INDICATOR ANALYSIS

Infant mortality rates

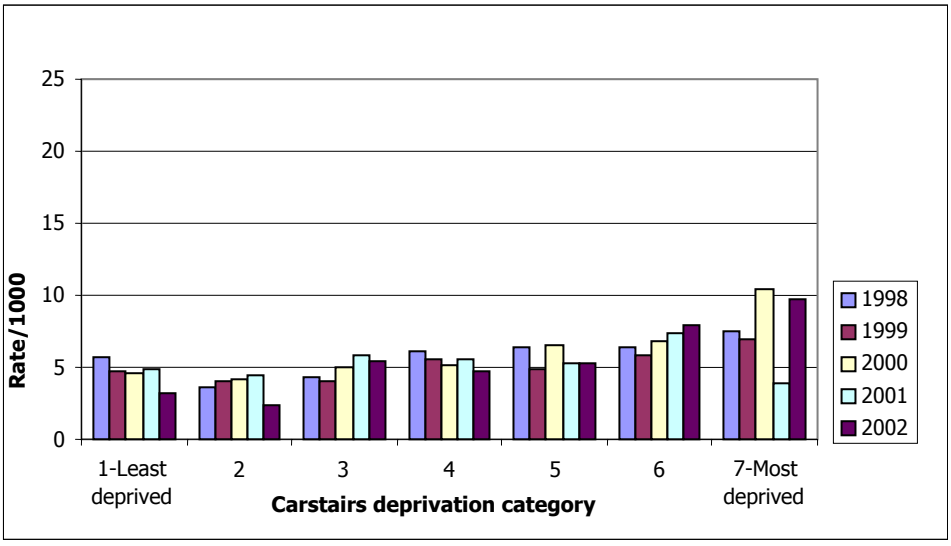
2.9 Rates of infant mortality (that is deaths in the first year of life), have remained at around 5 per thousand live births from 1998 to 2002 (Figure 2.1). The general trend is for a higher rate of infant mortality in more deprived areas, with levels reaching 10 per thousand live births in the most deprived areas in some years (Figure 2.2). There is no notable pattern by rural or urban location (Figure 2.3).

Figure 2.1 Infant mortality in the first year of life (rate/thousand live births)



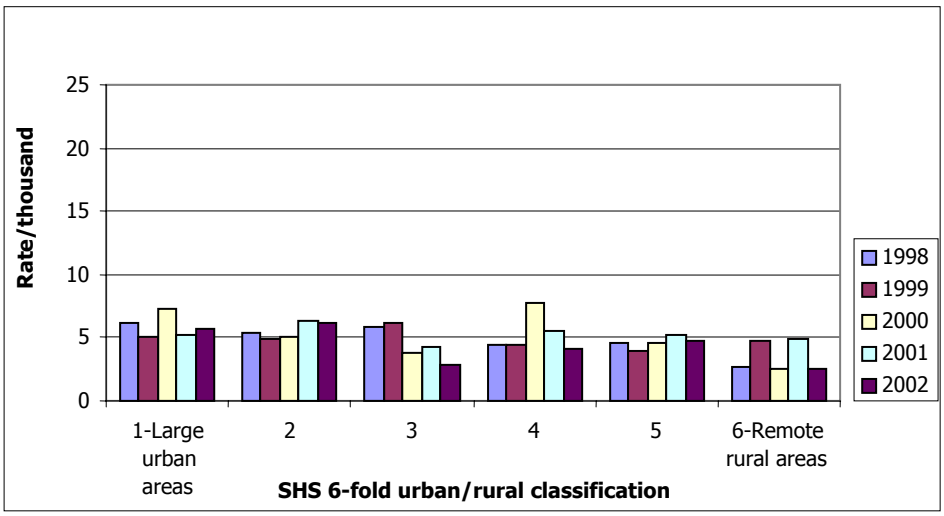
Source: GROS registered births, Scottish stillbirths and infant deaths survey

Figure 2.2 Infant mortality in the first year of life (rate/thousand live births) by deprivation level



Source: GROS registered births, Scottish stillbirths and infant deaths survey

Figure 2.3 Infant mortality in the first year of life (rate/thousand live births) by urban/rural location



Source: GROS registered births, Scottish stillbirths and infant deaths survey

Immunisations

2.10 Figures 2.4 to 2.8 show the uptake of immunisations against common childhood illnesses[6]. Data are shown for all the standard antigens except Meningitis C and MMR, and for MMR separately[7]. Separate reporting of the MMR vaccination rates is useful because adverse publicity has affected uptake of this immunisation, while other vaccinations have been far less affected.

2.11 The data in Figure 2.4 show that by the age of 12 months 95% of children in Scotland had received the primary immunisations in each year from 1999 to 2002 (and 94% had received these in 1998). The proportion immunised against MMR has fallen from 93% in 1998-2000, to 88% in 2002.

2.12 While there has been little overall change in the proportion of children receiving their primary immunisations at 12 months, Figure 2.5 reveals that there have been variations within certain groups. Those categorised in the most deprived areas (according to the 1991 Carstairs index), have seen greatest rates of increase in immunisations. Between 1998 and 2002, the proportion of those in the most deprived areas immunised at 12 months rose from

[6] This information was supplied by ISD. Information on primary immunisation is recorded in the Scottish Immunisation Recall System (SIRS).
Cohorts used in the calculation of uptake rates are based on all children reaching a specified age who were alive and registered on the systems at the end of the reporting period.

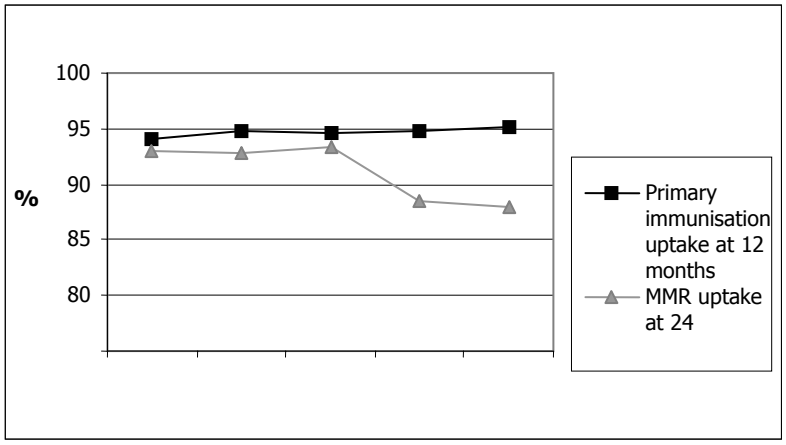
[7] Those said to have received the 'primary immunisations' have completed all of the following courses: Diphtheria; Pertussis; Tetanus; Polio and Hib.
Meningitis C (MenC) was implemented in 2000 when it became part of the immunisation programme. Children born before January 2000 should have been offered MenC as part of the 'mop up' process during the year 2000. However the 'mop-up' period was extended past this date and therefore MenC uptake rates are only available for year ending December 2001 onwards. In order to make rates comparable, MenC has been excluded from this analysis.

88% to 91%. For those in category 6 on the Carstairs Index, rates of immunisation at 12 months have also risen, from 93% in 1998 to 95% in 2002. The only other Carstairs group to see a rise of as much as 2 percentage points, was the most affluent group, where rates of immunisation rose from 95% in 1998 to 97% in 2002.

2.13 Looking at rates of immunisation in relation to whether people live in an urban or rural location, Figure 2.6 shows that levels of immunisation at 12 months were lowest in Scotland's 5 city areas and, at the other extreme, in remote rural areas. In both these areas, gains have been made between 1998 and 2002.

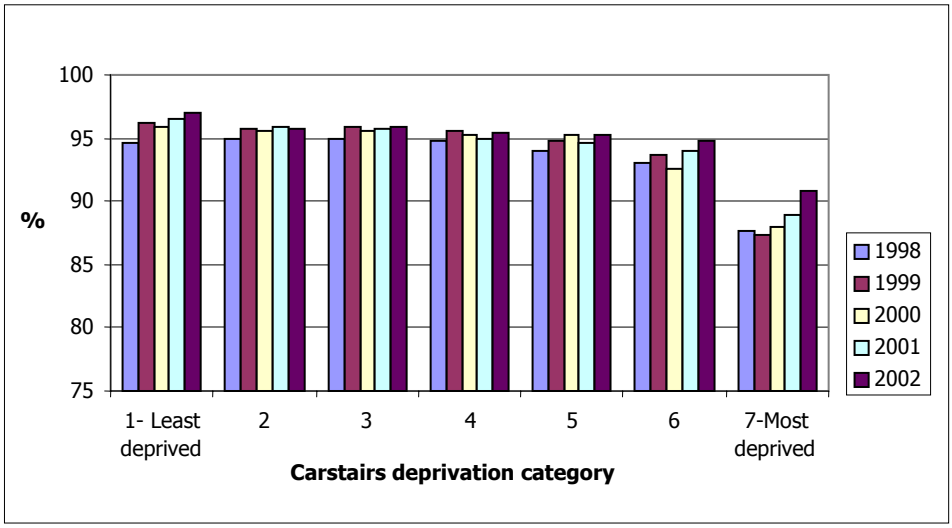
2.14 Turning to look at the MMR vaccinations, Figure 2.7 shows a small rise in rates of uptake between 1998 and 2000 for most areas (although not the most deprived areas), followed by a sharp fall off in uptake among all groups. Among those in the most advantaged areas, by 2002 90% of children had received the MMR vaccination. The corresponding proportion for those in Carstairs category 7, was 83%. Rates of uptake of MMR were lowest in remote rural areas where 83% of children were immunised in 2002, compared with almost 89% in accessible urban areas and 87% of those in the large city areas.

Figure 2.4 Immunisation uptake at 12 & 24 months



Source: SIRS, ISD Scotland

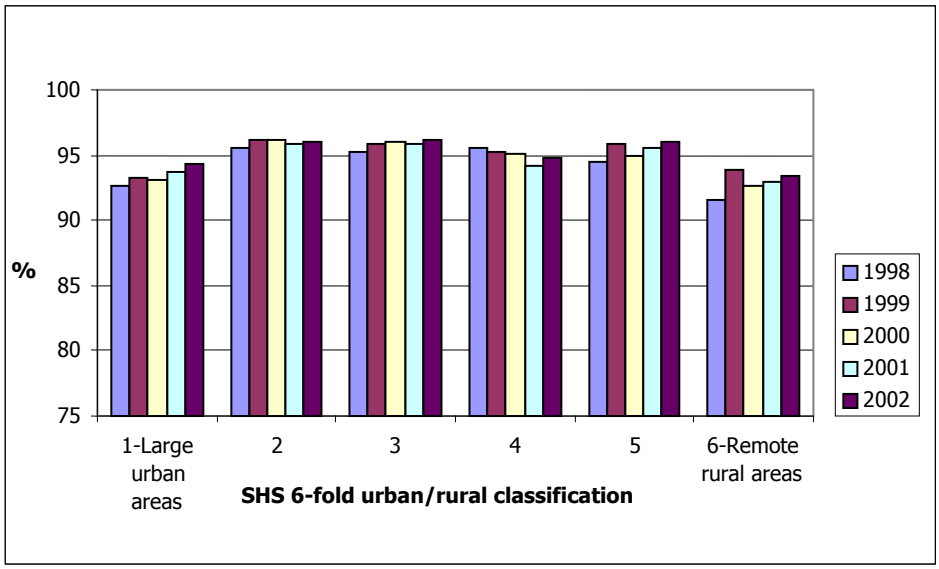
Figure 2.5 Primary immunisation uptake at 12 months by deprivation level



* excludes MMR & MenC

Source: SIRS, ISD Scotland

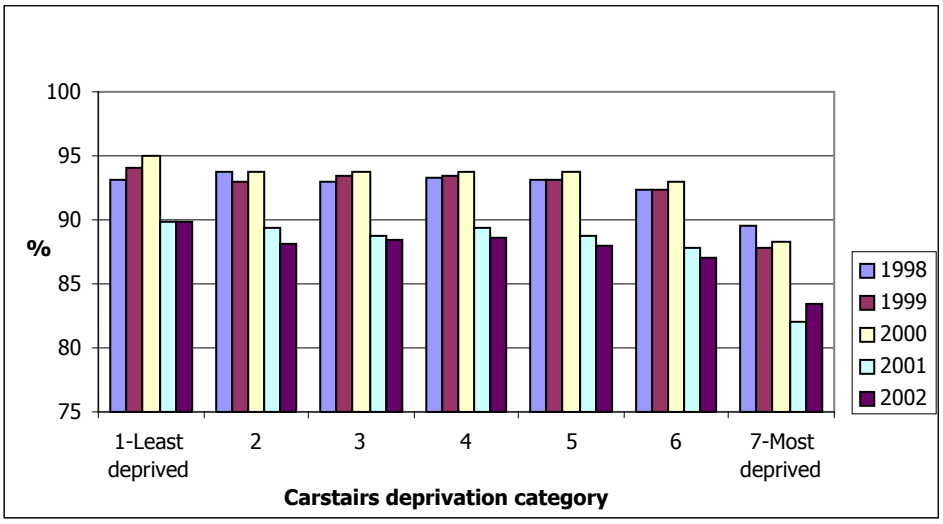
Figure 2.6 Primary immunisation uptake at 12 months by urban/rural location



* excluding MMR & MenC

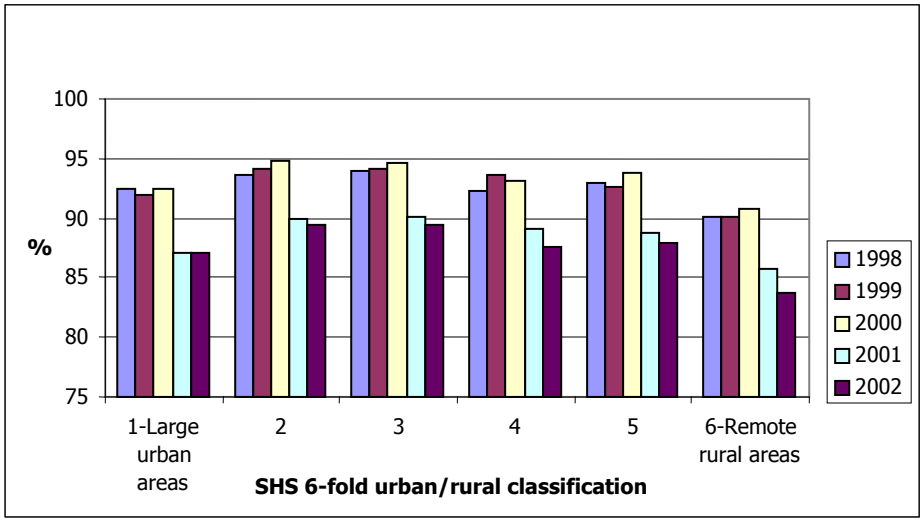
Source: SIRS, ISD Scotland

Figure 2.7 MMR uptake at 24 months by deprivation level



Source: SIRS, ISD Scotland

Figure 2.8 MMR uptake rates at 24 months by urban/rural location



Source: SIRS, ISD Scotland

Breast feeding

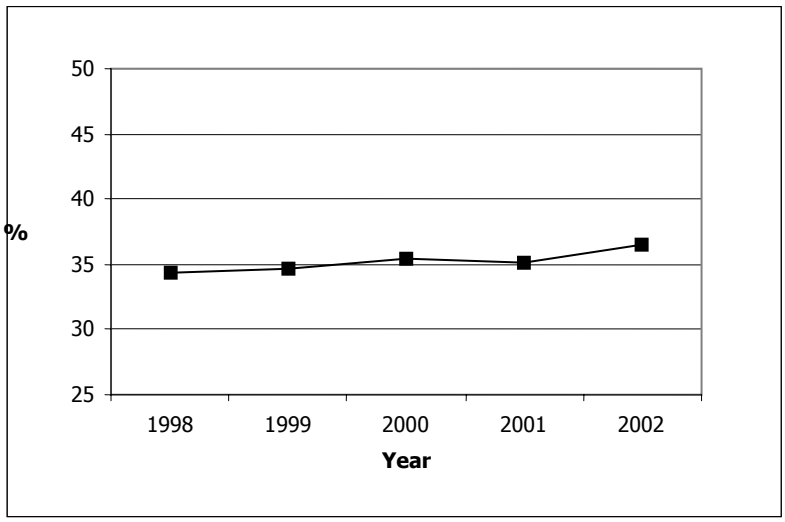
2.15 Information on breast-feeding rates have been extracted from the 6-8 week review on the Child Health Surveillance Programme (CHSP)[8]. Breastfeeding includes both children exclusively breastfed and those fed both breast and formula milk. Invalid breastfeeding data have been excluded from the figures.

2.16 Overall Figure 2.9 shows there appears to have been a slight increase in the proportion of children being breast-fed at 6-8 weeks between 1998 and 2002 – from 34% to 36%.

2.17 Figure 2.10 reveals large variations in breast-feeding across the different deprivation categories. In 2002, 60% of children in the least deprived areas were being breast fed at 6-8 weeks compared with just 20% of those in the most deprived areas. However, the 2002 figures do represent an improvement since 1998 for those in the most deprived areas. In 1998 only 13% of children in such areas were breast-fed.

2.18 Figure 2.11 shows highest rates of breast feeding among those in remote rural areas, followed by those in accessible rural areas. Babies in Scotland's large cities and other urban areas are least likely to be breast-fed at 6-8 weeks. Growing rates of breast-feeding were evident in Scotland's large cities over the period 1998-2002.

Figure 2.9 Proportion of children breast-fed* at 6-8 weeks



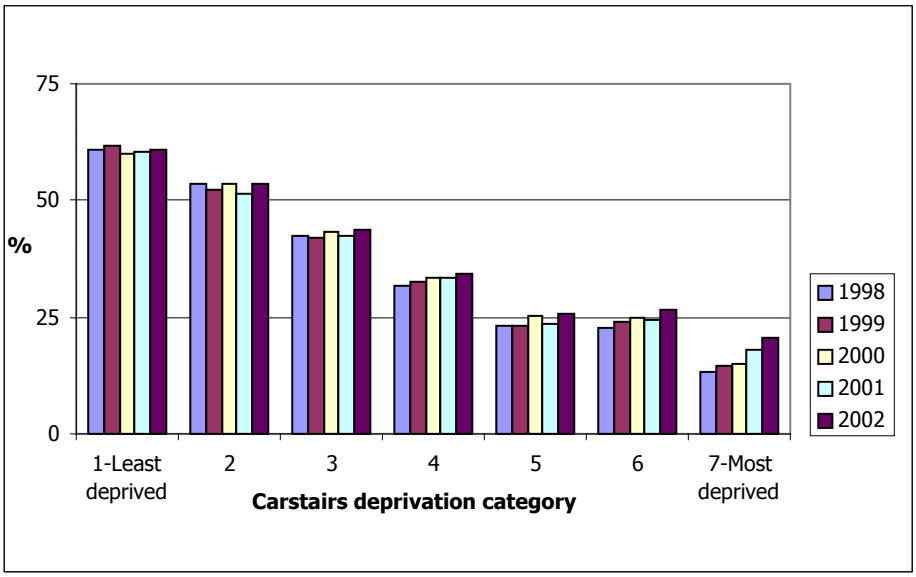
* includes children breast-fed or fed breast & formula milk

Source: CHSP-PS, ISD Scotland

8 Data provided by ISD. The CHSP-PS system was introduced in 1991 and now has 10 participating NHS Boards. These 10 boards (Argyll & Clyde, Ayrshire & Arran, Borders, Dumfries & Galloway, Fife, Forth Valley, Greater Glasgow, Lanarkshire, Lothian, Tayside) account for approximately 84% of Scotland's pre-school population.

The surveillance programme currently recommends reviews at 10 days (first visit), 6-8 weeks, 8-9 months, 22-24 months, 39-42 months and 48-54 months (pre-school). The first visit is normally undertaken by a health visitor in the home and coverage is usually high at around 92%. Coverage then falls slightly across the reviews (89% at 6-8wks; 86% at 8-9mth; 82% at 22-24mth; 75% at 39mth and 67% at pre-school).

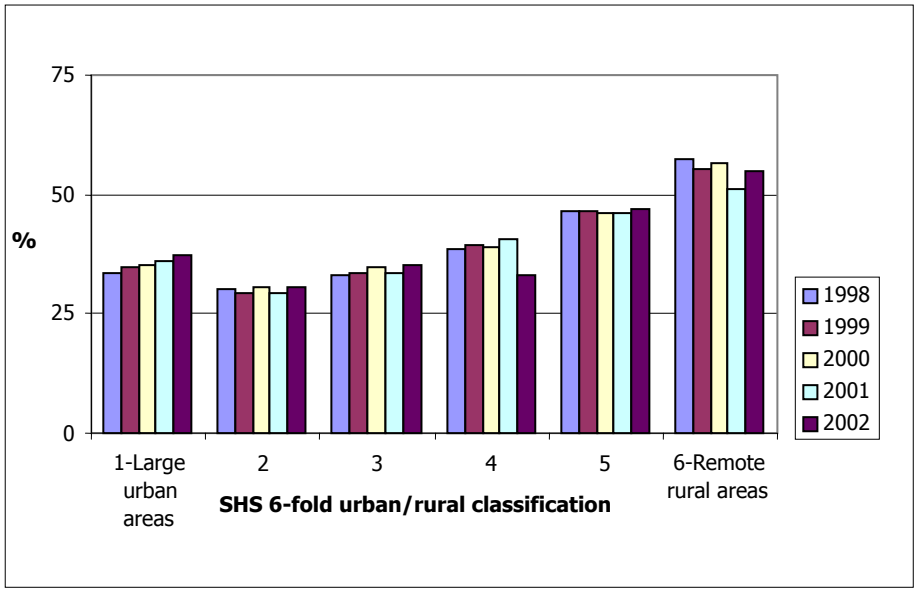
Figure 2.10 Proportion of children breast-fed* at 6-8 weeks by deprivation level



* includes children breast fed or breast & formula fed

Source: CHSP-PS, ISD Scotland

Figure 2.11 Proportion of children breast-fed* at 6-8 weeks by urban/rural location



* includes children breast-fed or breast & formula fed

Source: CHSP-PS, ISD Scotland

Childhood obesity and children over- and under-weight

2.19 The CHSP-PS routinely collects data on height and weight. These data can be used to calculate body mass index (BMI) and estimate the prevalence of obesity and under-nutrition in Scottish children.

2.20 BMI is a simple ratio of weight adjusted for height [weight(kg)/height(m)2] which provides an index of fatness or thinness. The prevalence of obesity and under-nutrition in a population of children relative to the UK 1990 population can be estimated by comparing the distribution of this ratio[9]. For the purposes of this analysis, the following definitions apply: children who fall under the 5th centile are defined as having low BMI. Those children who are above the 85th centile are defined as overweight, and those above the 95th centile are defined as obese.

2.21 Figure 2.12 shows little change in the proportion of children recorded as obese at the 39-42 month review between 1998 and 1999 (8%). Figures are unfortunately not yet available for subsequent years. These figures are themselves indicative of a rise in obesity since 1990 when the reference curves were established and 5% of children were recorded as being this weight.

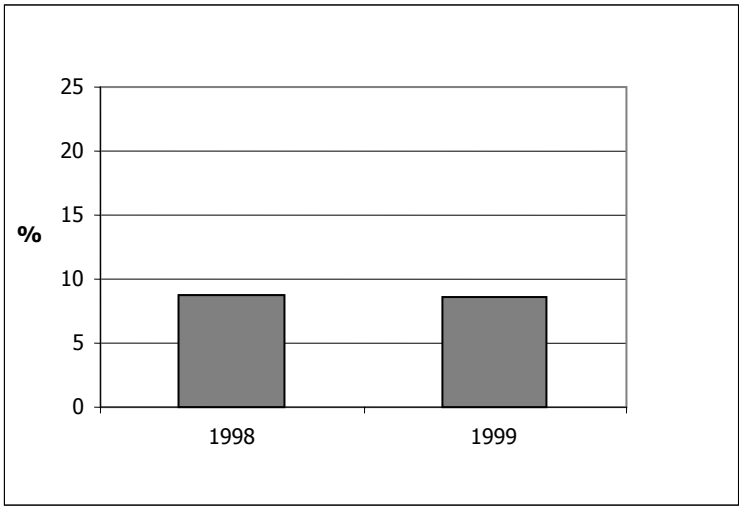
2.22 Figure 2.13 shows higher levels of childhood obesity in areas of greater deprivation – with 9% of those in the most deprived areas recorded as obese in 1999 compared with 6% of those in the least deprived areas. Figure 2.14 shows the distribution of obesity by rurality. Within the two remote categories (remote rural areas and remote small towns), there appears to have been some change between 1998 and 1999, however these categories each contain relatively small proportions of children and thus the trends cannot be accurately interpreted on the basis of this evidence.

2.23 Figure 2.15 shows that over 21% of all children in Scotland were overweight at the 39-42 month review in both 1998 and 1999, while Figure 2.16 shows that only among those in the least deprived group were fewer than 20% overweight.

2.24 Looking at the other end of the spectrum, 6% children were recorded as being underweight in 1998 and 1999 (Figure 2.18). The proportion of those who were underweight, was higher among those in more deprived areas (Figure 2.19).

[9] In 1995 new reference growth curves for weight and height of UK children were published replacing the Tanner-Whitehouse reference curves for children's growth in the 1960's. The new curves represent UK children in 1990 and are widely accepted as the reference for growth screening for the UK. The reference data used were collected between 1978 and 1990 and were obtained by combining data from 11 distinct surveys which were representative of children in England, Scotland and Wales. From this national data set, BMI reference curves for children and young people were established providing BMI centiles covering birth to 23 years of age.2

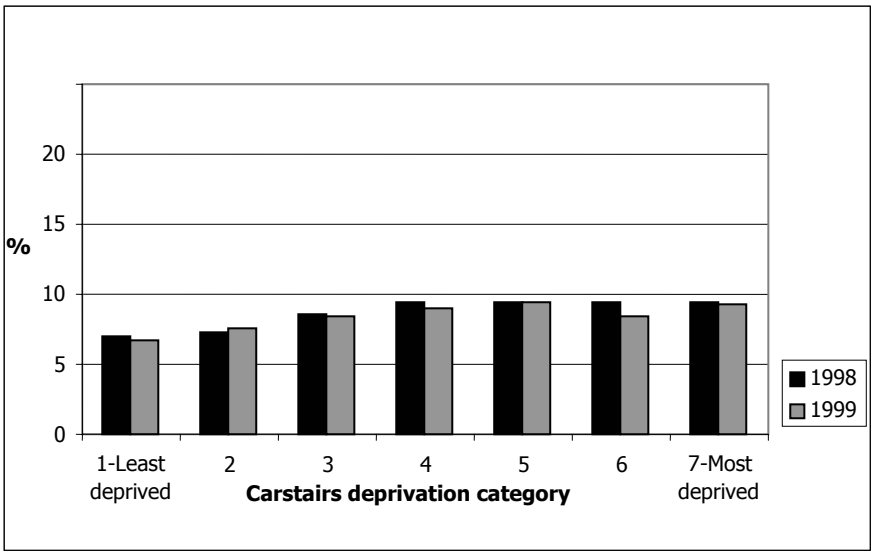
Figure 2.12 Proportion of children obese at 39-42 month review* by year



* overweight at 95th percentile in 1990

Source: CHSP-PS, ISD Scotland

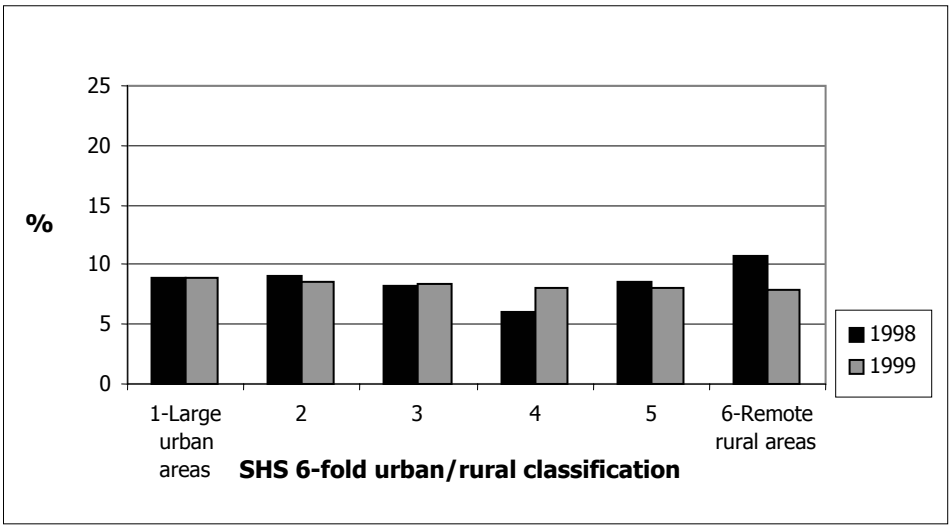
Figure 2.13 Proportion of children obese at 39-42 month review* by deprivation level



* overweight at 95th percentile in 1990

Source: CHSP-PS, ISD Scotland

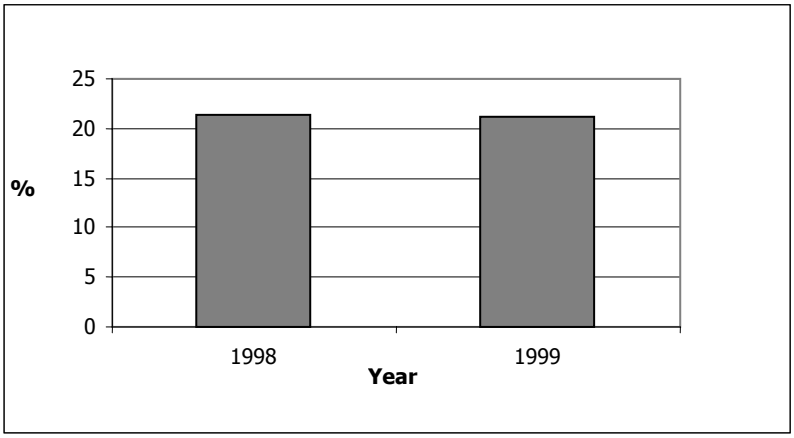
Figure 2.14 Proportion of children obese at 39-42 month review* by urban/rural location



* overweight at 95th percentile in 1990

Source: CHSP-PS, ISD Scotland

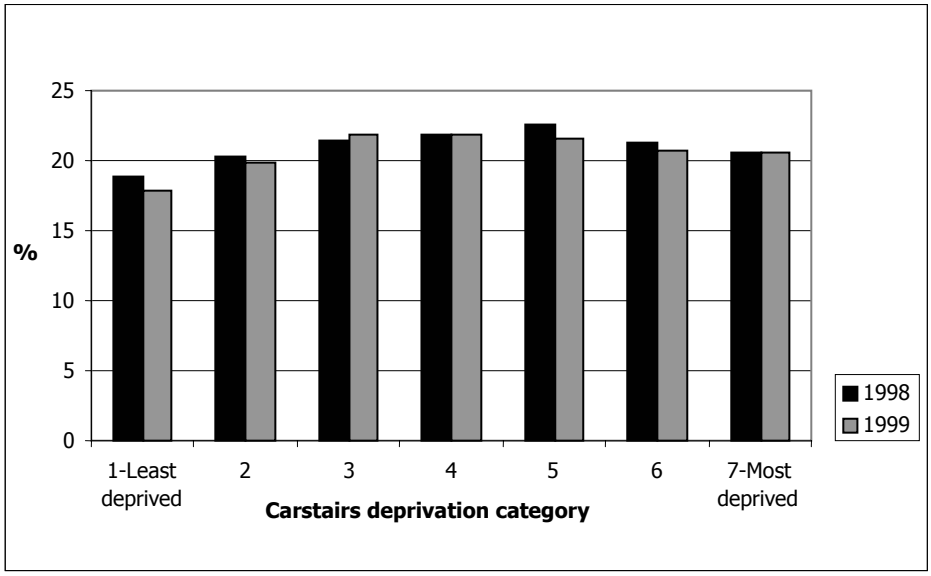
Figure 2.15 Proportion of children overweight at 39-42 month review*



* overweight at 85th percentile in 1990

Source: CHSP-PS, ISD Scotland

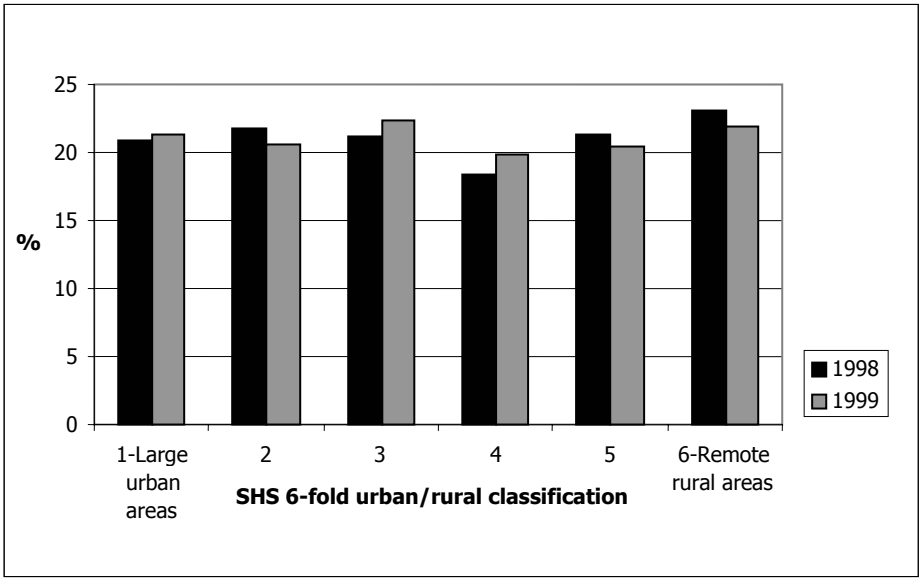
Figure 2.16 Proportion of children overweight at 39-42 month review* by deprivation level



* overweight at 85th percentile in 1990

Source: CHSP-PS, ISD Scotland

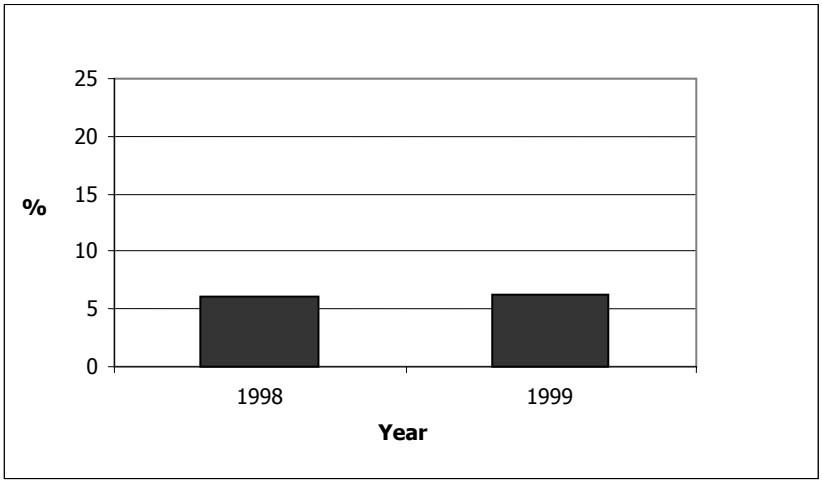
Figure 2.17 Proportion children overweight at 39-42 month review* by urban/rural location



* overweight at 85th percentile in 1990

Source: CHSP-PS, ISD Scotland

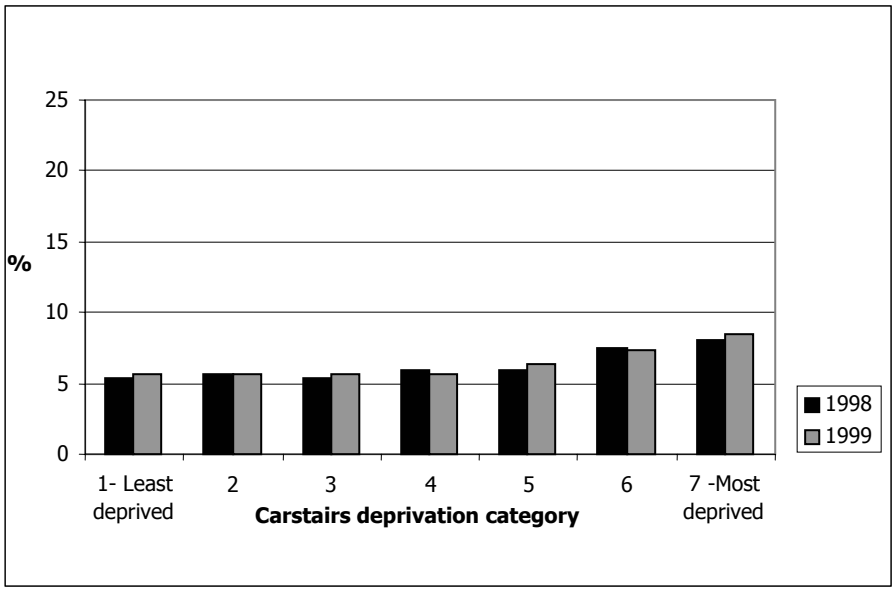
Figure 2.18 Proportion of children with low body-mass index at 39-42 month review*



* underweight at 5th percentile in 1990

Source: CHSP-PS, ISD Scotland

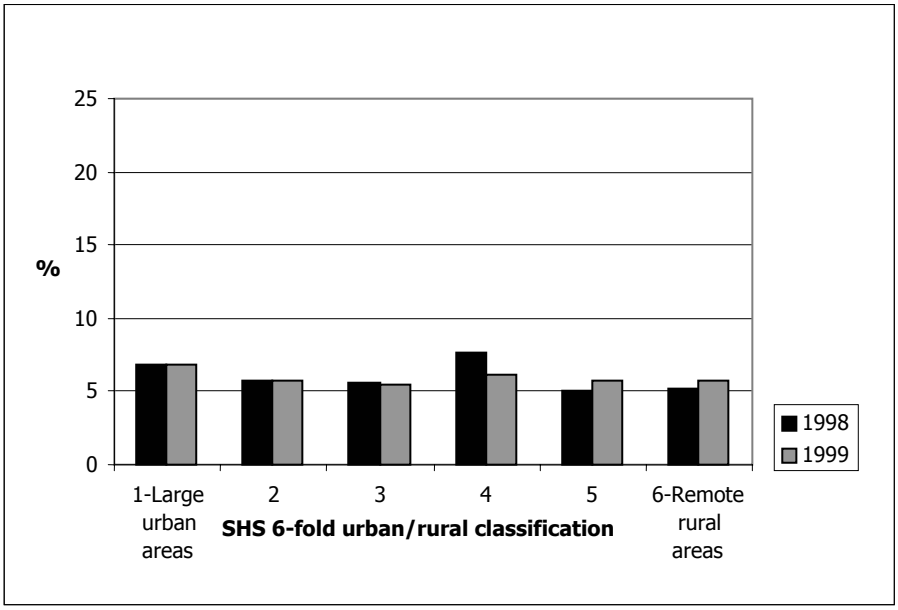
Figure 2.19 Proportion children with low body-mass index at 39-42 month review* by deprivation level



* underweight at 5th percentile in 1990

Source: CHSP-PS, ISD Scotland

Figure 2.20 Proportion of children with low body-mass index at 39-42 month review* by urban/rural location



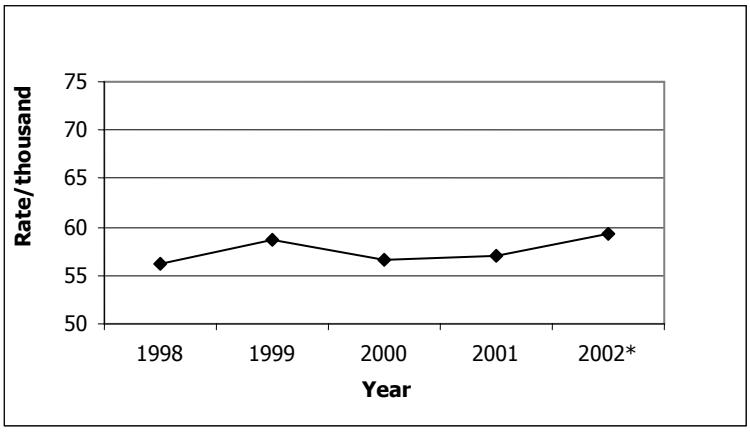
* underweight at 5th percentile in 1990

Source: CHSP-PS, ISD Scotland

Low Birth Weight

2.25 Birth weight figures are supplied to ISD by individual health boards and can then be reported for Scotland as a whole. Between 1998 and 2002, out of every thousand babies born alive, 56-59 had a low birth weight. (Figure 2.21). This proportion varied dramatically in relation to deprivation level, with around 40 low birth weight babies per thousand live births among those in the least deprived areas, and over 85 per thousand among those in the most deprived areas. Low birth weight babies were generally more common in Scotland's large urban areas and other urban areas, than in rural parts. While there have been small fluctuations over time, a consistent pattern of change is not evident.

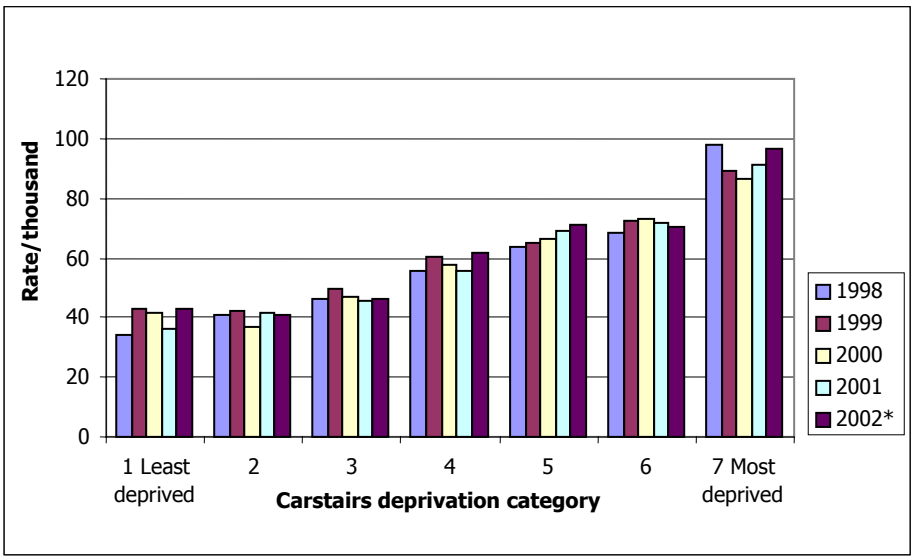
Figure 2.21 Low birth weight babies (rate/thousand live births)



* 2002 figures are provisional

Source: ISD Scotland

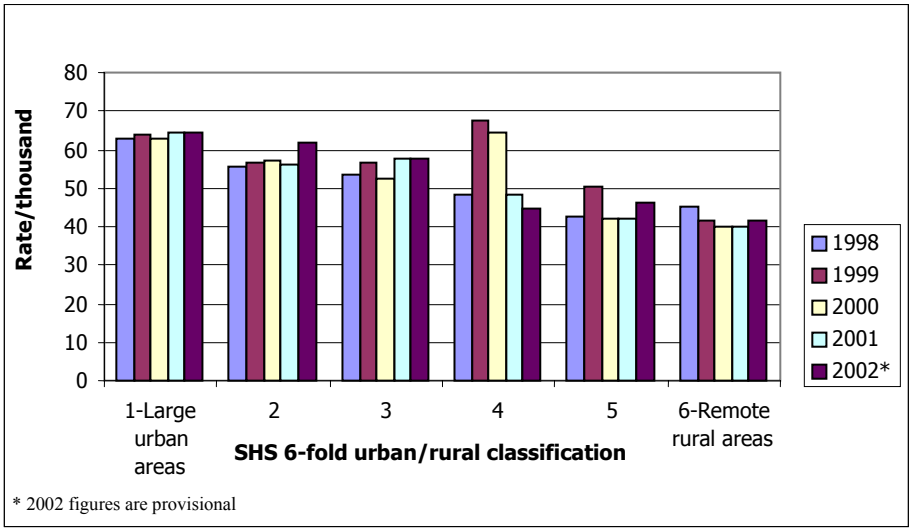
Figure 2.22 Low birth weight babies (rate/thousand live births) by deprivation level



* 2002 figures are provisional

Source: ISD Scotland

Figure 2.23 Low birth weight babies (rate/thousand live births) by urban/rural location



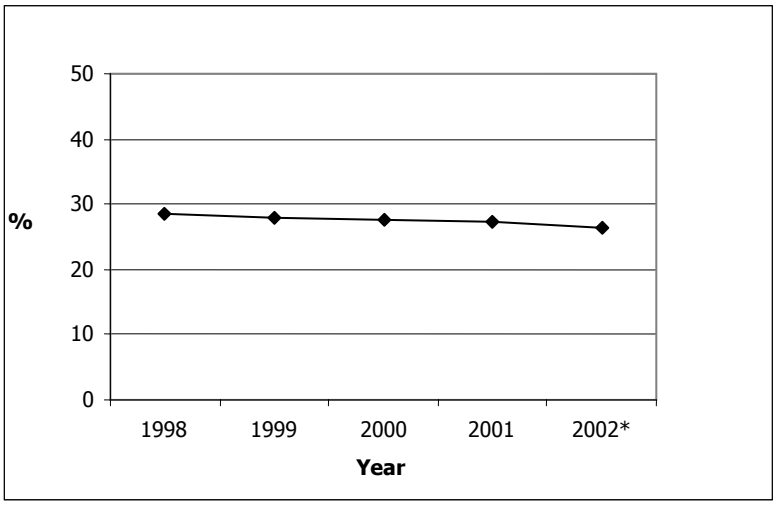
Source: ISD Scotland

Maternal smoking

2.26 Information on mothers' smoking is obtained from the Scottish Maternity Record, and has been supplied by ISD. The data on smoking behaviour is based on self-reported information obtained from mothers at their booking ante-natal visit in the community or at hospital.

2.27 Between 1998 and 2002, there has been a slight reduction in the proportion of mothers reporting that they smoked at the time they gave birth (from 29% to 26%). Again there is considerable variation in relation to deprivation area. Only around 10% of those in the least deprived areas reported smoking at booking in 1998, compared with 50% of those in the most deprived areas. However, it appears that most of the change in the overall pattern over time, is accounted for by a reduction in smoking among new mothers in the most deprived areas. In 2002 the proportion of those in Carstairs category 7 who reported smoking at booking in, had reduced to a little over a third. Smoking at booking in can be seen to be most prevalent in Scotland's cities and other urban areas, and least prevalent in rural areas.

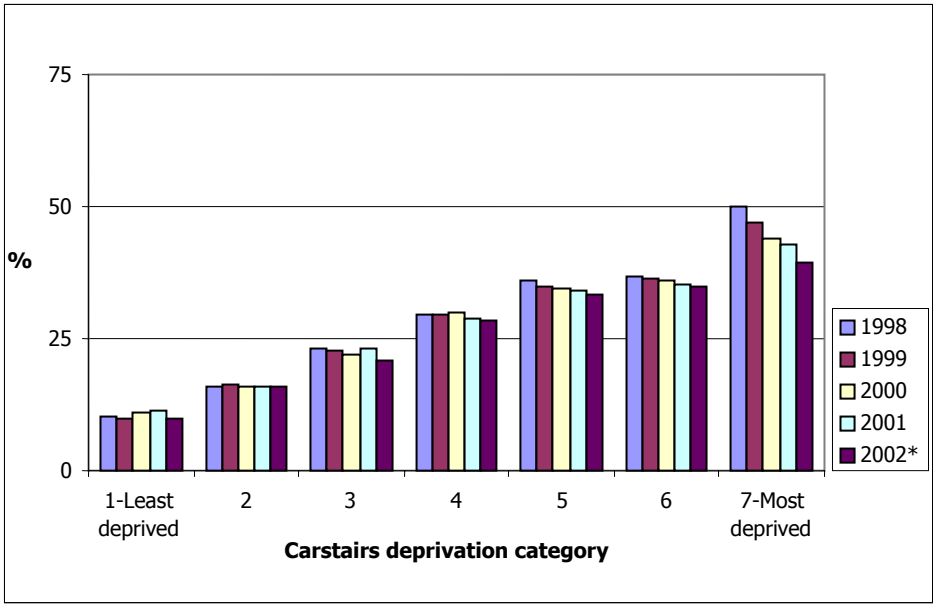
Figure 2.24 Proportion of new mothers reporting smoking at 'booking in'



* 2002 figures are provisional

Source: SMR02, ISD Scotland

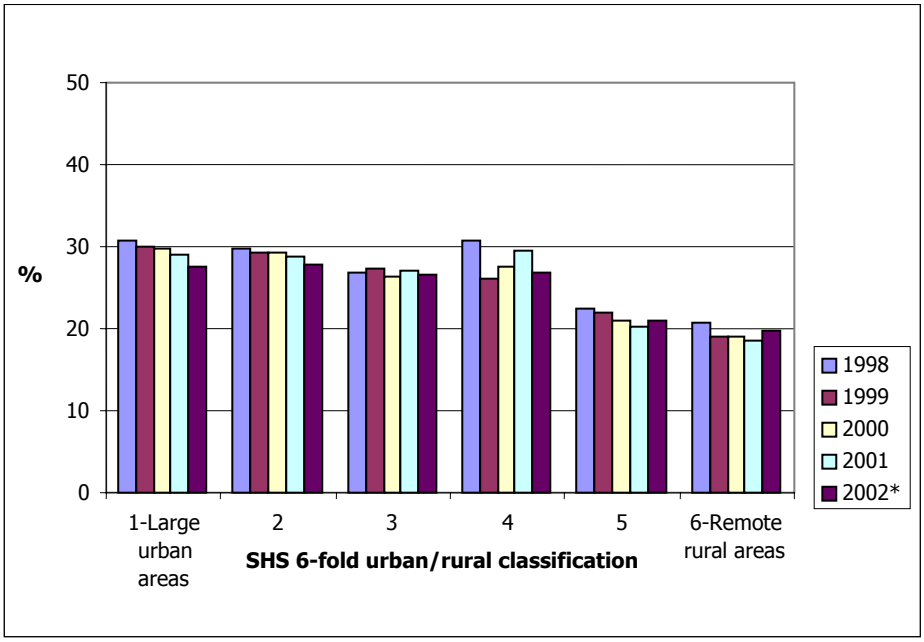
Figure 2.25 Proportion of new mothers reporting smoking at 'booking in' by deprivation level



* 2002 figures are provisional

Source: SMR02, ISD Scotland

Figure 2.26 Proportion of new mothers reporting smoking at 'booking in' by urban/rural location



* 2002 figures are provisional

Source: SMR02, ISD Scotland

Dental decay

2.28 The British Association for the Study of Community Dentistry (BASCD) is responsible for the co-ordination of locally based surveys of child dental health which permit local and national comparisons between health authorities and regions. These surveys began in 1987/88 in Scotland and different aged children are examined annually. Thus data for the youngest children examined, those aged 5, are not available at every time point.

2.29 From these studies, it is possible to look at the proportion of children with no experience of dental decay, and the proportion with some experience of dental decay – in terms of active decay, teeth lost due to decay or teeth which have been treated for decay by filling. Data used in this report are drawn from the 1999-00 Scottish Health Boards Dental Epidemiology Programme and the 2002-2003 National Dental Inspection Programme surveys of 5 year olds.

2.30 Table 2.3 reveals that at the age of 5, 45% of Scotland's children have some experience of dental decay. There has been no change in this indicator between 1999 and 2003.

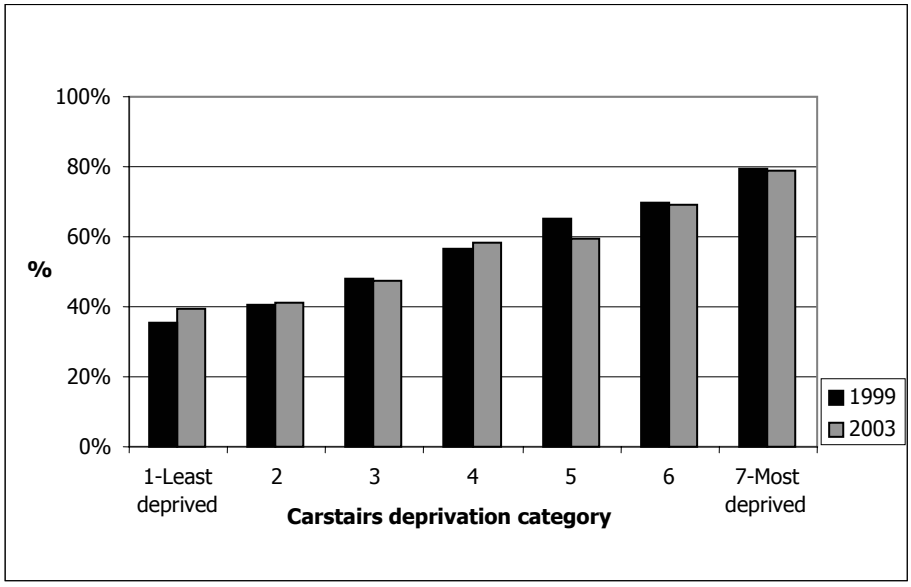
2.31 Experience of dental decay is far higher among those living in more deprived areas, than among those living in more affluent areas (Figure 2.27). Almost 80% of those in the most deprived areas had some experience of dental decay in 2003, compared with just under 40% of those in the most affluent areas. While some fluctuation in patterns of dental decay is evident by rural or urban area, there is not a consistent pattern (Figure 2.28)

Table 2.3 Experience of dental decay at age 5; 1999 and 2003

	1999	2003
	%	%
Some decayed, missing (due to decay) or filled teeth	45	45
No decayed, missing or filled teeth	55	55
Sample size	6994	10080

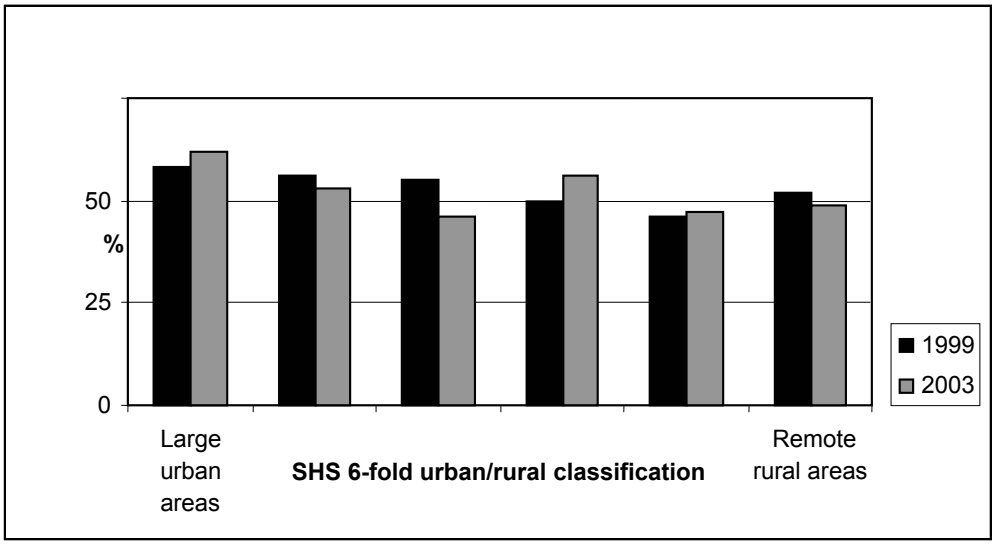
Source: Dental epidemiological programme

Figure 2.27 Proportion of 5 year olds with some experience of dental decay by deprivation level



Source: Dental epidemiological programme

Figure 2.28 Experience of dental decay at age 5 by urban or rural location, 1999 & 2003



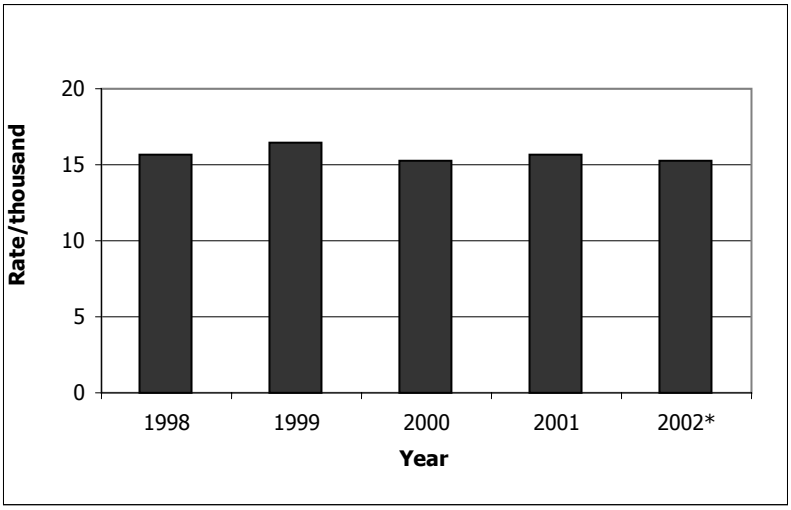
Source: Dental epidemiological programme

Emergency hospital admissions: Unintentional injuries and accidental deaths

2.32 Around 15 out of every thousand children aged 0 to 4 went to hospital as a result of an accidental injury in each year between 1998 and 2002 (Figure 2.29). There was no notable pattern in relation to deprivation level (Figure 2.30), although it appeared that there had been fewer accidents each year among those in more deprived areas. Rural/ urban analysis was not possible for this measure.

2.33 Data on accidental deaths are reported in tabular format only since the figures are too small to graph effectively (Table 2.4).

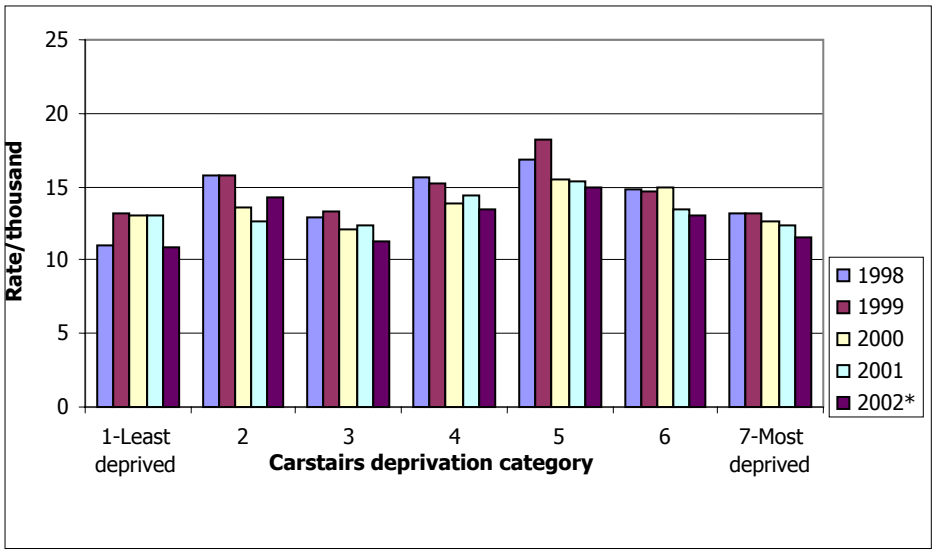
Figure 2.29 Unintentional injuries leading to hospital admissions



* 2002 figures are provisional

Source: SMR01, ISD Scotland

Figure 2.30 Unintentional injuries leading to hospital admissions by deprivation level



* 2002 figures are provisional

Source: SMR01, ISD Scotland

Table 2.4 Deaths (as a result of 'unintentional injuries') children aged 0-4, by year

Year	Rate/ thousand
1998	0.1
1999	0.1
2000	0.1
2001	0.1
2002*	0.1

*2002 figures provisional

Source: SMR01, ISD Scotland

Child protection

2.34 Child protection figures are somewhat difficult to interpret, since an increase in the proportion of children in the child protection system might mean EITHER that more children are at risk (which would suggest the situation is worsening), or that the same, or a smaller proportion are at risk, but that more at risk situations are being identified and dealt with (which would suggest the situation is improving).

2.35 Between 2000 and 2003, the years for which data are available, the proportion of children on the child protection register has changed little – from 0.3% to 0.4%. There has also been little change in the proportion referred for child protection enquiries, which was 0.7% in 1998 and 0.9% in 2003. These figures are shown in Table 2.5. They are not available in relation to deprivation area or rurality.

Table 2.5 Child protection data for Scotland, by year

Year	% of 0-4 year olds referred for Child Protection enquiries	% of 0-4 year olds on the Child Protection Register
1998	0.7	-*
1999	0.7	-*
2000	0.8	0.3
2001	0.7	0.3
2002	0.7	0.3
2003	0.9	0.4

* Data not available

Source: Child Protection Statistics

Pre-school education and childcare

2.36 Much of the available information about pre-school education and childcare comes from the Scottish Executive's annual censuses of pre-school education and childcare providers[10]. Over the years these have been subject to alteration, hence it is not always possible to provide comparisons over time. Within the pre-school and day care census, children are categorised as being in the:

- ante pre-school year
- pre-school year, or
- pre-school year deferred

2.37 These categorisations are very closely related to the child's age, and hence in the remainder of this Chapter, for ease of interpretation, we refer to the children as being 3 (ante pre-school year), 4 (pre-school year) or 5 (pre-school year deferred). The latter category may also include a very small number of children over 5 who have remained in pre-school beyond the age of 5. Rural/ urban analysis is not possible for the data in this Section.

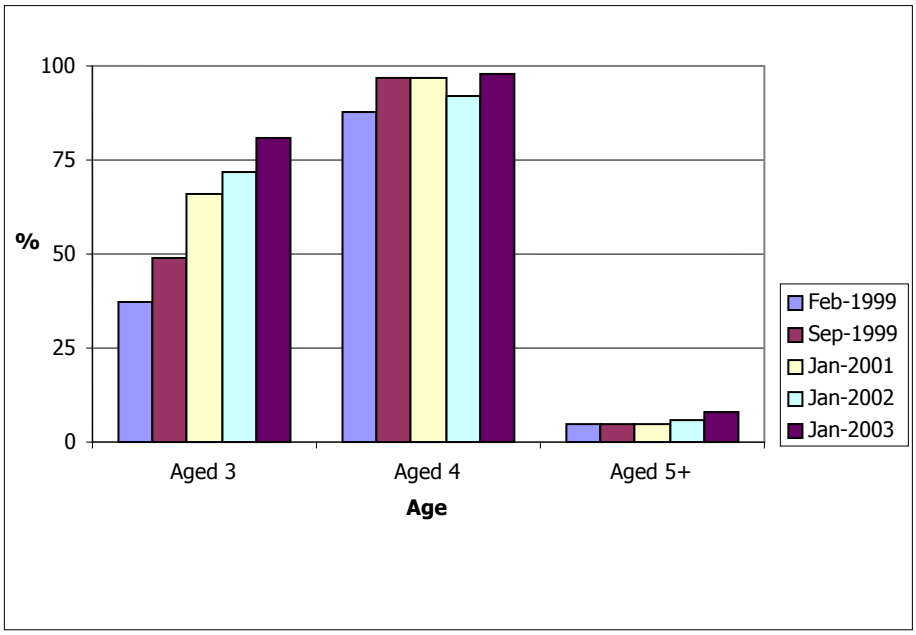
2.38 As can be seen in Figure 2.31, recent years have seen a dramatic increase in the proportion of children aged 3 receiving pre-school education. In 2002, 37% of three year olds were receiving pre-school education compared with just over 20% in 1999. At the same time there has been a smaller rise in receipt of pre-school education among those aged 4 and 5, although this was starting from a much higher base.

2.39 These figures are based on a census of providers not children, hence if a child attends more than one centre, it is likely that they will be double-counted. These figures on attendance do not take account of the amount of time children spend at the provider, so in some cases children will be receiving full time care, while in others they may just be attending for a few hours per week.

2.40 Data are also available to show the number of full-time equivalent places taken up by children of each age group (Figure 2.32). This reflects the amount of hours of nursery provision in total that is available. It can be seen that there were filled full time equivalent places for 50% of those aged 4 in 1999 and slightly more in 2003, which means for example, that every child of this age could be attending half time. Between 1999 and 2002, the increase in nursery provision for those aged 3, took the number of full time equivalent places from covering less than a quarter of children, to 37%. This means that every child could be attending for a little over a third of the day, (although in reality obviously some children attend full time and some not at all, with the majority attending part time).

[10] Each Census attains a response rate of around 90% and data are estimated for missing centres.

Figure 2.31 Proportion of children attending pre-school education by age

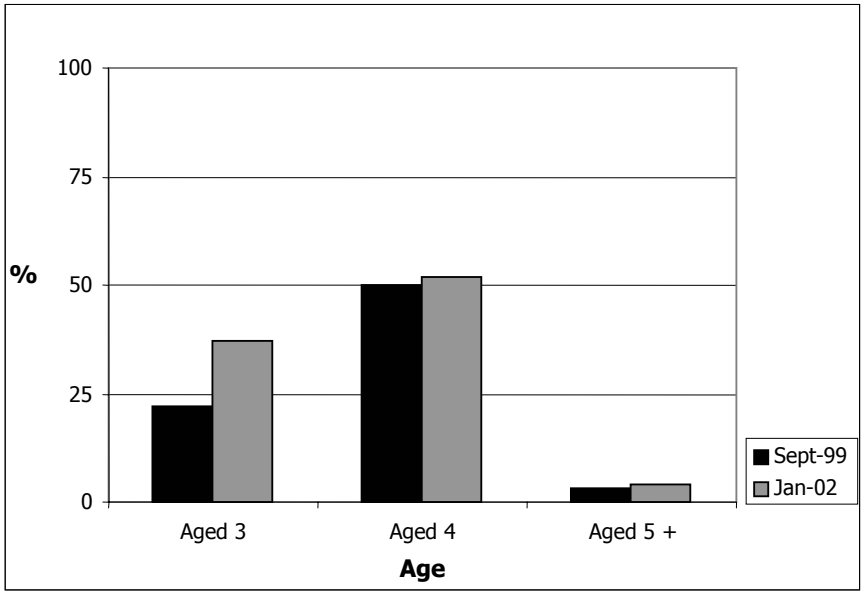


* Figures for 2000 are not available

** This figure shows the no. of full time or part time places filled by children. Children attending more than one centre may be counted twice

Source: Pre-school and day care census

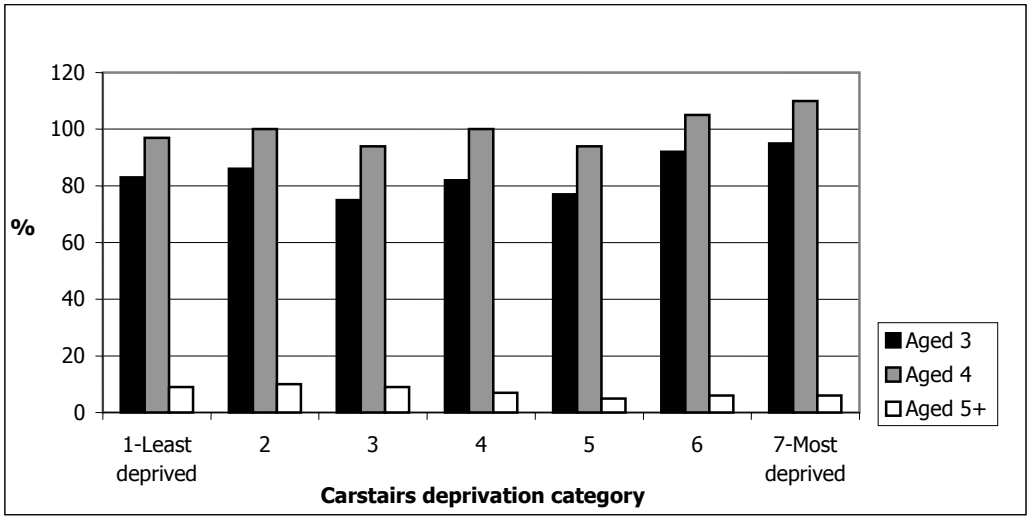
Figure 2.32 Full time equivalent children receiving pre-school education by age



Source: Pre-school and day care census

2.41 Figure 2.33 shows the data from Fig 2.31 in relation to deprivation category, for 2002. This suggests that provision is higher in more deprived areas, than in less deprived areas. For example, in the most deprived group, among those aged 4, it appears that more than 100% of children are attending some form of provision – reflecting the fact that some children in these areas are attending more than one centre. In the least deprived areas, just over 80% of those aged 3 are attending some provision, compared with almost 100% in the most deprived areas.

Figure 2.33 Proportion of children attending pre-school education by deprivation level: Jan 2003



Source: Pre-school and day care census

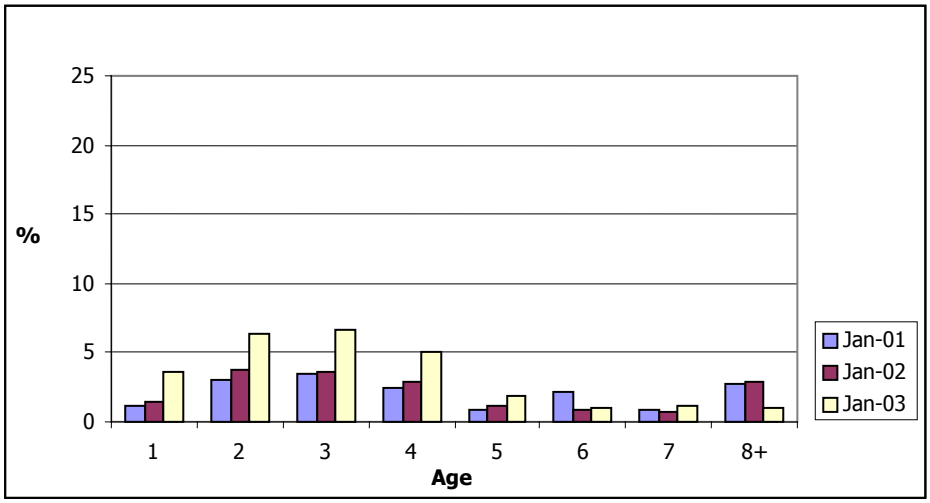
Attendance at family centres

2.42 Family Centres are designed to provide an integrated service, offering a wider range of facilities than simply child care and pre-school education, and making services available to family members other than the pre-school child – for example, parents, grandparents and other children in the family. They have been in use for a number of years, but their use has been more widely promoted through the Early Years' policies introduced in Scotland since 1999.

2.43 While the proportion of all children attending such centres remains relatively low (fewer than 5% in most age groups), the proportion attending family centres has doubled between 2001 and 2003. The proportions of two and three year olds attending family centres in 2003 were 6% and 7% respectively.

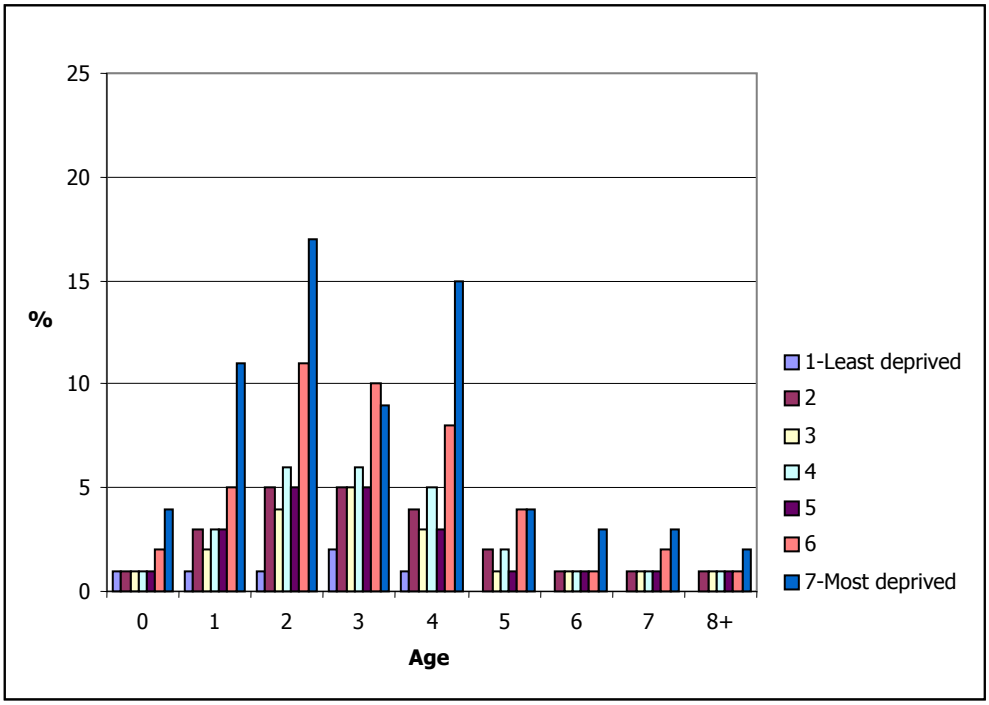
2.44 Attendance at family centres varies markedly in relation to the type of area people live in. Those in the most deprived areas are far more likely to attend than those in less deprived areas (Figure 2.35). This is particularly the case for children aged 0-2 and 4.

Figure 2.34 Proportion of children attending family centres by age



Source: Pre-school and day care census

Figure 2.35 Proportion of children attending family centres by deprivation level: Jan 2003



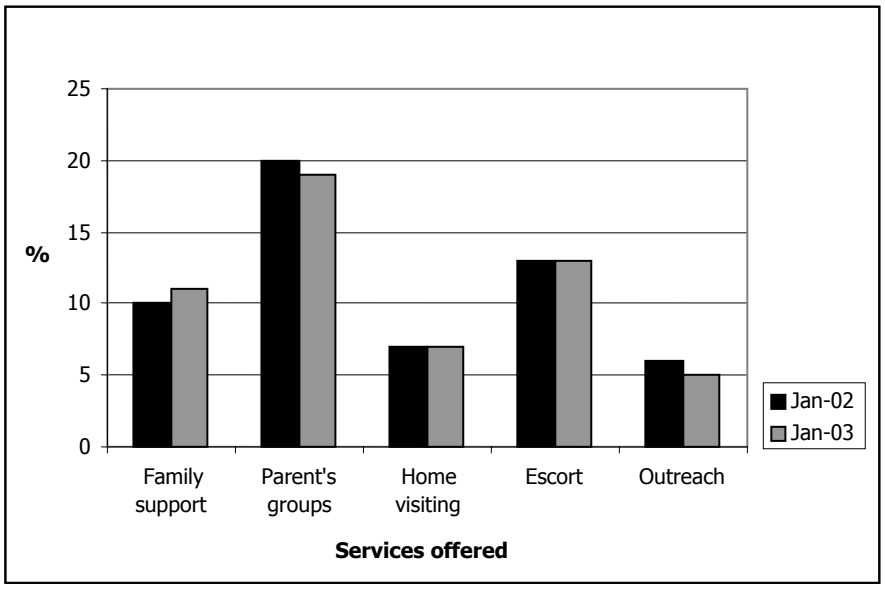
Source: Pre-school and day care census

SERVICES OFFERED BY PRE SCHOOL PROVIDERS

2.45 As well as providing nursery education, many providers now offer additional services. These include parents' groups, home visiting, outreach services, escort services to assist children in getting to the provider and family support. The most prevalent service offered is a parents' group (just under 20% of providers), followed by an escort service (around 13% of providers). Home visiting and outreach are both less common services, available at just over 5% of services. Such additional information has only been gathered in 2002 and 2003, and there has been little change over this period.

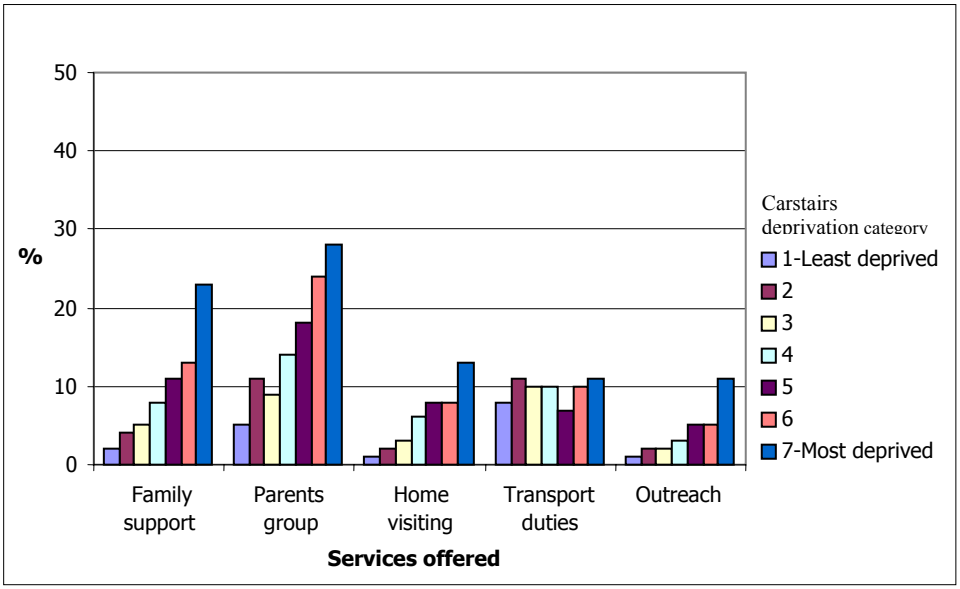
2.46 Looking at the services available at centres attended by children in different types of areas, reveals considerably higher use of all these services, except 'escort' services, in more deprived areas. For example, Figure 2.37 shows that over 20% of children in the most deprived areas attended services offering parents' groups and family support, compared with 5% or fewer of those in the least deprived group.

Figure 2.36 Proportion of children attending centres offering different services



Source: Pre-school and day care census

Figure 2.37 Proportion of children attending centres offering specific services by deprivation level: Jan 2003



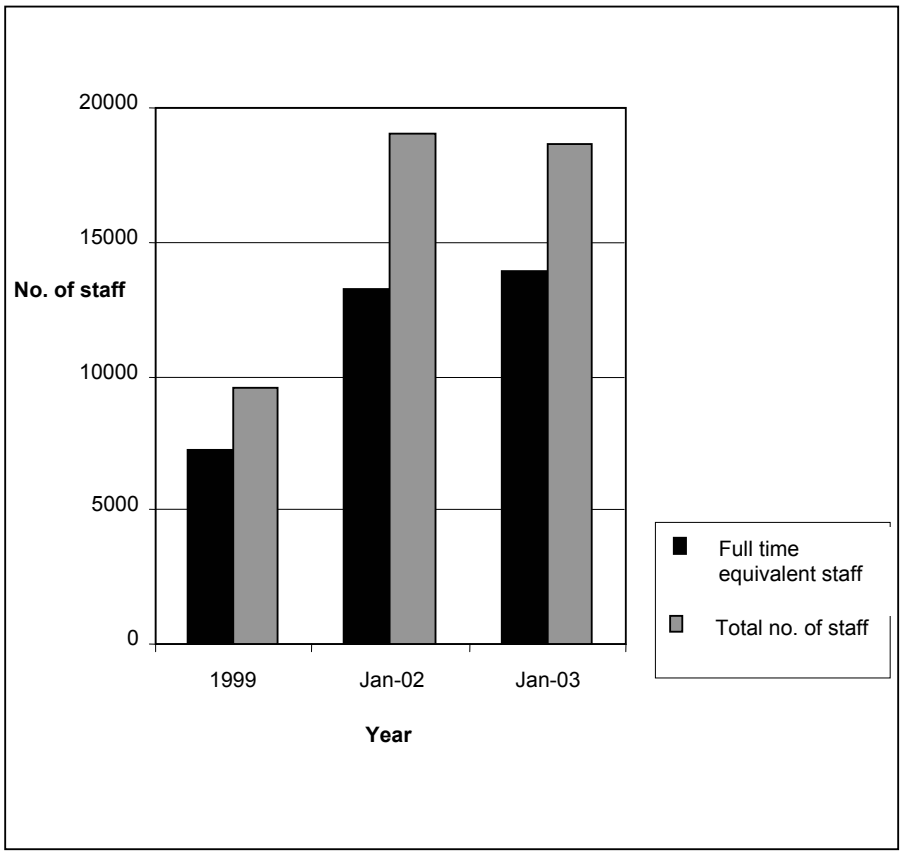
Source: Pre-school and day care census

Staff Numbers In Pre-School Settings

2.47 Figure 2.38 provides data on the number of staff employed in centres providing pre-school education. The taller bars show the total number of staff and the shorter bars portray this information in terms of full-time equivalent staff. It is clear that there has been a notable increase in staff numbers (whichever figures are used) between 1999 and 2002, although the 2003 figures are not notably different from those the previous year. However, changes in the number of full time equivalent staff may be masked by the fact that the reporting system for this measure changed between 2002 and 2003[11].

[11] Staff FTE figures were collected in a different way in 2003, to make it easier for centres to complete the forms. Previous, centres were asked for the total number of hours worked by full-time and part-time staff working there, and FTEs were calculated from this. In 2003, centres were simply asked for the number of staff who worked 35 hours or more, the number who worked between 16 & 35 hours, and the number who worked less than 16 hours.
It was then assumed that those working between 16 & 35 hours worked an average of 25.5 hours, and those working less than 16 hours worked an average of 8 hours.
This means that FTE figures may not be comparable between 2003 and previous years, and the total numbers of staff will probably provide a better comparison.

Figure 2.38 Total & Full time equivalent staff numbers in centres providing pre-school education*



* In 2003 the way staff FTE figs were collected changed. This means the FTE figures may not be comparable between 2003 and previous years

Source: Pre-school and day care census

Child staff ratio

2.48 The Child: staff ratio gives an indication of the individual attention children might expect to receive in a pre-school setting. In 2002, there were 5.5 children to every staff member, compared with almost 8 children to every member of staff in February 1999.

Table 2.6 Child: staff ratio in pre school education by year

Year	Ratio
Feb-99	7.9
Sep-99	6.2
Jan-00	-*
Jan-01	-*
Jan-02	5.5
Jan-03	-*

* Figures not available

** Figures are based on total number of staff working in pre-school education

Source: Pre-school and day care census

Special Educational Needs

2.49 Programmes such as Sure Start Scotland aim to enable the inclusion of children with special needs in mainstream childcare and pre-school provision, where appropriate. In the Census of pre-school education providers, respondents are asked to quantify the number of children who have special educational needs. Figures are available to show at each age, the proportion of children with a record of needs, who are in the process of being recorded, and who are not recorded, but none-the-less, do have special needs. Table 2.7 shows that in total, the proportion of children aged 3-5+ in pre-school education identified as having some special educational needs increased from 3% in 1999 to 6% in 2003. The proportion with a formal 'Record of Needs' rose from under 1% to 2% over this same period. The proportion of children identified as having special needs increases with age – this is partly due to the greater time in which to such needs can be identified. However, it is worth nothing that the figures below, for those at age 5, where 25% are identified as having some special educational needs in 2003, might not be representative of all those of this age, since one of the reasons children's entry to primary school might be deferred for a year, is the presence of special needs.

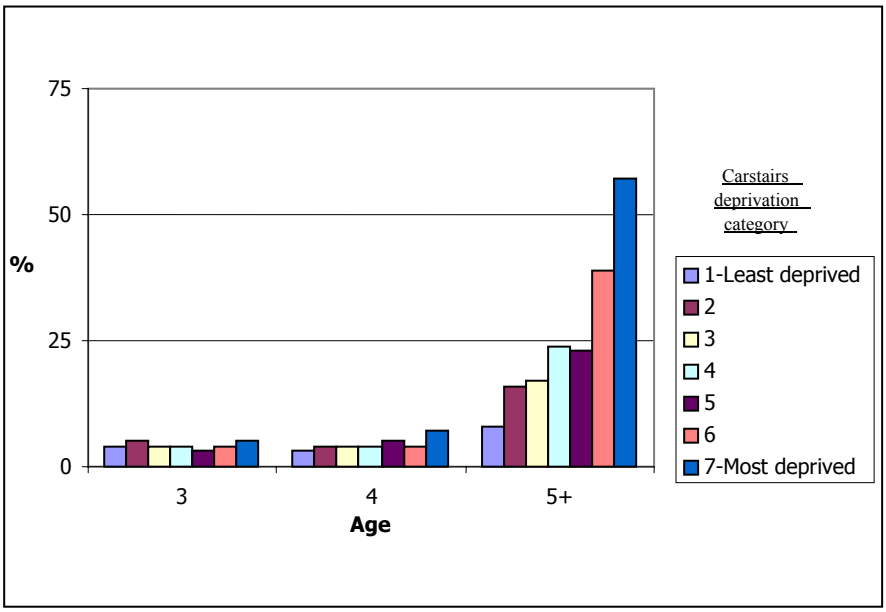
2.50 Figure 2.39 shows the presence of special educational needs for those of each age group, by the Carstairs Deprivation Index in 2003. There appears to be a markedly higher proportion of children aged 5 with special needs in more deprived areas, however it should be noted that among this age group, the total numbers of children in the most and least deprived categories are relatively small, and thus these findings should be interpreted with caution.

Table 2.7 Special educational needs by age and year

	1999	**2002**	**2003**
	%	%	%
Age 3			
Record of needs	0	1	2
Being recorded	0	0	1
SEN but no RON	2	2	2
TOTAL	2	3	5
Age 4			
Record of needs	0	1	1
Being recorded	0	1	1
SEN but no RON	2	3	2
TOTAL	2	5	4
Age 5+			
Record of needs	4	4	7
Being recorded	4	4	5
SEN but no RON	12	14	13
TOTAL	20	22	25
ALL aged 3-5+			
Record of needs	0	1	2
Being recorded	1	1	1
SEN but no RON	2	3	3
TOTAL	**3**	**5**	**6**

Source: Pre-school and day care census

Figure 2.39 Proportion of children attending pre-school education with special needs by deprivation level: Jan 2003



* includes those with a record of needs, in process of being recorded and those with non-recorded special needs

Source: Pre-school and day care census

CONCLUSIONS

2.51 This exercise has served to demonstrate some changes in health and educational indicators between 1999 and 2003. Table 2.8 below summarises the changes identified and direction of change (i.e. whether there has been an improvement, no change, or a worsening of the situation for each indicator over time). In some cases, we do not have data for enough time points to be able to say whether there has been a change.

Table 2.8 Change and direction of change over time of various indicators

Indicator		Change over time	Comment
Infant mortality rates	😐	No change	
Primary immunisations	😐	No change	Has been small increase in most deprived areas
MMR immunisation	☹	Notable Decline	
Breast-feeding at 6-8 weeks	☺	Slight increase	Increase most marked among those in more deprived areas (where initial rates lowest)
Obesity at age 3-4	😐	Too early to say	Data not yet available post-99
Underweight at age 3-4	😐	Too early to say	Data not yet available post-99
Low birth weight	😐	No real change	
Maternal smoking during pregnancy	☺	Small reduction	Reduction most marked among those in more deprived rates where rates are highest.
Dental decay at age 5	😐	No change	
Accidental injuries among 0-4 year olds (resulting in emergency hospital admission)	😐	No change	
Accidental deaths among children 0-4	😐	No change	
% children 0-4 on child protection register/ referred for enquiries	😐	No change	
Number of children attending pre-school education	☺	Big increase – particularly at age 3	Highest rates of provision in most deprived areas
Number of filled full-time equivalent places in pre-school education	☺	Big increase at age 3	
Number of children attending family centres	☺	Marked increase	Particularly among most deprived groups
Child: staff ratio in pre-school education	☺	More staff to every child	
Pre-school education providers offering services such as parents' groups/ family support/ home visiting/ escort	😐	Baseline missing	Figures available for 2002 and 2003 only.
Number of staff working in pre-school education settings	☺	Increase	

2.52 It can be seen that for about a third of the indicators, there has been an improvement, while for many, no change has been identified (in some cases, there are data to confirm that there has been no change, while in other cases, the data are insufficient to show whether there has been a change or not). For only one indicator, the MMR vaccination, is the situation known to have worsened over recent years.

Recommendations on future use of indicators

2.53 Compiling these indicators has been a time-consuming task. This is partly due to the complexities of the datasets involved and the need to tightly specify the figures required, and largely due to the other pressures on the staff involved in compiling the indicators. For the future however, updating the findings for these indicators should be a more straightforward task, since the specifications are available, old syntax can be saved, and a greater time period in which to create the tables can be offered.

2.54 However, there are another set of problems which are less readily overcome. In the same way that the policy environment around early years is constantly shifting, so too are the drivers for data sources and this means that over time, indicators come and go, and will continue to do so. At the present time there is a review of the CHSP-PS underway which may well mean that in future some of the indicators drawn from this source will not be available. Some recent revisions to the childcare and day care census, which have made comparisons over time difficult in this exercise, are likely to be reduced over time, as moves are afoot to standardise the approach to data collection and the measures included. This can only be welcomed, since the value of a repeat survey, is largely in the time series data it provides, as well as the obvious benefits of cross-sectional analysis.

2.55 The previous report of the feasibility study, highlighted 'gaps' where no data were available to provide an indicator of an area the early years' policies were seeking to address. Furthermore, some of the indicators, which we had envisaged would be available, were found not to be when the detailed work of compiling the figures began. This is disappointing, in that it means that data are being collected on a topic, but are then proving insufficiently reliable for work such as this. Attention should be given to improving the quality of such information and putting in place steps to ensure the consistency of recording over time and across areas. One of the aims of the review of the CHSP-PS is to make improvements in this area. The issue of data gaps is in part being addressed at present through the commissioning of a new longitudinal survey of the early years which will gather information on a wide range of topics. It is to be hoped that the importance of gathering robust information, in a consistent way over time, will be prioritised in this study, if the full benefits of undertaking longitudinal work are to be exploited.

CHAPTER THREE THE CASE STUDY AREAS: POLICY AND AGENCY STRUCTURE CONTEXTS

3.1 The case study part of the research aimed to explore in-depth the factors influencing the planning and delivery of services to meet the objectives of early years' policies and to assess the perceived impacts on children, families and communities. It is complementary to the indicator study, emphasising areas where the data from the indicators was weak or incomplete, such as the areas of 'families and communities' and 'system capacity'. It is also aimed to produce evidence of the experience of service providers and users and of how policy objectives relating to social and emotional well-being, health and education are being met. However local contexts and institutional frameworks shape the implementation of policies, so it is important to present an overview to introduce the two case study contexts in the round before focusing our gaze on early years' policies and services. This chapter presents the two case study areas, Dundee City and Highland, with reference to their particular local contextual features, traditions and issues related to policy provision. The choice of these two areas was determined by the wish to have contrasting contexts in relation to rural or urban settings, different socio-economic circumstances, different implementation frameworks, and to be manageable within the short timescale of the project. The overall background to policy and agency structure is described. Previous agency structures are illustrated, highlighting where any recent reorganisation has resulted in significant differences. It draws on material sourced locally, supplemented by information from interviews. The chapter concludes by comparing and contrasting the two areas, in relation to a number of key dimensions.

HIGHLAND AREA PROFILE

Geography and Population

3.2 Highland is the largest local authority in Scotland (also in Europe) and has a land mass greater than Wales (26,500 sq. km as compared with 20,800 sq. km). It has a coastline of 4,905 km and much of the land is mountainous with about 80% rising over 300m. With a population of 208,914 (2001 census), Highland is one of the most sparsely populated parts of Europe, with a population density of 8 persons /sq. km as compared with 22 for Scotland as a whole. The proportion of retired population is expected to rise significantly while the proportion of children is projected to fall. The 2001 Census indicates that 28% of all households in Highland have dependent children. Over two thirds, 68%, of households with dependent children are headed by a married couple, 11% a cohabiting couple and 20% a lone parent. In addition, 5007 dependent children (11%) live in households where no adults are in employment. About 9% of those aged 3 and over understand, speak, read or can write in the Gaelic medium, around 18,400 people. Over 99% of Highland's population is categorised as white in terms of ethnic group (Census 2001). In terms of service provision for ethnic groups in Highland, the populations referred to are either Gypsy/Travellers (0.2% school roll population) or Gaelic speakers.

Social Context

3.3 Income and employment:

- Annual earnings are around 7% less than the Scottish average
- A slightly higher proportion, just over two thirds, of the population aged 16-74 than in Scotland as a whole are economically active
- The GDP for Highland was 22% lower than the Scottish average in 1997
- Only 24% of the economically active population earn more than £20,000 p.a.
- 36% of the economically active population earn less than £10,000 pa
- Average prices were 4% higher than those in Aberdeen and 1% higher than in Edinburgh in 2000. There is a huge variation in prices across Highland, particularly in relation to fuel costs
- Unemployment is higher in Highland than in Scotland as a whole, though uptake of income support is much lower

3.4 Housing

- Highland housing stock differs from that of Scotland in several ways: there is lower proportion of affordable rented housing, there is more owner occupied housing and more privately rented housing. Non-effective housing (vacant houses, holiday homes or caravans) is almost double the Scottish average.
- Over half of those 8000 households with live applications for Council housing or transfer live in circumstances classed as 'insecure'.
- Housing in Highland is 44% more likely to be damp than in Scotland as a whole
- Housing is 13% less likely to be energy efficient than the Scottish average.
- Rising and penetrating damp is 3 times the Scottish average and is mainly concentrated in older buildings in rural areas.
- 42% of all Highland households experience fuel poverty. Severe fuel poverty affects more than 1 in 10 households. Over half of these are pensioners
- On average, housing costs are lower than in Scotland as a whole, although in Inverness they are significantly higher than other parts of Highland.
- Nearly 1,000 households presented to the Council as homeless in 2000/01. Over half were assessed as being homeless and in priority need. Homelessness has increased by 111% in the last 10 years in Highland compared with 85% in Scotland as a whole
- The rate of car ownership in Highland is higher than in Scotland as a whole

3.5 Other life circumstances

- Crime is 36% lower than the Scottish average
- School leavers in Highland have grades 12% higher than the Scottish average
- It is estimated that it costs the NHS in Highland around £5m pa to provide services to women affected by domestic abuse (Joint Health Improvement Plan 2002-2004, Highland Wellbeing Alliance)

3.6 In terms of deprivation, 3 wards in Highland fall within the quintile of most deprived wards in Scotland (from Inverness, Caithness and Ross and Cromarty local authority Areas), indeed one in Inverness is ranked 8th in Scotland. Seven wards fall within the quintile of least deprived (6 from Inverness and one from Nairn local authority Areas).

Looked after children and children with disabilities

3.7 According to social work data, there is a total of 34 children aged 0 - 5 years who are on the Child Protection Register as at 31 August 2003, comprising 39% of children on the Register. There are 74 looked after children aged 0 to 5 years, 20% of the total number. The number of children aged 0 to 5 years affected by a disability and known to the local authority as at 31 August 2003 is 83, 17% of the total number of children with disabilities.

General Health Context of Highland

3.8 The average life expectancy of Highland men is 73 years compared to the Scottish mean of 68 years, and for Highland women it is 79 compared to the Scottish average of 76 years, and all of these are below all European countries. Over 29% of Highland residents live with a longstanding and limiting disease or infirmity and over half felt that their condition noticeably limited their day-to-day life. Health service provision in Highland is above the Scottish average: more doctors, more dentists, more nurses and more spend per head of the population than the Scottish average. Waiting lists for in and outpatient care are lower than the Scottish average. (Joint Health Improvement Plan 2002-2004, Highland Wellbeing Alliance)

HIGHLAND CHILDREN'S SERVICES AGENCY STRUCTURES

3.9 Highland area has been characterised by a period of innovative and ambitious agency restructuring leading to the current agency structures that have been organised to deliver integrated children's services and multi-agency collaboration. Successive national policy initiatives in relation to children, young people and families have made it necessary for local authorities and health authorities to put in place staff with responsibility for translating these policies into the local context, taking into account the characteristics of their particular area and population. The authorities have also needed to put in place structures for the implementation and delivery of services as a consequence of these policies. In Highland, it is possible to identify 4 phases of development over a 4 to 5 year period, reflecting the rapidly changing policy context of this period. In this chapter the earlier structures are outlined. Chapter 4 then describes the current agency structures for children's services.

Evolution of a Children, Young People and Families agency structure

Phase 1: Youth Strategy Officer –Well Being Alliance

3.10 In Highland the first development of a workforce with specific responsibility for children was the Youth Strategy Officer. Prior to this post there was simply generic management in both social work and education departments. The Youth Strategy Officer post was created in response to The Well being Alliance initiative, funded jointly by social work, education and housing, and part of the remit was to manage developments for Early Years.

Phase 2: Childcare planning Officer/Vouchers/Sure Start

3.11 A childcare planning post was created in social work to support the work of the Youth Strategy Officer (and together they took responsibility for the initial work of Sure Start initiatives. Contemporary with these developments, one of the Education service Deputes was given responsibility for the introduction of the voucher system for free nursery school places resulting from the Childcare Strategy initiative and a small team of staff was created to deliver this service. The agency structure for early education and childcare policy development and service delivery in the late 90's was therefore rather thin.

Phase 3: The Egg (because of its shape)

3.12 As with other local authorities, Highland was involved in discussions with the independent action team preparing 'For Scotland's Children' for the Scottish Executive. Highland expressed their views about what they felt the policy should contain based on their experience and what Highland wanted to do on the ground. In anticipation of 'For Scotland's Children', combined with a raft of Scottish Executive policies to do with integration of children's services and multi-agency collaboration, Highland reorganised their early education and childcare workforce to put in place a coherent and integrated agency structure (diagram H1).

3.13 However because of the rapidly moving agenda and again in anticipation of national policy developments it became clear within the space of a year that the relevance of this structure was out grown. As one interviewee observed:

> *"National early year's policies have been fundamental in driving this restructuring, however, we have always had to interpret what the next stage is. We have interpreted those drivers and turned them into what we saw as a holistic model. For example we have spent a lot of time talking (with Scottish Executive) about what we wanted 'The Integrated Early Years Strategy' to say. I think the model we've got now has gone a stage further and I think what we are doing is a level of integrated service provision that is ahead of what is in the draft of 'The Integrated Early Years Strategy' but it is trying to make sense of where we are." (Head of Service)*

3.14 And so, as of April 2003, early years services were again restructured to take their current form, a complex and integrated multi-agency structure for policy planning, strategic development, service management and service delivery, is summarised below and more fully described in chapter 4.

The planning framework for early years policies in Highland

3.15 The Children and Family Support Services planning framework that has evolved in Highland is set out in the document *For Highland's Children* (2001), reflecting the national document *For Scotland's Children*. It is published jointly by Highland Council and NHS Highland. An updated version of *For Highland's Children* has been published as part of the guidance notes for the New Community Schools Approach in Highland (*For Highland's Children New Community Schools Approach Guidance 2003*) and it is envisaged that *For*

Highland's Children 2 will be published incorporating a community planning approach. Highland's Family Support Strategy underpins their planning and delivery of services for children and families, taking a life-course approach in conjunction with Hardiker's 'Triangle of Tariffs' (Valuing Children, Supporting Families, Strengthening Communities). NHS Highland is currently preparing a Child Health Strategy. Each of these documents illustrates how Highland policy has evolved to integrate policy planning for children, young people and families in Highland across agencies and incorporating the evolving national policy framework.

DUNDEE CITY AREA PROFILE

> *"We try to get the children at two years if possible, because, by getting them at this age, we can do so much for them." Mabel Seaman Brydie (1923) A Nursery School in Dundee*

Demographic Profile

3.16 Dundee City, the fourth largest city in Scotland, covers an area of about 26 miles and is one of the smallest local authority areas in Scotland. Dundee is one of three authorities that form NHS Tayside. Perth and Kinross and Angus, the two other local authorities that comprise NHS Tayside, are predominantly rural. It is a city with familiar urban problems and an established tradition of Labour-dominated local politics and government. Many of its traditional industries have gone but it has been fairly successful in attracting new industries in the science and medical fields. However a legacy of its traditional industries has included a high level of women's labour market participation, women's participation in political and community organisations and a relatively high level of day nursery provision. Dundee, known by some as 'a women's town' has a tradition of women as breadwinners in working class families that informs its sense of history and identity. As put by the local press:

> *"In the jute mills women outnumbered men by three to one. Their strong economic position allowed them to act in ways which often ignored convention. They were overdressed, loud, bold-eyed girls, and the sight of a women bein roarin' fou was commonplace*[12]

3.17 That tradition may explain in part the predominance of women in planning and senior management positions within local government and the strong role of women working in local networks.

3.18 It is a city that various professionals interviewed for this study described as being 'like a village' in which there is little mobility in traditional communities, and where extended families live near each other. While this has obvious strengths, it can also have a downside, as one health professional observed: "There is just no confidentiality at local level. . . . they need services in the city, on a bus route where no one knows them." Extended families can be important sources of support and providers of informal childcare for parents of young children, but they can also inhibit change, as one service provider said: "It makes it very

[12] Mill Girls, Dundee Courier

difficult to change attitudes and behaviour because of the influence mothers and grannies have."

3.19 The population of the city was144,180 in 2002[13], a decline of 7.3% since 1991. There are currently 7956 children aged 0-4.[14] The population under 20 is expected to fall by 12% over the next 15 years, in line with the Scottish average. The number of children aged 0-15 is projected to fall to 25,577 by 2003 and 23,949 by 2006.[15]. Out migration is a key issue in Dundee.

3.20 Dundee has higher than average levels of deprivation. Life expectancy at birth in Dundee is lower than in Scotland as a whole.[16] For males it is 71.4 years, compared to 72.6 years for Scotland; and for females it is 77.6 years, compared to 78.0 for Scotland.[17] A higher proportion of its population than the national average are on low incomes, are unemployed, are chronically sick, are lone parents, or are elderly. One quarter of wards have unemployment rates more than twice the national average. It has many deprived areas and nearly one third of the population live within these areas and over half of all children. Dundee's teenage pregnancy rate is twice the national average, and the highest across the four major Scottish cities between 1995 and 2001[18]. It has high rates of crime and drug use. Significant numbers of families are affected by HIV/AIDS. There is a higher rate of absence from school and a lower proportion of children attaining Standard and Higher Grade passes than the national average. In 2002, there were 287 children aged 0 to 4 years old looked after by Dundee City Council, 70% of the total number of looked after children in the local authority area.

3.21 Dundee has the third highest concentration of minority ethnic people in Scotland, with a higher than average proportion of children from minority ethnic communities. Approximately 7.4% of Scotland's minority ethnic population live in Tayside.[19] The largest minority ethnic group in Dundee is Pakistani, followed by the Indian and Chinese communities.

3.22 Dundee has a declining birth rate in line with the rest of Scotland. Accidents are the single largest cause of death of children in each age group from the ages of one up to 15. Sudden Infant Death Syndrome is the major cause of death among babies between one and 12 months. The main causes of morbidity in children are asthma, mental health problems, disabilities, childhood cancers, cystic fibrosis and diabetes. Health problems associated with pregnancy and birth include high rates of smoking during pregnancy, post natal depression and low birth weight. Immunisation rates reflect the national pattern.

Dundee City agency structures prior to delivering integrated children's services

3.23 Dundee City delivers integrated children's services through an agency structure that has evolved incrementally from previous structures and remains very similar to them. Here

[13] Dundee City Council, About Dundee 2003
[14] Dundee City Council, About Dundee 2003
[15] Dundee Early Years and Childcare Plan 2001-2004
[16] This measure of life expectancy in Dundee differs from the measure used for Highland in para. 3.8.
[17] Health Statistics Quarterly 11 ONS Autumn 2001.
[18] Dundee City Council, About Dundee 2003, p.34
[19] Tayside NHS Board. Information and Performance Management Team.

we outline the historical structures that have provided the foundation for the current agency structure, which is more fully described in chapter 4. Before local government reorganization in 1996, the educational and social work functions in Dundee were organized at the regional level. While they both operated at the same level of local government, their work in the area of early years' provision was quite separate, both structurally and philosophically, divided between early education (delivered by education authorities) and nursery care (delivered by social work), and that separateness has remained to a degree. However, in 1996 they were brought within a much smaller city council structure with its tradition of collaborative networks around childcare. Since then education and social work have moved from their separate positions towards closer collaboration. Before Sure Start Scotland, education had little involvement with children under 3, but this has now changed with the introduction of a range of integrated services across the city. From 1996, social work services in Dundee were organized around functional divisions, such as children's services, community care and criminal justice, rather than geographic divisions. The relatively high level of day nursery provision became the foundation from which Child and Family Centres developed. As one planner said:

> *"Social work has been a traditional provider of large amounts of childcare provision. Unlike others we have a history of being the day nursery provider and therefore have a legacy of a much larger number of services and buildings than elsewhere."*

3.24 There is a history of collaboration and joint work within the local authority in the area of early years' provision. For example, a Tayside Steering Group for Services for Children Under 8 was formed as a result of the Children Act 1989[20] and became the Early Years Forum at the change to unitary authorities in 1996. This, in turn, formed the basis for the Dundee Early Years and Childcare Partnership (EYCCP) which was established in January 1999 and brought together the public, voluntary and private providers of early years childcare, health and family services, parents planners and others.[21] The current Strategic Planning Group developed from this. As one policy planner stated:

> *"The structures haven't changed that much. As far as early years work went there were always areas of joint work and collaboration. There was the Tayside Steering Group for Services for Children Under 8, formed as a result of the Children Act 1989 where all stakeholders came together to work on shared approaches. The significant change now is that Health are more involved."*

3.25 The boundaries between the local authority, responsible for social work and education on the one hand and the health authority on the other hand, are not coterminous. Tayside Health Board is one of the largest NHS administrations in Scotland, responsible for the health of a population of 389,000 living within its area. It covers the local government authorities of the City of Dundee, Perth and Kinross and Angus. There are three NHS organizations in Tayside, three local health care cooperatives (LHCCs) and three local authorities. Dundee City has one LHCC. Within the health authority, there has been a historical separation in child health between acute and primary care services, although there are now more linkages across these two areas; see chapter 4.

[20] Although the 1989 Act applies to England and Wales, and not Scotland, it provided the impetus for Dundee to begin thinking about related issues.
[21] Dundee Early Years and Childcare Plan 2001-2004

THE DUNDEE PLANNING FRAMEWORK FOR EARLY YEARS' POLICIES

3.26 The planning of early years' policies in Dundee is closely linked to Children's Services Plans which were developed as part of local authority duties under The Children (Scotland) Act 1995.[22] A national framework for all agencies was developed in 1998, *Protecting Children: A Shared Responsibility*. Dundee published its first Children's Services Plan in 1998. A requirement was placed on local authorities to consult NHS Boards, NHS Trusts, voluntary organisations, children's panels, children's reporter and housing agencies. The Chief Executive established a Children's Services Planning group which acts as a focus for the joint work necessary to produce and consult on a plan. The planning of early years and childcare services in Dundee is also linked to other planning frameworks which include:

- Dundee City Council Plan
- Education Department Plan
- Community Plan for Dundee
- Tayside Health Improvement Plan[23]

CONCLUSION

3.27 Highland and Dundee City are sharply contrasting case study areas in various respects. Their geographic and demographic profiles are distinguished by the urban/rural dimension, the geographic spread of the population, the nature and extent of deprivation across their areas, the extent of labour market participation of mothers of young children, the scale of minority ethnic communities, numbers of children living in poverty and the dominant complexion of local politics and government. Both have declining populations of young people, albeit for different reasons, low fertility rates and low levels of geographic mobility. Highland has a tradition of a low level of early years' provision, compared with Dundee whose provision was more extensive and developed, and therefore the expansion of early years provision in both areas was from very different baselines.

3.28 As far as agency structures are concerned, we can see two contrasting approaches to the re-organisation required for delivering integrated children's services, one evolutionary and incremental, the other innovative and ambitious, reflecting their perceptions of the degree of change that would be necessary to implement integrated early years' policies. Dundee is a small city which had well developed inter-agency working structures that are, by and large, simpler and more traditional in form than in Highland. They have placed greater emphasis on developing integrated provision than on re-organising their existing structures, which were seen to be largely up to the challenge of delivering and extending integrated early year's services. Highland, on the other hand, with its previously low levels of early years' provision, embarked on an innovative and ambitious programme of re-structuring so that an integrated structure would be in place to underpin the planning and delivery of integrated children's services.

[22] Sections 22,53 and 57 of the Act specifically required local authorities to *safeguard and promote the welfare of children in their area who are in need.*
[23] Dundee Early Years and Childcare Plan 2001-2004

CHAPTER FOUR AGENCY STRUCTURES AND ORGANISATIONAL FRAMEWORK FOR INTEGRATED EARLY YEARS SERVICES

INTRODUCTION

4.1 As early year's policies have been developed, so local authorities have adapted their ways of working and planning to meet the new challenges. Parallel to this is a need to put in place structures for the implementation and delivery of services. Integrated services imply and in some cases demand joint planning structures, but the ways in which these have been interpreted vary from council to council. In the case study areas we have contrasting models of organisational frameworks as well as contrasting approaches to the process of strategic planning in relation to the demands of the early years agenda.

4.2 Key factors in the development of strategic frameworks for the delivery of early years services include the development of Children's Services Planning and Childcare Partnerships. Children's services planning had been introduced by the Children (Scotland) Act 1995 and included a duty for all of the agencies to get around the table in planning children's services. The focus for this work has been 'children in need' as defined by the 1995 Act, but as policies are developed and integration becomes a higher priority this process is also being developed.

4.3 Childcare Partnerships were charged with the oversight and development of child care in each local authority area. These were multi-agency groups from the start:

> *"We will depend on the expertise and knowledge of local authorities, childcare providers, parents, local enterprise companies and employers to deliver the (childcare) strategy. We will set up new 'childcare' partnerships based on existing 'Early Years Fora'……Above all we want to engage all those concerned with childcare – childcare providers, local authorities, Local Enterprise companies, employers, voluntary bodies, as well as parents themselves in shaping and delivering the strategy" Meeting the Childcare Challenge: A Childcare strategy for Scotland (1998)*

4.4 These childcare partnerships therefore, were already engaged in a multi-agency planning process which, whilst covering the 0-14 age group, has a focus on the pre-school years. These have been adapted and included in the development of council planning structures.

4.5 Another factor framing the development of planning structure has been local government reorganisation in 1996. In the Tayside area, the regional council was split, and social work and education formerly part of the regional responsibilities, came under the remit of Dundee City Council – a new structure, amalgamated with the existing city council structure. In contrast, although Highland was also reorganised into a unitary authority, the boundaries remained unchanged, but the departments of education and leisure joined to form the department of Education Culture and Sport. The social work department has also been restructured and this process is continuing as part of the New Community Schools agenda. In addition the current Children and Young people and Families structure has evolved, but remains linked through operational responsibilities to both the Education, Culture and Sport department and the Social work department respectively. [See Appendix 3]

4.6 This history, alongside the differences in political flavour, and historical development as discussed in Chapter 3, all bear upon the way in which the areas now react to the demands of delivering integrated services in the early years. Both authorities have changed structures to reflect the need for a more integrated approach to strategy for early years provision, but have done so in very different ways, with Highland opting to create a new strategic framework, whilst Dundee built upon and adapted its existing one.

HIGHLAND –THE CURRENT PICTURE

4.7 The complexity of an integrated, multi-agency approach to Highland Early Years policy planning, strategic development, service management and service delivery is challenging to describe precisely because of the level of integration and collaboration at different levels. With a degree of simplification, diagrams H1, H2 and H3 in Appendix 3 attempt to illustrate the structures that are currently in place.

4.8 Highland Council's departments of Education Culture and Sport and Social Work have together with Highland Health Board funded the post of Head of Children, Young People and Families (Appendix 3 diagram H1). This post has a pan-Highland remit for strategic lead and has responsibility for ensuring policy and service integration across Highland Council, the Health Board and other voluntary and private agencies. This strategic lead is delivered through The Childcare and Early Education Service (Appendix 3 diagram H2). There is a multi-disciplinary team of Officers based in Inverness providing a pan-Highland strategic lead to a number of Area Early Education Officers and Area Childcare and Family Resource Officers working across Highland at a local level. The Area Officers provide a strategic lead at a local level through the Area Children's Services Forum (Appendix 3 diagram H3). However it is worth noting that operational management of the Area Officers remains the responsibility of Education, Culture and Sport and Social work respectively and is provided through the Area Education Manager and the Area Children's Services Manager.

> *"it's all very good to be joined up but someone needs to be accountable. The Head of Education Services is (accountable) for the educational element and the Head of Operations for Children and Families is (accountable) for the social work element, and the Head of Children, Young People and Families is (accountable) for making sure we all work together." (Head of Service)*

4.9 The single service system for children and young people in Highland is illustrated in Appendix 3 diagram H3. It brings together children's services covering the ages of 0-19. Integration is organised within agency structures, not simply horizontally across services for families with children aged 0-5, but vertically for services from birth to adulthood.

4.10 The Joint Committee for Children and Young People is a partnership body with responsibility for an overview of services for all children (0-19) and a particular focus on 'vulnerable children' (Review of For Highland's Children: Services for Children and their Families in highland 2001 – 2004 Review March 2003,). Its membership comprises representation from elected members from Highland Council; NHS Highland, Well-Being Alliance Partners, plus a range of voluntary organisations (Section 3, Report of Joint Committee on Children and Young People August 2003, Section 3)

"effectively you have got a sub-grouping of the Council and a sub-grouping of the Health Board meeting around the same table to discuss the same agenda, and that's very exciting. The Joint Committee structure has recently been reviewed and they now have the Community Planning partners (Well-Being Alliance) on too" (Head of Service)

4.11 The Area Children's Services Fora (ACSF) have been established to facilitate closer working between agencies (at area level). Each ACSF will act as the lead body co-ordinating the development of more integrated ways of service delivery, particularly to progress the intent of 'For Highland's Children' and the rollout of 'New Community Schools Approaches'. ('For Highland's Children - New Community School Approach Guidance, 2003).

"Each Area Children's Services Forum is preparing a development plan that sets out how ' For Highlands Children' is being implemented locally." (Review of For Highland's Children: Services for Children and their Families in Highland 2001 – 2004 Review March 2003)

4.12 Again the ACSFs have responsibility for services for 0-19 year olds. The precise membership of each ACSF varies but will usually comprise a core of those listed below. There is then usually an additional list of people invited to attend as appropriate and this may include staff from nursing (health visitors and school nurses), housing, Youth Action, voluntary agencies, health promotion, paediatrics, public health practitioner, police, social work teams, and Local Enterprise Companies.

Area Children's Services Manager (SWS)
Area Education Manager (ECS)
LHCC Manager (NHS)
Area Education Development Officer
Childcare and Family Resource Officer
Area Community Learning and Leisure Manager
Secondary Head Teacher Representative
Primary Head Teacher Representative
New Community School Approach Integration Manager
'Children's Champion' (elected member of Highland Council)

4.13 In some Areas there is a third tier of activity called 'network meetings' in which there is open access to any staff involved in children's and family services. These serve the purpose of bringing together people from different agencies for exchange of information. The meetings usually have a thematic focus.

4.14 The Family Resource Alliance and the Area Partnerships have evolved from the Childcare Strategy impetus to create a Childcare Partnership in each local authority. In Highland, one was set up but for reasons of geography, it was felt there were problems of representation for the whole Council area. So an Area Partnership was established in the Council sub areas. The findings of a consultative review of the workings of these Childcare Partnerships were that:

- They needed to be more autonomous
- They needed to have more of a role in the decision making process
- They needed better clarity over their budget

- They needed a broader remit than simply childcare (i.e. getting people back to work and broader family support services.

4.15 Consequently in Highland, the Area Childcare Partnerships

> *"have moved beyond the childcare agenda and have already moved to the Integrated Early Years Agenda" (Head of Service)*

and the overarching Highland Childcare Partnership has been renamed the Family Resources Alliance. Each Area continues to have an Area Partnership but with a broader remit than simply childcare issues.

> *"the childcare agenda has been fundamentally critical, but the reality of what we are doing now isn't just about providing childcare for working families, it's clearly something more." (Head of Service)*

4.16 The Family Resource Alliance and Area Partnerships are responsible for services for children aged 0-14 because they have evolved from the Childcare Strategy. Membership of the Family Resource Alliance consists of:

- Joint Committee members
- Area Children's Services Fora representatives
- Highland Council Services Representatives
- Area Partnership Chairs
- Key private and voluntary sector organisations' representatives
- Parents, Young People's and community groups' representatives
- Highland Council and NHS Highland lead Officers
- Well Being Alliance Partners

4.17 The Family Resource Alliance has an advisory role as a reference group and it services the Joint Committee. The Area Partnerships have an advisory role as a reference group, and they service the Area Children's Services Fora. The Joint Committee and the Area Children's Services Fora have an executive role and are the budget holders. The Area Committee comprise the elected Councillors for each Area. The School Liaison Group is part of the New Community Schools Approach and acts as a reference group for the Area Children's Services Fora.

4.18 The Head of Children, Young People and Families (Appendix 3 Diagram H1) services the Joint committee (as does the Child Health Commissioner from NHS Highland). The Senior Childcare and Family Resources Officer (Appendix 3 Diagram H2) services the Family Resource Alliance. The Area Childcare and Family Resource Officers service the Area Partnerships and also provide the link between the Area Partnerships and the Area Children's Services Fora. The Early Years Development Officers also service the Area Children's Services Fora (Appendix 3 Diagram H4).

4.19 So in Highland, there is a model of agency structure in which operational responsibility for Early Education services has been retained within the education department. Operational responsibility for Childcare and Family services has been retained within the social work department. However there is a structure of integrated strategic planning led at pan-Highland and Area levels. In response to the large rural nature of Highland, strategic planning and integration of services is orchestrated at a pan-Highland level, but there is real

devolution of responsibility for service planning and development at Area level. This structure has evolved rapidly at pan-Highland level. The pace of development in each of the Areas has differed. Some have been up and running for some time, others are currently recruiting and appointing members and staff. During the course of this investigation, staff were being appointed to some of the Childcare and Family Resource Officer and Early Education Officer posts. Clearly as they provide the links between Highland and the Areas and the links between service providers and the Area Children's Services Fora, the impact of their work is just about to begin. Lochaber and Ross and Cromarty are often cited as Areas that have achieved a 'maturity' of function.

4.20 Comparing agency structures and early education and childcare services now with what was in place previously reveals marked change.

> *"I think you will see a huge difference, the amount of people and the amount of resources that are available to children and families now compared with 5 years ago is massive" (Development Officer]*

NHS HIGHLAND AGENCY STRUCTURE INTERFACE

4.21 Like other Health Boards, NHS Highland is currently undergoing major agency restructuring. The current, but outgoing structure is summarised in diagram H5. NHS Highland have participated and worked collaboratively for 2 ½ years in the Joint Committee, and Area Children's Services Fora structure. They also participate in the Family Resource Alliance and in the Area Partnerships. On an individual basis staff working with service users have forged collaborative relationships with other childcare, early education or voluntary agency staff. However, a sense of frustration has been expressed that their outgoing agency structure provides a barrier to full integration and collaboration:

- in terms of appointing representation that can speak on behalf of other groups:

> *"Health has been quite difficult. When we set up the Highland Childcare Partnership, health was represented by someone from health promotion. She was really great but she could not speak on behalf of the acute services or the primary care trusts and it used to cause a lot of difficulty for her" (Development Officer)*

- in terms of generalists dealing with specialist services:

> *"in the ACSF, the Education Manager is there representing children's education, the Social Work Manager is there representing children and families. The LHCC manager has much broader responsibilities. It really does depend on what their slant is. The post holder until recently in Lochaber had a real interest in Childcare and it showed, it was really great. But the next post holder, unless they have that slant, it's hit or miss really' (Development Officer)*

- in terms of lines of communication:

> *"if next week we wanted to communicate with all health visitors, there isn't an easy mechanism for us to do that, although it is better now we have the health secondments". (Development Officer)*

4.22 In line with the National Health Service Reform Bill, LHCCs are being phased out and replaced by Community Health Partnerships. The most recent information on the new agency structure of NHS Highland is that there will be 3 Community Health Partnerships: 1 covering Caithness and Sutherland; 1 covering Inverness, Nairn, and Badenoch and Strathspey; and 1 covering Ross and Cromarty, Lochaber and Skye and Lochalsh (Appendix 3 diagram H5) The Board has endorsed the development of a combined children's service involving secondary care services (acute and community paediatrics and associated nursing and Allied Health Professionals) currently provided separately across the 2 Highland Trusts. This combined service will be located within the Direct Health Services Unit of the new NHS Highland structure.

> *"it's about managing pathways and about clinical governance, and it's about having a clear strategic level in maternity services and paediatrics. There will be links between them and that makes a lot of sense rather than the fragmentation that we have at present between the acute trust, the primary care trust and the Board. But they won't have operational management and that is why it is a network and not a managed level." (Head of Service)*

4.23 Work is in progress to outline the relationships, accountabilities and governance frameworks for the Community Health Partnerships to this structure. This in turn will inform representation at Area Children's Services Forum level.

> *"From an integrated services perspective, this is seen as a logical next step for children's services and is already happening to some extent around services for young children and services for autism." (Head of Service)*

4.24 There is some concern in the local authority about how 3 Community Health Partnerships are going to interface with 7 Areas, Area Children's Services Fora in particular,

> *"there's no way we can organise services across those geographies, there is going to have to be something at a local level". (Head of Service)*

NEW COMMUNITY SCHOOLS APPROACH

4.25 Social Work is currently being restructured as part of the New Community Schools Approach (NCSA). The roll out of the NCSA is the vehicle by which Highland will better integrate services for children and families. The NCSA is to operate across all sectors and all ages at the same time. It is early days yet for involvement with pre-school provision, but for example:

> *"where you have a local authority nursery attached to a primary school, it is envisaged the school liaison group will include representation of the pre-school classes. The school liaison groups are new but relate to the community planning approach." (Area Manager)*

4.26 In line with the NCSA, social work boundaries have been realigned to secondary school catchment areas in Highland. An example of what is being proposed for Inverness is: (Inverness is divided east and west by the river.)

"Social work will shift towards a patch focus, there will still be an East team and a West Team, rather than an across Inverness structure. In each team, a Senior Social Worker has responsibility for the Referral and Assessment Team. Then, a number of Senior Family Liaison Officers have responsibility for a 'patch' or 'community', based around an Associated School Group (i.e. a secondary school plus its associated primaries).

VOLUNTARY SECTOR AGENCY STRUCTURES

4.27 The various structures of the voluntary groups involved in children's services have not shaped the development of the 'single service system' (diagram 4), rather they have been shaped by it to the extent that they participate at pan-Highland and Area levels in what ever capacity they can.

4.28 HPS director for example attends meetings of the Joint Committee, NCH and Family First attend the Family Resource Alliance. Then at Area level, the Family First co-ordinators and the NCH project leaders will attend their local Area Partnership meetings and some may attend their Area Children's Services Forum. Fieldwork staff are more likely to attend the network meetings rather than the business meetings. The precise details of who attends what varies across the Areas.

DUNDEE THE CURRENT PICTURE

4.29 In contrast with Highland, Dundee has maintained a central planning structure, building upon existing fora to develop a more integrated approach. The historical structures of departments within Dundee City have not changed greatly since integrated funding has come on stream. As mentioned in Chapter 3 earlier there has always been a history of collaboration within the local authority in the area of early years. A Tayside Steering Group for Services for Children Under 8 was formed as a result of the Children Act 1989 and became the Early Years Forum at the change to unitary authorities in 1996, which in turn formed the bases for the Early Years Child Care Partnership. The only new aspect is that health has become more involved and that the general impetus to change has increased. As one policy planner states:

"The structures haven't changed that much. As far as early years work went there were always areas of joint work and collaboration. There was the Tayside Steering Group for Services for Children Under 8, formed as a result of the Children Act 1989 where all stakeholders came together to work on shared approaches. The significant change now is that Health are more involved."

4.30 However, many of the old planning mechanisms did not work with the new integrated structures. "New *posts new roles needed new mechanisms to inform planning*". (Health planner) A new Strategic Planning Group has brought a more focussed approach to planning. Cross agency information sharing has allowed the next phase of planning to be put in place. Information and quality monitoring posts have been created. Funding periods are being synchronised and joint bids are now common place.

THE STRATEGIC PLANNING GROUP

4.31 The Strategic Planning Group was established to bring together the different strands in planning. Strategic leadership is regarded as both important and necessary.

> *"There are strong messages coming from the Director of Social Work and Director of Education. About what we want and vision we have and it is very much a joint vision and we are very strongly putting this message across. There is the expectation there. Realising that that is what we want and not settling for anything else. Even gone out together to talk to staff. To say jointly we want this." (HoS)*

4.32 The strategic planning group comprises representatives from:

- Social work,
- Education,
- Housing,
- Neighbourhood Resources and development,
- Support services,
- NHS Tayside,
- Tayside Police,
- Scottish Children's Reporter's Administration,
- Children's Panel,
- Leisure and Arts Department,
- Dundee Local Health Care Co-operative,
- Early Years and Childcare Partnership.

4.33 This group is responsible for the development and oversight of the Children's Services Plan, and its remit includes 'to promote integrated planning, development and provision of services and effective use of resources' (p119) 'Working together for Dundee's children' (2002) Children's Services Planning has in the past focussed on children deemed 'in need' under the Children (Scotland) Act 1995, but the remit of the strategic planning group has recently been extended to include responsibility for early years, in terms of both universal and targeted services.

4.34 In order to unify the Strategic Planning group and the children's services planning process with the Child Health Strategy and the Childcare Partnership a Children's Services Executive Group has been established (See Diagram D1 in Appendix 3).

> *"…these three elements have tended to be a little bit distinctive in their processes. We have now brought that together and there is now One Executive whose aim will be to produce the one plan which will cover both the universal services, needed by the children.. and those who have a poor start in life" (HoS)*

4.35 The Children's Services Executive Group provides the lead for the delivery of services, with a manager for early years and childcare services co-ordinating work in the early years and providing a link between the Education Department's provision and the wider work of the Childcare Partnership on which he/she sits. However, in contrast to Highland, there is no integration of structure beyond the executive group, with social work and education having separate spheres and lines of command.

The Dundee Early Years and Childcare Partnership (DEYCCP)

4.36 The Dundee Early Years and Childcare Partnership was established in January 1999 and brought together the public, voluntary and private providers of early years childcare, health and family services, parents planners and others.24 The DEYCCP published a first Early Years Childcare Plan in 2000. The plan was further strengthened by:

- A Quality Assurance and Improvement Framework
- A Recruitment, Training and Staff Development Strategy
- Early Years Information Service
- Consultation and Involvement Strategies.

4.37 The planning for Child Health in Tayside also drew on relevant national policy documents such as For Scotland's Children: Better Integrated Services for Children and The Template for Child Health within Unified Boards. A Child Health Strategy Group was formed and produced a Child Health Strategy which formed the basis for service development for improving child health. The Tayside Health Strategy was developed within a framework of Children's Service Plans, a Local Health Plan and local Authority Community Plans. It is supported by the Child Health Implementation Plan (CHIP) which identifies milestones for performance review.

CHILD HEALTH STRATEGY GROUP

4.38 The planning for Child Health in Tayside draws on relevant policy documents such as For Scotland's Children: Better Integrated Services for Children and The Template for Child Health within Unified Boards. A Child Health Strategy Group was formed and produced a Child Health Strategy: the basis of service development for improving child health. The Tayside Health Strategy was developed within a framework of Children's Services Plans, Local Health Plan and local Authority Community Plans. It is supported by the Child Health Implementation Plan (CHIP) which identifies milestones for performance review.

4.39 Local authority boundaries and health board boundaries are not coterminous in Tayside. The Strategic Planning Group was a response to this and a mechanism to foster a unified approach. In considering the meshing of region-wide priorities to local priorities, the response is positive. We are moving on this.

> *"There has always been a lot of inter-agency collaboration among Early Years [staff]. But what we are getting now is a more strategic framework within which this can be supported" (HoS.)*

4.40 However, a decision has still to be reached on the final structure of a Single Health and Local Authority Child Health Plan.

4.41 Historically the main separation in child health had been between acute and primary care services. The new policy of Joint Futures and Dundee Health Living Initiative have provided a means of linking primary and secondary health prevention in children. Links with the acute sector and tertiary sectors are being strengthened and health intervention is around healthcare provision and lifestyle.

[24] Dundee Early Years and Childcare Plan 2001-2004

THE HEALTH INTERFACE WITH LOCAL AUTHORITIES

4.42 The Health Dundee: Working Together for a Healthy Dundee Strategic Action Plan 1999-2004 is the main interface between local authorities and the health sector in policy development. In 1997 a multi-agency coordinating group was established as a health alliance among key partners. The Group includes representation from Dundee City Council, Tayside Health Board, Tayside Health Council, Dundee Healthcare, NHS Trust, primary care and the voluntary sector. The plan acknowledged the intrinsic relationship between life circumstances, lifestyles and health outcomes. This linked into the Council's anti-poverty strategy and other plans. See diagram D2 in Appendix 3.

Social work and health collaboration at planning level

4.43 Each local authority in Tayside has a Children's Strategic Planning Group which has a range of planning sub groups whose remit is to implement and action Children's Service Plans. There is representation from health on the local authorities' Children's Services Planning Groups and by local authorities on the Child Health Strategy Group.

4.44 There is greater joint working between local authorities and health particularly in respect of Changing Children's Services plan and the Changing Children's services fund. This is most evident in the agreed priority areas of sexual health, complex needs, child and adolescent mental health and child protection. But there is a need for closer working.

4.45 Cadicott guidance on the sharing of information in respect to child protection has been drawn up and agreed by the local authority and health. A mapping exercise in strategic planning forums and funding streams in health and local authority has been completed.

Child Protection

4.46 A Child Protection Liaison Group has been established to develop a child protection network to ensure effective links across primary care, community, hospitals and other care agencies. The Group reports to the CHSG. A programme of Child Protection Training has been introduced and rolled out across the city. The Group also develop ed an action plan in line with the National Child Health Review of 2002 and reported in February 2002.

4.47 Priorities have been refocused to address the needs of children and families exposed to substance misuse. The Drug Action Team has tried to link services together to stop duplication. Health workers are now based within the voluntary sector and different voluntary sectors are providing a wider range of services.

COMMUNITY SCHOOLS – HEALTH PROMOTION AND JOINT PLANNING

4.48 Joint planning for New Community Schools (NCS) in Dundee take place between Health Promotion Departments and Local Authority Education Departments in Tayside. This joint working between Tayside Health Board's Health Promotion Centre (THPC) and the Education Departments of Dundee, Angus and Perth & Kinross ensured that health promotion was a key element in the development of the early NCS projects in Perth and Kinross at

Blairgowrie and its primary school cluster), Dundee (Baldragon Academy) and Angus (Arbroath Academy and its primary school cluster). There was also direct involvement of the LHCCs and NHS Trusts in Tayside. Each of these initial NCS projects had a multi-disciplinary team led by a Project Manager. Within Baldragon Academy in Dundee the team consisted of a part time Health Promotion Worker employed by THPC but funded by Dundee City Council and one part time School Nurse who until May 2001 was funded by Dundee City Council but was funded by Tayside University Hospitals Trust from September 2001. Developments between school nursing and other health services are progressing and new integrated services for children have been developed such as drop in centers, described more fully in Chapter 6.

VOLUNTARY SECTOR

4.49 The voluntary sector is represented on the EYCCP (Early Years and Childcare Partnership) by Scottish Pre School Playgroup Association (SPPA), Dundee Voluntary Action and SCMA and HomeStart Dundee. There is a forum for the voluntary sector providers who are receiving funding from the EYCC Partnership. Dundee City provide granted support to voluntary organisations of £100,000 in 2001-2002. Those who benefited included:

- Homestart
- Dundee Sitter Service.
- MidCraigie Linlathen Under 12 Project
- Dundee Women and Children Project
- Dundee families project
- Mains Family Centre

4.50 A SPPA development workers post has also funded and a Family Support Co-ordinator provides ongoing support to parent and toddler groups and voluntary management committees. The EYCC is looking at trying to link the projects more closely and to find better ways to support voluntary partners.

CONCLUSION

4.51 The contrasting approaches of the two case study areas provide interesting grounds for comparison. The differences reflect different starting points as well as different assessment of the need for change and development. It is difficult to make an assessment of the effectiveness of either structural approach at the moment, given that it is early days for both approaches. The following chapters reflect the ways in which these different approaches affect the delivery and management of services.

CHAPTER FIVE INTER AND INTRA AGENCY COLLABORATION

5.1 As the planning process has changed to reflect the demands of the move towards integration, so levels of inter and intra agency collaboration in the management and delivery of services have been developed with a goal of providing a seamless service to children in the early years and their families. A whole range of mechanisms and approaches have been developed and rolled out in local authorities across Scotland, aiming to break down the barriers between sectors, and to increase collaboration.

5.2 At this stage it is perhaps worth making the distinction between integration and collaboration. Integration can be seen when separate professional boundaries begin to be blurred, when it is no longer clear if this is a social work role, an education role or a health role. An example might be one of the NCH Sure Start staff in Highland working with vulnerable families: they work therapeutically with families on relationships, they educate both parents and children on issues of child development, they respond to health issues such as appropriate weaning, oral hygiene etc.

5.3 Collaboration can be seen when separate agencies work effectively together in pursuit of common aims and objectives. Examples of this can be seen in the joint agency decision making between departments or sectors or the merging of funding streams from social work and education.

5.4 This distinction itself can become blurred when looking at multi-agency structures in which different professionals are brought together under one roof to 'work together'. It is hard to assess the extent to which services are becoming integrated, and the ways in which collaboration may lead towards integration. The aim of 'capitalise (ing) on the complementary role that health, education and social care services play in securing the best start for all of our children' may suggest that integration can only be measured from the perspective of the service users. (Integrated Strategy for the Early Years (2003))

5.5 A feature of the delivery of services in the two areas is the contrast in starting points. Dundee, a mostly urban environment, a small geographical area, and a fairly high level of existing services has built on existing structures and provision. In Highland - a large rural area with a fairly low level of existing services, it was possible to develop a structure for provision which takes integration as its starting point. Having a clean slate may make integration a simpler task, although Highland services are in their early stages and it will be some time before the success of the approach can be appraised. It is also impossible to say which approach is better and given that historical context cannot be altered the variety of approaches across local authorities may be a strength.

5.6 The main contrast then, is that Highland have moved towards delivering an integrated package of services in each of the seven areas through the organisation of new posts of jointly managed workers, a system aiming a strategic approach across areas. Dundee is seeking to develop joint working with existing and developing provision, using mainly existing posts and structures. However there are similarities in some aspects of delivering more integrated services, with co-location of workers from different department being a feature in both areas, and joint training used. Both areas have found it easier to integrate work between Social work, and Education, and less easy with health. Both have also experienced some of the same problems. There are similar issues reflected at management and service delivery levels.

MAIN COMPONENTS OF INTER AND INTRA AGENCY COLLABORATION

Highland

5.7 In Highland there is a vision of integrated services for children and family support based on collaboration between the Highland Council, NHS Highland, various voluntary agencies, and the private sector. It can be evidenced in local policies, Highland agency structures, management of funding and through the delivery of services. The move towards a single joint structure for the delivery of services is seen as the key to achieving collaborative working.

> *"We are breaking new ground and it is evolutionary. We have created these children's service worker posts in Highland, they are joint posts of social work and education, and they will be in all but one of the target schools in Inverness. They are formally part of social work, they are professionally supported and supervised by social work, but they are working out of schools and on a day to day basis they will be managed by schools, line managed by head teacher in primary and depute head in secondary. Again its early days, but there is lots of good stuff coming from them. It forces together education and social work. There have been boundary issues already, but that's to be expected. And by having boundary issues it requires the education manager and the social work manager to sit down together to resolve them, and that immediately has an impact in terms of better integrating services." (Area Manager)*

5.8 To enable an integrated approach, Highland Council, in partnership with NHS Highland has evolved a single service system structure for children and family support services that is separate from, but aligned to the Council department of Education Culture and Sport and the department of Social Work. Each of these departments has undergone reorganisation in their own right.

5.9 The single service system takes political lead from the Joint Committee, with reference to the Highland Family Alliance. The responsibilities for budget and service development are in the process of being devolved to seven Area Children's Service Forums, with reference to the Area Partnerships. The Area political lead is through the Area Committee and the New Community Schools are represented through the School Liaison Group. (Some of these Area structures are mature in operation; some are still being established and not fully functional.)

> *"The Areas have a good degree of devolution, discretion whatever, but there still has to be a fit with the pan Highland structure. There are natural tensions within that. And the tensions will increase with time, as the Area Forum becomes clearer in terms of being planning structures for their own particular area. And they will have folk who generally know best what the right fit for Sutherland is, or the right fit for Lochaber is. Pan-Highland won't have that degree of clarity. And this structure will begin to be tested in terms of 'the Governance' arrangements. This is the providing of legal legitimacy, not just in terms of education and social work but also our partners, particularly NHS Highland. We are effectively talking about budgets that are pooled, shared decision making and how do you do that. At a Highland level they have what is effectively a subcommittee of the Health Board and a subcommittee of the Council sit and meet together and that is the*

Joint Committee. We now have to take forward governance arrangements at an area level. If we take on board whatever bit of NHS Community Health Partnership represents our Area, if they come on board as formally part of the decision making process in terms of what children services provision is, they're not going to want to be deferential to the Joint committee level/ Highland level), so there will be issues, there will be boundary issues. But I think the Head of Children, Young People and Families job will be to hold these together- to work out what's acceptable in terms of divergence from whole Highland policy. So there will be interesting dynamics between pan-Highland and Areas." (Area Manager)

5.10 The New Community School Approach has led to a restructuring of social work as discussed in the previous chapter, with an aim of increasing collaboration between agencies with the school as the focus for organising such an approach. Some progress towards this structure has been achieved:

"The main shift in Inverness has been that in each of the two teams, three social workers are dealing with the sharp end of referrals, the new intake, rather than everyone doing it. The time lag from referral to assessment visit is much closer to target than previously. This has taken a lot of manpower out of each team, but the remaining workers who are aligned to school catchments, are now doing the ongoing work of working with kids and families on a more reliable and regular basis; doing some of the therapeutic work that they are trained for. Its still too early to say how well it will work, there are still stresses in the system. I'll be meeting the social work children's managers at the end of November, we will be discussing further modelling of their service based on school catchments and their relationship with schools. Good guidance staff in schools often have a clear picture of issues for a child or family because their engagement with them has been sustained over a period of time." (Area Manager)

5.11 Although this approach is in the early stages, it has many supporters, and creates opportunities for further collaboration.

"At Highland level the vision is very positive about devolving management of services and at service delivery level there are some very strong examples of collaboration. There are still some areas of difficulty in middle management. Some resistance from those who want to retain their old structures." (provider)

Dundee

5.12 In Dundee integration has been seen as an extension of existing work, although there are some disagreements about boundaries and management approaches at a middle management level. The approach has been to increase collaboration where opportunities arise, and to build on an existing history of working together. The Strategic Planning Group is seen as a key development and has necessitated the sharing of information for planning. Joint quality systems in training and information handling have also been developed and funding timetables and databases have been integrated. There has been development of joint training and joint bids for service developments.

5.13 In terms of service delivery so called 'Co-located centres' – joint social work and education centres are a key feature of the move towards increased collaborative service delivery for social work and education. Other collaborative services include Sure Start Health Visitors, Pre-School Home Visiting Service to assist children with developmental needs, Early Intervention Teams, Parenting programmes – particularly universalising parental support and the assignment of Public Health Practitioners to Local Health Care Co-operatives. Interagency work has also led to the development of outreach services, developing integrated projects on health promotion , for example nutrition, commissioning services with partner providers and extending hours of service provision

> *"Some initial problems were encountered with integrating services particularly when change was overnight. The expectation was that integration would grow organically and no support was necessary." (health professional)*
>
> *"If [senior] mangers have a problem, we ignore them and work it out ourselves. We all work well together and trade stories of mothers, children recent happenings etc. Share transport and equipment, expertise. There is a great willingness to work together now." (Group: Devt workers, HT, CFC manger)*
>
> *"We have worked together before and just get on with things" (Co-located manger)*
>
> *"It's taken about 2 years now and we are just getting it right." (Co-located manger)*

Co-located working

5.14 In Dundee, Co-located Centres provide services for 0-5 year olds located in the same setting. These incorporate pre-school nursery provision for 3-5 year olds and child and family centre services for 0-3 year olds. Some co-located centres provide also for those children with complex needs, or those with delayed development.

5.15 Each co-located centre is different. But the overarching view is that the two structures, Child and Family Centre and pre-school, are separate and are run as such even though located in one building. This does not prevent joint working or cover or joint training however. One such centre was subject to dual inspection (HMIE, CC) and was awarded a starred rating. It does however have cost and management implications.

5.16 The benefits of this approach are that proximity benefits children and encourages closer contact between agencies. It enables a fast and flexible response to be made to a child or families immediate needs, promotes closer contact between Primary Schools which helps transition and enables some parents to have closer links with centre staff in a more universal setting. It also allows for continuity of support from 0-5 for children and families.

5.17 There remain however, a number of problems for co-located centres in Dundee. There is a lack of clarity about the boundaries, and these are currently being redrawn which is promoting concerns amongst staff.

5.18 Some staff feel unsupported in moving towards integrated working and there remain a number of differences in terms and conditions of staff from different professions as well as

different philosophies and management styles. There are also different access criteria for children depending on which referral route they come through, and different attitudes towards education in 0-3s in Child and Family Centres. Staff are moved around in over-stretched Child and Family Centres which prevents continuity and building of relationships.

5.19 In Highland co-location occurs in terms of staff being based at the same location, and is seen as having a positive effect.

> *"We share this office and we are part of the same team, having said that when I have a team meeting, I have a meeting with my Childcare and Family Resource Officers, not with the Early Education Officers. Our team has got so big now it is difficult for everyone to meet regularly. But we meet regularly and we chat every day. For example there was a crisis this morning that both of us have to address and it's much easier because we are together in the same office. And again I wouldn't say that because we are in the same office that we share the same understanding of things but it certainly much easier. I know that if early education worked in an office in Dingwall, it wouldn't be the same. No, it is good to be part of the same team." (Development Officer)*

5.20 However co-location does not necessarily overcome all barriers to joint working:

> *"I still think there is a divide for example between our service and Head Teachers in relation to childcare, because they don't see it as part of their jobs. They are teachers, not a babysitting service." (Development Officer)*

POSITIVE ASPECTS OF COLLABORATION

Highland

5.21 In Highland, positive aspects of inter-agency working were cited by respondents in relation to many sectors. In the voluntary sector a history of collaborative working was seen the basis for new relationships.

> *"I have always had a close working relationship with various private and voluntary agencies in the childcare sector. I have worked with them setting in place Local Authority Standards- 'we've always worked together'. That was how the Highland Childcare Partnership was quick to set up and run, there was a trust there. I couldn't do my job without them and they couldn't do theirs without me" (Development Officer)*

5.22 Despite some problems in collaborating with health, the progress made was appreciated.

> *"since we have had the Health Development Officer, we have been able to get better insight into the workings of the health services. But it is not easy. It is better since we have had the health secondments" (Development Officer)*

5.23 Opportunities to offer wraparound care from nurseries without having to develop new expertise was a tangible benefit to education, as well as offering a more holistic approach to education and care.

> *"Head teachers would have an overseeing role, they would have to line manage an extra person, but would not themselves need to get bogged down in running such a service. I have a flier ready to test interest among primary head teachers in having a go at some form of 'wraparound' provision. It's the continental model, its what they have in Scandinavia. I think we need a couple of pathfinders to work out how we do it, what model fits. On the financial side of it, it has to be set to be the best financial deal for parents, but I also feel, potentially it can be an income generator for schools. The private sector is doing it for profit." (Area Manager)*

> *"the early education development officers are primarily about the delivery of quality education, The Childcare and Family Resource Officers are about childcare and family support services. Where they come together is over the provision of childcare in an educational setting, and the lead for that is taken by the CFROs." (Head of Service)*

5.24 Experiences of multi-agency working were also positive.

> *"Very positive, the voluntary sector has always been good at doing that. Working across the NHS and the local authority that's newer. The Play at Home project has an advisory group with a very broad membership from libraries, physiotherapist, health visitors, social work – it's all been very positive. In terms of rolling out Play @ Home, people have been very willing to assist, from private providers or community groups or health visitors." (Development Officer)*

5.25 In Highland posts have been created with responsibility for overseeing integration at pan Highland and Area levels:

> *"Integration managers are the Area presence of the Head of Children's Services" (Area Manager)*

Dundee

5.26 In Dundee various projects and initiatives were cited by respondents as positive developments. These included:

- Co-located provision addressing integration of children with particular needs. Proximity is helpful in dealing with crisis situations. Encourages fast and flexible response, contact between primary schools and helping with transition, settling in younger children.
- Early intervention through Pre-school Home Visiting, Sure Start Health Visitors and outreach workers are picking up vulnerable children earlier
- Joint training or common training such as Video Interactive Guidance is proving beneficial for staff relationships in integrated provision.
- Use of new technology is helping parents and staff in communication, interaction and staff development.

- Links with Primary schools improving and calling in specialist services. There is an awareness of these increasing as primary school children become involved more in community and health events
- Involving parents in training and community work is increasing. Increasingly confident mothers are becoming involved in broader range of activities related to supporting children. Links with other agencies are improving and increasing.

5.27 There is unanimity in the value that Sure Start Health Visitors bring to integrated working. All agencies wanted their profile raised and more of them. As one health professional stated.

> *"They are pivotal in the development of inter-agency working, leading a new style of health delivery."*

5.28 They are often described as the glue or an example of integration working.

> *"They are working with communities, vulnerable groups, identified areas within the population where there is deprivation, identified key health needs that we are looking to promote intervention with. So that we can do impact assessment from that. These are key." (Health professional)*

Others had clear views on what the future role for Sure Start Health Visitors would be.

> *"If you were doing forward planning around that you would hope to have a mechanism in areas of deprivation, Healthy Living Initiative or around school clusters .You have these women working as a Team. And there you have the planned intervention if they are working with schools, local authority workers. You could really make and impact. I see Sure Start women as being co-ordinators of a lot of initiatives in the future."*

> *Sure Start Health Visitors view their role as an holistic one, empowering parents to access and use agencies. They are instrumental in linking parents to mainstream services, particularly those who have been excluded from GP lists or have had negative experiences with health agencies. "We are working our way through what their role is in support, doing health promotion work when we already have links with existing health visitors [family health visitors]. The real challenge is to maintain these links. At the same time getting more out of the opportunities of people who have a more dedicated remit." (planner)*

DIFFICULTIES IN COLLABORATION

Highland

5.29 The whole approach of restructuring the ways in which services in Highland are planned and delivered has had its own problems. The changes are driven from the centre, and it will take time for them to be fully realised on the ground.

> *"Some individuals have been key drivers of this integrated approach, if they were more passive then, well I don't know where we would be but we might still be*

talking about it rather than doing it. But it is sore- the pace of development, there are casualties, folk under huge amounts of pressure, working silly hours. But it is in recognition of the importance of this – people say if the wheel aint broke don't fix it, but the wheel is broken. Professional teams that are feeling the pressure of it, they are still compliant because they know that the existing system is not what it should be. They hope like anything the new world is better than the old one. They may not have full confidence that it is going to be but they do at least recognise that where they are currently, isn't the best use of resources, their time and they are not getting fulfilment from it, using their skills and so on. It's exciting stuff." (Area Manager)

"So much has been done so quickly that in some Areas, we have some managers and professionals that are there by accident rather than design. We may have integrated services in place, but we have not yet got integrated managers to run the services. I think that is needing some development and support." (provider)

5.30 There are difficulties in collaboration between the local authority and health:

"Health has been quite difficult - on the ground, at a local level, it is not a problem, people work with health visitors and it's not a problem at all. But at the decision making level it has been a problem – because their structures are so different." (Development Officer)

5.31 The particular picture in Highland has meant that it has taken time to develop collaboration between education and other services.

"In Highland there was no history of pre-school education and so it has taken a while to realise there is a whole raft of childcare services that can be worked alongside" (Development Officer)

5.32 In Highland, turnover of staff in the statutory agencies has been a major break on the development of collaborative working:

"the long term vacancies and turnover of social worker posts has been very difficult for establishing working relationships. There has been some turnover in health visitors too but not nearly to the same extent" (fieldworker)

"In the first year there were 5 different Health Visitors between maternity leave, sickness and people moving on. It is not that we are any less enthusiastic, but you do the big sell to one set of people and they start to refer and the next minute you've got different people who are saying -well I don't really know what your Service is about so I'm not referring." (provider)

Dundee

5.33 The different cultures that exist within each of the main agencies brings some difficulties to integrated working. In co-located centres these come to the fore when speaking to education and social work personnel. There are two very different management forms. The views of these are interesting. Head teachers are managed loosely. Their policy objectives are

laid down and so long as these are met they are allowed a fair degree of flexibility in managing their nursery schools. Social work, on the other hand are described as over managed. Most decisions are referred and discussed before action is taken. This is seen as too rigid a structure while education is seen as too flexible. Education was described a being unable to manage and plan forward. What educationalists describe as flexibility, social work see as inability to plan. *"They just say well that's not working, lets try this out" (service provider).*

5.34 One health professional described the difficulties in attitudes between the two agencies.

> *"And there are distinct attitudes. In social work for example, if you are only dealing with poor and disadvantaged people, you begin to see them perhaps as second class citizens and tell them what to do. It is a, you know best attitude or, you're not going to change them anyway because they are their own worst enemy attitude. And the philosophy from education is different. They tend not to put people in compartments so readily as social work."*

5.35 Social work was often referred to in the course of this study as authoritarian, negative and inflexible. There is recognition of this at senior management level in social work and attempts are being made promote a more flexible positive approach.

> *"There is a culture now about promoting the positive and building on our strengths. Trying to promote a more positive management culture in the service and promote this more widely in social work. VIG is helping to do this." (senior planner)*

5.36 Parents are aware of these different approaches. Many said they would not go to services if they knew there was social work involvement. This was confirmed by those developing community initiatives. The very careful packaging of parenting initiatives emphasised the need to avoid making parents feel they had failed. Health professionals also mentioned the difficulties parents faced when a child did not reach their development milestones and thought that more positive approach was needed.

5.37 The culture in the health service came in for some criticism also. Several health professionals stated that the divisions within health were greater than those between other agencies. "We are just getting to know consultants who deal with adoption and fostering" (health planner). New approaches to health delivery received a rocky reception. Health visitors were using an approach which placed a

> *"Higher emphasis on the health of the mother, her mental and physical health. Nutrition and diet and her empowerment. Understanding that if she is not happy how can she nurture her children. Building self esteem and confidence and kudos in mothering. It uses cartoon and these are accepted across all groups. It does not matter how educated you are, mothering is scary. Again found a lot of support in interagency colleagues but not from within health. We got the money from New Community Schools 3 plus." (health planner).*

> *"There needs to be equitable levels of responsibility from acute to primary care. If we are going to implement the White Paper, we are looking at the workforce as*

a united workforce, with different skills but the levels of responsibility have got to be able to be matched between acute sector and primary sector" (health professional).

5.38 Internal competitiveness was regarded as a particular inhibiter to integrated working.

"There are targets to reach, performance assessments. Everyone seeking to achieve in their own department, You know sometimes we need to stand back and look at the bigger picture. Health care has become very competitive and I think people are focused on their own personal professional agendas. We are still hierarchical, people don't like saying that, but health still is. So people want to take the kudos for developments and Early Years Policies is not really about that. It is about personal and public partnerships, achieving together." (health planner)

5.39 Or on consultation with service users. All those interviewed from health services agreed that *"we're [health] not good at listening to people. Not very good at consultation."* (health planner). Health however are developing interactive and information services to combat this.

CONCLUSIONS

5.40 There are contrasting approaches to developing collaborative working in the two case study areas, although many of the same issues arise. Benefits from closer working are seen as positive by many respondents in this study. Difficulties in defining boundaries between professional groups exist in both settings, and there can be tensions around different terms and conditions or professional ethos. There are tensions between the strategic planning, management and service delivery levels, with collaborative working being driven in different ways, at different speeds and having different consequences at each level. There is a need for time and support for workers in achieving effective collaborative working, particularly for those involved in service delivery. There is a commitment by many interviewed to delivering better services through increased collaboration and to overcoming barriers to both collaboration and integration.

CHAPTER SIX EARLY YEARS SERVICES DEVELOPMENT

6.1 This chapter presents an account of early years' service development in Highland and Dundee, including the rationales for what services, where located, and to whom targeted (e.g. towards vulnerable or disadvantaged social groups, or universally targeted). The influence of the financial framework and funding streams on the development and delivery of services is also discussed. It also presents examples of good practice in early years' provision. Finally it considers the extent to which early years service development is explicitly linked to the aims of early years policies and to funding sources.

6.2 A theory of change approach suggests that in order to evaluate long term outcomes of a complex community initiative, a number of intermediate steps are necessary, including the identification of early and intermediate outcomes, the contextual factors likely to influence implementation processes at community, institutional, family and individual levels. Part of this task is to understand how various stakeholders think that interventions will achieve the intended outcomes and identify differences in approach across sectors and communities.

6.3 This chapter addresses several aims of the case study component of this research, namely, an analysis of policy implementation that identifies the approaches used across sectors, and common aims and areas of conflict; a mapping of service development and implementation; and some observation of service delivery. It will consider each case study area in turn, and will conclude with comparison between them.

EARLY YEARS' SERVICE DEVELOPMENT IN HIGHLAND

6.4 In Highland, early years' education is seen as being one of the major growth areas because there was little or no local authority nursery provision in place prior to the Childcare Strategy policy. There was, however, a network of voluntary and private sector provision. In a series of meetings throughout Highland, parents were consulted as to their views about how they wished their local provision to develop. In a relatively short time, Highland now has in place educational provision for 3 and 4 year olds using a mix of local authority provision and voluntary partner providers. There are a small percentage of families not making use of this provision, but it is not clear why this is so. There are several possible explanations for non-take up, such as: families choose not to because they wish the child to be at home; where they live is too remote from the provision either in terms of distance or transport availability; they are one of the vulnerable families who do not have the resources to engage fully with services and provision.

6.5 Services targeting vulnerable families have increased across Highland, both centre based and out reach. Some use paid staff and some use trained volunteers. Childcare services have grown, although it is thought that new childminding registrations have dropped dramatically since the Care Commission took over that responsibility. There are gaps in services, both in terms of service type and by area. An awareness of these gaps is influencing current service development but funding constraints are ever present.

The development of childcare and family support services

6.6 The development of childcare and family support services in Highland has been driven by the Childcare Strategy and by Sure Start; and then added to or enhanced through HIF. In the main, the childcare strategy has driven the development of universal provision and Sure Start the development of targeted provision. Early years provision in Highland consists of a diverse, complex and heterogeneous mix of services; the current level of provision is first briefly compared with provision in 1995 to outline its evolution. Then each type of provision is more fully described, as is Highland's approach to the mix of targeted and universal services.

Comparison of early education and childcare services in 2003 with provision in 1995

6.7 The mapping of childcare services has illustrated that since 1995 there have been some losses and some gains in terms of individuals or centres providing services. If we look back to 1995 we have the picture of early education and childcare services before the impact of the early years policies, and of the childcare strategy in particular. Table 6.1 presents 1995 data from a report published in that year[25] and 2003 data collected for the study published in autumn 2003 for Highland Area. The table should be read with caution since a comparison is somewhat problematic in that services have some times been grouped together differently in 1995 and services have evolved to perform different functions.

Table 6.1 Comparison of Highland provision 1995 with 2003, number of services

Service	1995	2003
Pre-school education centres 4 year olds-local authority	24	145
Pre-school education centres 4 year olds-other[26]	0	67
Pre-school education centres 3 year olds-local authority	0	103
Pre-school education centres 3 year olds-other	0	104
Playgroups and Toddler groups and Day care[27]	246	248
Playgroups -commissioned	0	79
Playgroups-non commissioned	D/k	23
Toddler Groups	D/k	117
Full Day Nurseries	[28]14	29
Childminders	486	477
Out of School Clubs (term-time)	5	26
Holiday playschemes	29	27
Toy Libraries (one mobile in both counts)	7	3
Play @ Home active in Areas for births after 08/02	0	8
Gaelic Groups (nurseries, playgroups and toddler groups)	45	[29]31
NCH work active in Areas	1	3
Home Start active in Areas	1	2
Family First active in Areas	0	6

[25] Highland Regional Council's Review of Day Care Provision for Children Under 8 Years of Age
[26] Playgroups and day care nurseries
[27] Data for 1995 gives HSPPA member groups-playgroups and toddler groups combined, then gives 32 other groups- possibly HSPPA non-members.
[28] Estimate based on 2003 list giving those existing pre-1999
[29] In 2003-these are Gaelic Medium local authority nurseries; commissioned and non commissioned playgroups; and toddler groups. No information is available for the composition of 1995 data

Pre-school education

6.8 In 1995 pre-school education was available for 4 year olds at 24 local authority nursery schools. This compares directly with 145 local authority centres offering nursery education to 4 year olds in 2003. However in 2003, there are additional private and voluntary partner centres (playgroups and day nurseries in the main) commissioned by the local authority to provide early education of for 4 year olds at 67 centres. Also by 2003 there is a pre-school education service for 3 year olds offered at 103 of the (145) local authority centres, at 2 commissioned private partner centres and at 85 commissioned voluntary partner centres. Pre-school education services provided by the local authority have without a doubt undergone an enormous expansion. However there is less clarity in the private and voluntary sector because many of the centres concerned existed as playgroups or private nurseries and have changed in their status but are not totally new as a service. What can be said is that starting from a very limited base, Highland Council put in place free pre-school educational sessions for 3 year old and 4 year olds throughout Highland in a remarkably short time.

Playgroups and Toddler Groups (plus Day Care)

6.9 The data available for 1995 lists HSPPA member groups (214) and other (non-member) groups (32). It is not entirely clear but these figures may also include day-care nurseries (estimated at 14 in 1995). So the total of 246 is a bit of a mixed bag, but compares in 2003 with 257. Given the apparent growth in day-care nurseries (15) it would suggest not much change in the numbers of other groups, but it really is difficult to be certain just on the basis of the figures. Also by 2003, HSPPA has evolved into Highland Pre-school Services (HPS) and has expanded beyond simply offering support to its member groups. HPS totally manages some playgroups and toddler groups; in others HPS work with the committee but manage the staffing side of the group. They provide six additional support toddler groups; they have a separate company called Family First offering a home visiting befriending and support service to vulnerable families. They also have a separate company called Hi-MATS offering training to the childcare workforce. So the nature of what they are now as an organisation compared to what they were then is quite different.

Gaelic Groups

6.10 Comhairle Nan Sgoiltean Araich (CNSA) was active in 1995 and continues to be so in 2003; however, Gaelic groups would appear to have decreased considerably. The 2003 data includes playgroups and toddler groups; the 1995 data does not specify its composition but may include groups of older children, so the picture for pre-school groups is not clear.

Childcare

6.11 Numbers of full day care nurseries have expanded (by 15) and in 2003 comprises both private (18) and voluntary (11) provision. Childminders appear to have dropped in numbers but there is some uncertainty about the accuracy of the 2003 figures as the local authority is no longer responsible for registrations. Term-time Out of School Clubs have expanded considerably with every Area except Skye and Lochalsh having at least 1; holiday play schemes have stayed much the same and by their nature can fluctuate from year to year.

Resources

6.12 The number of Toy Libraries has decreased and they are absent from most areas in 2003. However the mobile Toy Library continues to operate from Inverness and travels within a 40 mile radius. Play @ Home is a resource promoting active play from birth and is available to all families with a child born from August 2002.

Services Targeting Vulnerable Families (Sure Start Funding)

6.13 Since 1995, NCH has consolidated its work in Inverness, plus they have an additional project in Inverness, one in Ross and Cromarty and one in Lochaber. In these they offer both group work for parents and for children, plus home visiting support. Since 1995 Home Start has consolidated its work in Ross and Cromarty and has further expanded to work in Caithness. They too offer group work and home visiting. New since 1995 is the activity of Family First in 6 of the 8 local authority areas. They offer group work and a home visiting service to vulnerable families.

Table 6.2 Childcare Centres and Places across Highland, 2001 and 2002

	Number of Centres 2001[30]	Total number of places 2001	Number of Centres 2002[31]	Total Number of Places 2002
Local Authority managed centres providing day care for 0-5's	0	0	146	2758
Voluntary Sector Playgroups	132	655	125	2380
Independent day nurseries (these may cater for children up to age 8, or older)	30	342	31	981
Out of School clubs (whether managed by local authority, voluntary sector or independent school) ▪ Before School ▪ After School (including evening)	20	 122 583	29	834
Holiday Playscheme	16	293	22	513
Childminders	578	1445	528	1312

[30] In April 2001, there were 3440 childcare places available across Highland, being used on a part and full-time basis. In 2001, the Council provides pre-school education places for 2328 four year olds, which is 98% of the estimated year group of 2380 children, comparing with a Scottish average of 97%. Provision for 3 year olds has grown considerably in recent years. In the current year there are places for 1926 children which is 77% of the population, comparing with a Scottish average of 80%. This provision will be made through 143 school nurseries, 94 voluntary groups and 18 private nurseries. 255 children attend Gaelic medium early education in 17 local authority and 8 partner centres. This involves 118 four year olds and 137 3 year olds. (*For Highland's Children*, 2001, page 10)

[31] *For Highland's Children Review* March 2003, p8:
In April 2002, there were 8778 childcare places available across Highland, being used on a part and full-time basis. In 2002, the Council provided pre-school education places for 2499 four year olds, which is 100% of the estimated year group, comparing with a Scottish average of 96%. The government target was to have provision for all three year olds in place by March 2002. In Highland there were 2363 three year olds taking up their free place, which is 99% of the estimated population, compared with the Scottish average of 85%. This provision was made through 146 school nurseries, 89 voluntary groups and 20 private nurseries. 283 children attended Gaelic medium early education in 19 local authority and 7 partner centres. This involved 128 four year olds and 155 three year olds.'

6.14 In assessing the impact of these changes on the number of 'places' for children, it can be seen from Table 6.2 that the growth in the number of centres and places over a two year period varies by the type of provision. If the number of pre-school education 'places' for children provided by the local education authority are included then clearly there has been an increase in childcare provision. Without doing further gathering of information and analysis it less clear precisely how childcare 'places' that are not pre-school education places provided by the education authority have changed in Highland. By their nature, some of the provision has a turnover of providers. Counting 'places' or 'children' also becomes complicated by a lack of clarity about the unit to be counted: children 'on the books', 'children receiving a service at the moment', 'children receiving a service in the preceding year'. Another indicator of the growth or otherwise in provision is the expansion of a workforce responsible for organising and delivering provision as well as the types of services on offer.

Childcare and family resource workforce (Highland Council and NHS Highland)

6.15 The current local authority and NHS staff comprise a Head of Children, Young People and Families; a Senior Childcare and Family Resource Officer; a Health Development Officer; Play Development Officer; Gypsy /Traveller Development Officer; an Ante and Post Natal Support for Vulnerable Families Officer (seconded); and a Gaelic Development Officer (shared with and managed by early education), each with pan-Highland responsibilities.

6.16 In addition to this pan Highland workforce there are Area Childcare and Family Resource Officers servicing the Area Partnerships and the Area Children's Services Forums.

6.17 The remit of the Head of Children, Young People and Families is to give pan-Highland strategic lead and to oversee the integration of services. The role also involves servicing the Joint Committee. This role encompasses services for 1-19 year olds and goes beyond the focus of this study. However in relation to the study it encompasses: early education, childcare service; new community schools approach and community planning of children's services.

6.18 The remit of the Senior Childcare and Family Resource Officer is:

- Servicing the Family Resource Alliance.
- Strategic lead for the Area Childcare and Family Resource Officers (with operational responsibility through the Area Children's Service Manager)
- Management of the Childcare Information service- a database of available childcare.
- Management of Sure Start in Highland
- Childcare workforce training
- Representation on Rural Children in Scotland, and sub-group dealing with rural childcare issues of recruitment and retention of the workforce.
- Links with the Integration managers (New Community Schools Approach)

6.19 The SCFRO was seconded to set up the Childcare Partnership. This has now evolved in to the Highland Family Resources Alliance with 7 Area Partnerships (2 local authority areas combined to form one Partnership). Also the secondment has evolved into a permanent post. The SCFRO works closely with the ACFROs, several of whom are recent appointments. The Childcare Information System was launched in 1999. Parents can phone the office or consult the web-site for information about childcare:

www.childcarelink.gov.uk/whitebox/cis.asp?cisid=5099&mapid=370 or to search for available places in different types of provision www.childcarelink.gov.uk/whitebox/mapsearch.asp?cisid=5099&mapid=370

6.20 The system works effectively for information and searching for available childcare but is not constructed in such a way as to readily provide a comprehensive picture for mapping of childcare provision in Highland. Currently Sure Start funding is managed through the SCFRO but in 2004 it is anticipated this function will be devolved to the Area Children's Services Managers and distributed through the Area Children's Services Forums.

6.21 Childcare workforce training in Highland is overseen by Action for Childcare Training (ACT) which identifies the workforce training requirements. Training is funded through workforce expansion funding and development funding linked to the childcare strategy. Much of the training is delivered by HiMATS (– Highland and Moray Accredited Training Services (related company of Highland Pre-school Services and Scottish Childminding Association)) or through individual organisations' internal training.

6.22 In their Area, the ACFROs offer advice and support to the childcare sector, working with the Area Partnership and the Area Children's Services Forum. Until April 2003, the main thrust of their work was concerned with supporting the development of childcare provision, but since then it has expanded to include family support in line with the New Community Schools Approach roll out. They are the link in the system between pan-Highland and Areas and have the local knowledge of their Areas.

6.23 The Health Development Officer's role is to work with colleagues in the early education and childcare sectors, ensuring that health is integrated into initiatives, services and curriculum. The post is funded by HIF and is directed at working alongside Sure Start projects in particular, giving an emphasis on the 0-3's. The post-holder described her job as that of '*knitting together health with children's services*' and indeed throughout this study there was evidence of her involvement across a wide range of initiatives. A major part of the work to-date has been the roll out of Play @ Home across Highland. The Development Officer for Ante and Post Natal Support Services for Vulnerable Families in Highland was seconded part-time as a practising mid-wife to review and advise on development of services. This involved talking to a range of service providers and to parents. A report of findings has not yet been submitted but some of the issues raised were:

- The linking-in of midwives as a profession with children's services- to date they are largely absent from the agenda, even at a fieldworkers level
- The need for parenting courses that went beyond labour and infant feeding
- Improved peri-natal support for women with depression
- Improved collaboration and links between midwives and specialist services for drug and alcohol abuse services- in particular specialist training for midwives
- Improving the midwife/health visitor hand over
- Improved multi-disciplinary collaboration between agencies over domestic abuse
- Revolutionising the client record system for community nursing- *"currently IT is almost non-existent or the systems don't talk to each other"*

6.24 The Development Officer for Gypsy/Travellers in Highland was not contacted directly but the role of the post is to improve access to services and support; to promote health, well-being and social inclusion amongst gypsy/traveller families whether on road, sites or housed, and in relation to children in particular, to provide equal opportunities for gypsy/traveller

children across the Highlands in the delivery of education services. In 2001, in co-operation with a part-time site-based health visitor and the housing department, NCH piloted a weekly pre-school resource for gypsy/traveller children at the Inverness Longman site. The children participated enthusiastically as indeed did their older siblings. The success of the pilot led to regular provision being put in place. 6.25 Again the Play Development Officer was not contacted directly but the role involves developing a Highland Play Policy as the basis for writing a play strategy; raising awareness in Highland around issues to do with play; to promote the development of outdoor play spaces within the NCSA and to organise an annual Play Seminar. 6.26 There has been a growth of providers in both the voluntary and private sectors, some are new providers, others have extended their provision. Following is a description of the wide range of services that have developed and some of the barriers that have impeded their development.

Pre-School Education

6.27 In Highland, free pre-school educational places for 3 and 4 year olds are delivered through local authority nurseries often associated with a primary school; and, through commissioned partner centres comprising voluntary sector playgroups; voluntary sector full day care nurseries; private sector full day care nurserie s; and private sessional day care. At least one of the centres in each Area is Gaelic medium. In Highland, of the 258 centres providing pre-school education, 145 are local authority centres;19 are commissioned private partners and 94 are commissioned voluntary partners. It should be noted however that because of small populations of pre-school children in the more remote rural areas, some of these centres do not currently have any 3's, or any 4's or indeed, any 3's and 4's. These 'empty' centres rightly remain part of the counting of provision because next-term, next year there could be children eligible. This can be seen when comparing numbers of children attending (347932 for Highland) with places available (6272 for Highland). Also the Council established provision in haste and pragmatically making use of existing voluntary and private groups. They are currently undertaking a review of provision community by community to establish gaps and duplication. This review may result in some changes to the provision, but in an area with such dispersed small populations of children, there will always be 'empty' places and temporarily 'empty' centres and over capacity.

Full Day Care

6.28 Full day care in Highland is provided by private companies (national groups and ind re 29 full day care centres, 18 private businesses and 11 run by voluntary groups. The majority are in Inverness (15). All 29 have partner centre status which means they are commissioned to provide pre-school education Three of the centres offer out of school care during term-time and holidays (another few will offer out of school care to children who have attended their nursery prior to attending school but not as a general service). There are 2 private nurseries in Inverness that are part of chains,

[32] 3479 reflects the position in November ‘03. There will be 2 further intakes of three year olds to this academic year in the next 2 terms thus filling some of the spare capacity.

but generally they tend to be small businesses, attached to a person's home. Though there is at least 1 full day care facility in every area, it does not mean they are accessible to all communities. Families living on the north-west coast of Sutherland would have to travel 50-60 miles, some of it on single-track roads, to use the 1 day care nursery in Sutherland, which is situated on the east coast of Sutherland. There have been applications for new nurseries in recent years but all have failed at the planning stage due to objections to increased volume of traffic and increased 'noise from the children playing. This has created a sense of frustration for planners. Small populations of young children and fluctuating or seasonal employment in remote rural areas can make full day care nurseries nonviable. Staff in the private and voluntary sector have access to training courses run by the local authority and HPS.

Childminders

6.29 Childminders offer an alternative day-care service in a family based setting. The Scottish Childminding Association is their umbrella organisation and is supported through funds from the Childcare Strategy. Childminders themselves can get a small start-up grant. The data in the mapping chapter would suggest that the number of childminders increased in the years following the introduction of the childcare strategy, but have fallen back recently. The Care Commission took over responsibility for registration in 2002. The impact of this is seen in very negative terms, not just because of the poorer reliability of the data base held by the local authority (who estimate the number of places at childminders as 2.5 per childminder because no better accuracy of information is available) but also because it is perceived to have a discouraging effect on applications for registration:

> *"we were getting about 30 applications a month from childminders, now I don't think we are getting 30 in a year." (Development Officer.*

6.30 The application form used by the Care Commission was perceived to be intimidating:[33]

> *"the form is a generic one, so if you are Westminster Health Care applying for a 75 bed Nursing Home you are filling in the same form as a childminder. It's too much for lots of people when a 69 page form comes through the letter box." (Development Officer)*

6.31 The basis for registration is also perceived to be different:

> *"The Care Commission is not about supporting people it is about processing applications. Previously a children's resource officer would deal with the registration, but also provide some support to the person applying. If you wanted to be a childminder, the local authority would have to prove you were incompetent to stop you from registering whereas now with the Care Commission you have to prove you are competent. So there is a completely different mind set" (Development Officer)*

6.32 Generating a worthwhile income from childminding in remote rural areas can be difficult. The demand can be limited and seasonal due to seasonal employment opportunities

[33] However, we understand that more recently, the Care Commission has simplified its form for childminders.

through tourism. To address the issue of sustainability of a childminding workforce, the SCMA have instigated 2 innovative projects, using NOF. First is the Remote Rural Retention project in which childminders are paid a grant to provide Out of School Care in areas where there is no Out of School Club. Secondly is the project to recruit Gaelic speaking childminders.

6.33 In addition the local authority, SCMA and HPS are working collaboratively on developing childcare services aimed at filling gaps in provision and matching services to the needs of a large rural area. One idea under discussion is the development of a childcare staff bank of trained child carers paid retainer fees in addition to the fee for any service they provide. This resource could have a number of applications:

- to provide relief cover in urban areas where staff cover for sick leave and training courses has proved difficult
- to provide a sitter service for urgent needs referred by community nursing staff and social workers
- a flexible/mobile crèche service (Play Direct) that would be available for training courses.

6.34 Another idea being discussed is the specialist training of childminders to support special needs. Currently if a childminder accepts a child with special needs they frequently do so on a one-to one basis. This disadvantages them financially and so can be a disincentive. If a childminder could be paid an additional retainer then it would be possible to develop a more stable pool of specialist childcare opportunities.

6.35 If all of these plans come to fruition then the pattern of childcare provision in Highland could look very different in a year's time.

Out of School Care/Clubs and Holiday Playschemes

6.36 These are categorised together because often, although not always, it is the same clubs or groups making the provision. A distinction needs to be made between Out of School Care and Out of School Clubs. The 'care' tends to be offered by private nurseries willing to take children, of school age, after school. Clubs are generally voluntary groups run by parents under the umbrella organisation 'The Out of School Care Federation'. The clubs are sometimes, although not always associated with a primary school.

6.37 The provision is very diverse. Some of the clubs/groups will only take children of 5 and over while others take children of any age, particularly the private nurseries and community holiday schemes. Some of the clubs/groups only operate in term-time and others only operate in holiday time. Some are serving only local children, others are open to summer visitors as well. Some term-time clubs offer a breakfast provision, others are 'after school' only. Out of school clubs exist in every area except Skye and Lochalsh. They consist of voluntary, parent run groups and private sector (usually day care provision) that will accept children before and/or after school with a pick up and drop off service. During the course of the study Highland's first Wraparound care was approved for an Out of School Club in Caithness that has been in existence since before 1995. It is hoped that wraparound will be running early in 2004 and that this is the first of many.

"We need to extend the service to include nursery aged children and not just primary. It can be provided by childminders as well as clubs, or a mixture of the two. What we want is a flexible service in which a parent can drop off their children before school or nursery, they are taken care of after their pre-school educational session, and then picked up whenever the parent finishes work." (Development Officer)

Playgroups and toddler groups

6.38 Toddler groups exist in all Areas. Highland Pre-school Services (HPS) is the umbrella organisation supporting playgroups and toddler groups in Highland and the majority of groups are members. As well as the ordinary model of toddler groups HPS has developed a model of 6 supported toddler groups in which paid staff assist with the running of the group and provide role models for management of child behaviour. Two of these are funded through Sure Start. Five of the Areas have CNSA Gaelic medium toddler groups. The HPS training courses offered cover training for play workers as well as service administration such as partner in-service training, policy training and Care Commission standards.

6.39 There are 79 commissioned playgroups in Highland. There are also a number of non-commissioned playgroups. These are playgroups *not* providing free places for 3's and 4's. They are often found where the local authority has taken over the provision of pre-school places for 3's. But, because a child is not accepted in to class until the term after their 3rd birthday, some children might only get one term in a local authority nursery. These playgroups bridge that gap by offering a playgroup provision for this age group until they can attend the local authority nursery.

Other services for children and families with an early years remit

6.40 There are a number of services with broader remits but with an early years dimension, such as Healthy Living Centres, Family Centres, parenting courses, child sitter services and other resources, as follows.

Healthy Living Centres

6.41 There are a number of Healthy Living Centres in Highland and 2 were identified as having project work relating specifically to mothers and young children. Room 22 is designated room in Tain Royal Academy offering family support, childcare training, parenting courses and a range of resources for parents. The Janny's Hoose is in Merkinch Primary school and they have 4 themes focusing on the well-being of parents and children: Feeling Good, Support for Parents, Nutrition, and Oral Health. In connection with these themes they are involved with tooth brushing initiatives, they run cookery groups focussing on low cost nutritious food, they run toddler taming sessions, antenatal groups meet there and baby massage groups are run.

Family Centres

6.42 Highland Council has not gone down the road of some authorities in providing purpose built Family Centres in the generally accepted definition. Sure Start projects are delivered through a number of voluntary agencies that carry out both group work and home visiting. However in many cases, the group work is also done on the basis of out-reach to be delivered from a venue accessible to the families concerned. So, although each project has an identifiable base and group work may be offered from that base, they are not quite Family Centres in the accepted definition of the provision. The group work is done with children; with parents and with parents and children together and takes many forms. The home visiting varies from intensive support for parents or parents and children through to domestic assistance or child sitting (although there is not an official child sitter service in the more formal use of the term).

Resources

6.43 The resource of Play @ Home is widely available to families with a child born from August 2002 onwards. There is funding for a Bookstart scheme but it is awaiting the appointment of a co-ordinator. Only 3 Toy libraries were identified which is many fewer than in 1995. The Inverness toy library is counted twice because it has a static base and a mobile service.

Parenting courses

6.44 Parenting courses have been offered throughout Highland and a variety of staff has received training in a variety of courses. However there is no overall picture of what is taking place. The appointment of a Parenting Development Officer for Highland is currently under discussion and it is hoped to have one appointed in 2004. It is envisaged that they would co-ordinate parenting courses and establish quality standards for the delivery of courses.

Child Sitter Service

6.45 There is no Child Sitter Service in Highland at the present time, but SCMA in collaboration with the Council, are investigating funding to develop such a service.

6.46 While many of these services are a mix of universal, area-based and targeted provision, there are others specifically targeted for vulnerable children and families, such as various Sure Start projects or services provided by National Children's Homes.

Sure Start Projects

> *"When Sure Start funding first arrived we started by identifying areas where SIPs activity was concentrated and where there were concentrations of free school meals payments." (Development Officer).*

6.47 In Highland, SIPs are thematic rather than area based and are targeted at 16-25 year olds. But it was argued

> *"increasingly, many of this age group are the parents of the children aged 0-5 that are the focus of early year policies" (Development Officer).*

National Children's Homes

6.48 NCH has provided a family support service in Inverness since 1986 and were well placed to respond to the development of family support services when Sure Start funding became available. Indeed they were invited to put forward a proposal. There are now 3 NCH Sure Start projects in Highland: Inverness (distinct from the pre existing NCH provision), Alness (Ross and Cromarty) and Lochaber. The service NCH provides is targeting families with:

> *"complex problems and long standing problems including abuse in the parents' own childhood; parental mental health issues; poor attachment between parents and their children and vice versa; little understanding of the importance of play and stimulation in general; poor language skills and little fun or joy in the relationships." (NCH, Inverness report 2002-2003)*

6.49 Each of the projects has responded to the needs expressed by parents *"each family is different and work is programmed to individual needs"*(fieldworker), and have taken account of other provision and of limitations of the accommodation available.

6.50 In Alness there is a partnership of NCH with Home Start, who provide a home visiting befriender service and women's group; and with HPS who provide a supported toddler group. In Lochaber NCH work from the An Drochaid Centre, as does Family First. They also out-reach to other venues such as Kinlochleven Childcare Centre run by HPS. The Inverness project works in partnership with NCH Inverness Family Project and with the local Inverness New Community School.

6.51 The Home Visiting service provided by NCH differs from that of Home Start and Family First:

> *"the families we are visiting are generally more complex with enduring problems and require more intensive work. We are 'user friendly' and supportive in the service we offer but at the same time can be very challenging and honest- if there are child protection issues on the horizon then we will raise them for discussion. We are not a befriending service although we are friendly towards the families we work with." (provider)*

Fubbyloofers : An example of good practice

6.52 An example of some of the work done in the NCH Sure Start projects is *Fubbyloofers*, a Sure Start Project in Alness. Fubbyloofers is a small group session with children under 3 prior to them taking up a nursery place. They have adopted a Highscope Approach which is person-centred and stresses achievement and building self-confidence. The children referred

have presenting issues around developmental delay, particularly with speech and language, social and emotional development, and gross motor skills. Seven of the children reported on had special needs, including Down's Syndrome, Autistic Spectrum Disorder and Attention Deficit Disorder. The staff collaborate closely with other professionals involved with the children and their families, for example: paediatricians, psychologists, speech and language therapists and the pre-school teacher. With parental consent, professionals have often valued the opportunity to observe the children at Fubbyloofers in a setting in which the children are at ease and behaving naturally. The NCH staff then reinforce the approach taken by the professionals. This results in consistency of approach for a child. For example, the staff will laminate text and pictures of a nursery rhyme containing animal noises. They will practice the rhyme in class and then the child takes home the laminated card to practice with parents.

6.53 Examples of good practice can be seen in their very visual 'Home Link' sheet informing parents of the child's activities, what has been eaten and drunk and what utensils they have used (all of which is based on sound healthy snacks and good practice). These sheets enable the parent to engage the child in discussion about what they have been doing and also to reinforce at home the approach taken at Fubbyloofers.

6.54 The staff make use of opportunities for health and have collaborated with the local Health Visitor in providing play sessions at the weekly child health clinic. The support they offer has encouraged families who might otherwise not have attended to come for immunisation and screening. Staff focus on the transition from their group onto nursery. They work closely with the three primary schools and have devised a transition document (along the lines of that used in the pre-school early education sector). They will also invite the receiving nursery teacher to observe a child in Fubbyloofers and, if circumstances require, accompany a child to nursery classes until they have settled.

6.55 The staff also offer stay and play sessions in which parents can participate in a play session. Parents can rehearse, in a safe and supportive environment, behaviour management techniques and build up confidence in playing with their children in a public setting and the parent has the opportunity to have fun with their child:

> *"I've got more ideas about what to play and make more of an effort to play with the children now – it's important" (parent),*
>
> *"he's not screaming the way he usually does" (parent),*
>
> *"the boys play together much better now, there aren't so many squabbles" (parent).*

The work done in Fubbyloofers aims to prepare a child for nursery by:

- Introducing the child to his/her peers and promoting appropriate social interactions
- Modelling a positive style of adult behaviour
- Promoting confident separation from the main care giver
- Equipping the child both emotionally and socially for nursery
- Familiarising the child with routines
- Offering the child a vast range of developmentally appropriate play experiences
- Equipping the child with skills around the resolution of conflict
- Progressing the development of a child in all areas
- Promoting the development of listening skills

- Familiarising the child with his/her community
- Promoting a positive sense of self

And to benefit parents by:

- Providing an opportunity to rehearse and establish the routines around time keeping and attendance which will be required when the child attends nursery
- Promoting parental confidence around accessing a community based resource
- Promoting contact with other parents
- Promoting parental interest and involvement in the child's placement
- Fostering positive links with the parent
- (Fubbyloofers Review)

Highland Pre-school Services (HPS)

6.56 The organisational structure of HPS comprises a series of separate companies each with functions tailored to early education, childcare provision, training and home visiting. A variety of funding sources are involved. HPS provision funded by Sure Start can be found in Caithness (Ormlie Centre) and in Lochaber (Kinlochleven Centre) and in Home Visiting through Family First. The Kinlochleven Children's Centre is leased by Highland Council and managed by HPS. They provide full day care, pre-school education and manage a supported toddler group. The Ormlie Centre (Thurso) provides pre-school education and manages a toddler group; full day care is not yet available. Home Start also work from this Centre.

Family First

6.57 Family First supports families with at least 1 child under 4. Support takes many forms but is through a flexible trained volunteers home visiting service or through self-help groups facilitated by trained locally based volunteers. Family First appointed a development manager in March 2001. The areas of greatest need were identified through consultation with Area Partnerships, Area Social Work Managers and local professionals throughout Highland. Family First is now active in all local authority Areas except Inverness (because it is urban, although there are discussions about developing an appropriate home visiting service for Inverness) and Caithness (because Home Start is the established home visiting service here). They are active in Ross and Cromarty on the west coast because Home Start 's activities are focussed on the east coast and it was felt the was a gap to be filled.

6.58 Local co-ordinators based in 7 offices around Highland recruit and train volunteers who have themselves experience of parenthood. They then 'match' the volunteers with referred families who are experiencing a period of stress and difficulty. Criteria of vulnerability are not applied in that Family First acknowledge that all families can face a period of vulnerability and that early support can prevent a situation from worsening. Referrals come from a range of agencies/professionals, but in the main from health visitors and self-referral. Family First are seen as a 'bridge' between families and agencies providing more focussed professional support. Families are invited to express their views on precisely what they would find helpful in terms of support.

6.59 As of September 2003, Family First were home visiting a total of 65 families in Highland: lone parents (23), parents with disabilities (5), parents with learning disabilities (4),

parents with physical health issues (13), parent with mental health issues (27) and parents with no extended family support who were socially isolated (3). There are 107 children in these families being home visited, of which 80 are under 4. As of September 2003, Family First recorded 130 families attending groups for which no formal referral is required. Children attending these groups with a parent, numbered 148. As of September 2003, 56 volunteers were trained, 8 were in training and 4 were waiting to attend training.

6.60 Family First is being evaluated externally by Childhood and Families Research and Development Centre. As Family First continues to consolidate its service they point to additional bonuses of their work:

> *"volunteers have gained considerable confidence and self-esteem a number of volunteers have been successful in finding paid employment (often still remaining as a volunteer)*
>
> *"parents who have received support have now become volunteers themselves" (provider)*

Home Start

6.61 Home Start has been active in Ross and Cromarty since 1988. It is a national voluntary organisation run by local committee. Trained volunteers offer regular support, friendship and practical assistance to families who are experiencing stress and have at least 1 child under 5. Families tend to be involved with the service for 6 months up to 3 years. If issues are continuing when a child reaches 5 then continuity of support is sought through the school. Referrals can be made by health visitors, social workers, friends, family, or other statutory or voluntary organisations helping the family. Families can also self-refer. In 2003 Home Start supported 77 families through home visits by 30 volunteers. A total of 186 children, 124 under 5, were in receipt of their service.

6.62 Home Start has been active in Caithness since July 1999. They work with families with a child aged 5 or under and about 85% of the children are aged under 4. Home Start Caithness has a volunteer home visiting service working with 25 families. They also run group work from 2 centres including Families with Twins support groups in both Wick and Ormlie, Thurso. Interestingly home visiting is generally seen as an appropriate vehicle for delivery of support in remote rural areas where people might find it difficult to access centre based provision. However, it was reported that in some rural areas where there is a tradition of binoculars sitting at the front window and everyone watching any activity, some people felt more anonymity through a centre based service. Hence some befriending services have placed more emphasis on developing centre based services.

HIGHLAND UNIVERSAL / TARGETED STRATEGY

6.63 Rather than designing provision that is either universal or targeted, Highland's Family Support Strategy attempts to strike a balance between universal and targeted services, with a four level 'pyramid' framework on a spectrum of universal/targeted service provision, with successively greater levels of support at each level, as described below.

6.64 Both universal and targeted services are considered valuable by service providers. Universal services are valued because they are preventive, they bring benefit to all, they enable early detection of issues and they are non stigmatised. Targeted services are valued because they focus resources on those most in need and they tackle complex and enduring issues

> *"Essentially what we are doing in Highland is taking a life course approach: pre-conception, conception, pregnancy, pre-school through to school and then after. At each of these transitions there are a number of services that can have a role to play. Out thinking is that from pre-conception through to pre-school, health is the universal provider and from pre-school, education is the universal provider. And the mantle of care is handed on from the midwife to the health visitor to the school nurse at these transitions." (Head of Service)*

6.65 The strategy outlines four levels of support and indicated how in Highland components of their activity and service provision fits with the model:

6.66 Level 1: Universal Resources and Services includes all universal services for health care, education, housing, income, employment, leisure and recreation including play activities, and is focused on the general population. Most important at this level is good, accessible information, guidance and advice to enable families and children to enjoy the benefits of ordinary day to day life, to promote good health, citizenship and to empower families and communities to develop their resources and support networks. Examples of this level in Highland are:

- The Caithness interagency parenting project
- The review of parent craft services
- Development of guidelines for parenting courses
- Play @ Home
- Revision of screening and surveillance for children in Highland (Hall 4)
- Review of the role of community nursing in Highland (Nursing for health)
- Toddler groups
- Play groups
- Pre-school education for 3's and 4's
- Childminders
- Full day care
- Out of school care/clubs

6.67 Level 2: Additional Community and Agency Resources and Service focus on ensuring that those who require additional support or assistance are directed quickly to the most appropriate service. Families or children experiencing initial difficulties are provided with support to reduce the need to become directly involved as a "patient", or "client". It is the point at which a broad range of preentative services operate so that early risk is identified and responded to, and where children can be supported in remaining outwith the care systems. Examples of services at this level are School Liaison groups, Support, Self help and Peer groups, supported toddler groups and some of Family First and Home Start group work that is open access (i.e. no needs assessment is required). Other examples of activity relating to this level are:

- Research funded by HIF to explore the experience and views of women and service providers involved with maternity services; acute mental health services; primary care services; Sure Start and related initiatives supporting vulnerable families

- NCH needs assessment for rural Inverness
- Co-ordinating group to review practice and service across mental health and maternity services
- Midwife secondment to Children's services team to review maternity services in relation to vulnerable families

6.68 Level 3: Targeted and Assessed Resources and Services are specifically targeted to individual families or children on the basis of assessed need. Assessments aim to be multi disciplinary, community based, and shares a consistent process and format. This level is intended for families and children with severe and acute or enduring problems such as truancy, mental health, delinquency, domestic violence, child abuse, and drugs or alcohol dependency. The aim at this level is to mediate and redress the effects of difficulties and problems, to seek to restore an acceptable level of personal or family functioning, to foster "good enough parenting" and to link families and children with support to prevent further deterioration in personal or social circumstances. Examples of services at this level are:

- Webster Stratton Parenting programme roll out in Highland
- Family First and Home start home visiting and group work (where needs are assessed prior to accessing the of service)
- pre-school learning support/special needs assistants
- some NCH project work

6.69 Level 4: Specialist Resources and Services are targeted mainly on families and children where there are severe and enduring difficulties impacting adversely on children, or on the ability of parents to provide adequately for their families. At this stage services for children with special needs or difficulties are provided in a focused and intense way, possibly outwith the family home or community or involving intensive work and specialist skills and resources to reconstitute families, rehabilitate children or to seek alternative or permanent homes for children who no longer are able to live within their birth families. NCH projects working with vulnerable families is an example of work at this level.

> *"The challenge to service planning lies in achieving what is at times, a fine balance between investing in high quality universal services while ensuring specialist resources for those who most need them. A needs based approach that is based on early intervention will help, as will the use of a single assessment tool across agencies to ensure a consistent approach to identifying need" (Highland Family Support Strategy)*

> *"Work in Highland is in progress to develop a single assessment tool that can be used across social work and health disciplines. Also in progress is the development of a Health Improvement Strategy and a Child Health Strategy" (Highland Family Support Strategy)*

6.70 There is an awareness of the need to deliver services without stigma:

> *"We took the decision to put out Play at Home universally. In Ayrshire it was targeted. We wanted to avoid stigma. We will review that as part of the evaluation using focus groups of professionals and parents." (Development Officer)*

There is clarity for the need for targeted services:

> *"Our work in Sure Start is targeted. We work with vulnerable families in general, but in particular: teenage mums; people living in poverty; people living in deprived areas; single parents; gypsy/traveller families; families with a child on the child protection register; families with a history of abuse –the child or the parent; parents with drugs or alcohol issues; parents with mental health issues; children with behavioural issues; parents with learning difficulties. Our families have complex problems and you can see it in their children." (provider)*

There is also recognition of the need for services to have the freedom to work at a pace dictated by the needs and circumstances of the family:

> *"Lochaber has an exceptionally high suicide rate amongst young adults and many of the families in the project have been affected. The workers in the home visiting service offer support and assistance to deal with these issues enabling parents to move forward, improving their abilities and confidence in working and playing with their children. Parents are also given assistance in accessing local services such as play groups and nursery, supporting them into these facilities. This can be painstaking, time consuming work over weeks and months." (Fieldworker)*

Services in Highland are evolving in the slip-stream of policy development and agency restructuring:

> *"For the bulk of my working life, it has been about rationalising public services. The last few years there has been a shift in that we are not rationalising as much, we are developing public services. There is still a time lag culturally in that people are uncertain of their ability to do that. Some of this provision needs to become mainstream, statutory, normal, universally accessed provision rather than project and initiative kind of thing, except where there is a good reason for it to be project or initiative." (Area Manager)*

6.71 A useful distinction can be made between universal services and universal access to services. The later can apply to both universal and targeted services and ties in with 'difficult to reach' families:

> *"At the moment they (NCH) provide very high quality services to geographically targeted families (because NCH Sure Start Projects are in 3 of 8 Highland Areas). Their service should be universal in access. So, should they provide a service for the tip of the pyramid where intensive services are require; should they offer an add on to statutory services; or do they have a developmental role- a professional development model of good practice that takes the rest of us down that road. They are a project but I think they should be more than that." (Area Manager)*

6.72 The family support strategy is in place but is service delivery reflecting the strategy?:

> *"The pyramid of care - I just have no confidence that currently the most vulnerable children and families with the greatest need are getting the highest levels of support. We need to step back and take an overview of this community of*

Highland, assess what current needs are, what resources there are, and try to get as good a match as we can. Part of that is by bolstering mainstream services and part of it is by clearly defining where the voluntary sector has a role to play." (Area Manager)

6.73 The voluntary sector has shown itself to be flexible and opportunistic in developing models of provision to fit the gaps in types provision:

"Childminders are a universal service but we are also looking at different projects to develop a specialist childminding service- for children with special needs, or a child sitter service taking referrals from social work." (Provider)

or geographical gaps in provision:

"Family First was developed as a remote rural home visiting service and have developed services where there is no other voluntary provision such as on Skye" (Provider/fieldworker)

6.74 And in this sense, Family First straddles the levels of 'the triangle' because in some areas they are the only voluntary sector family support service and therefore are having families referred to them, that in other areas might be referred to NCH projects.

6.75 Because of the family support strategy's approach of targeting support at vulnerable families, then all of the target groups identified in the early years policies were felt to be included. Indeed, it was felt that their approach rightly broadened the definition of who should receive support- so for example a mother with a severe physical illness, needing temporary support with her children pre and post an operation, was identifiably vulnerable, irrespective of whether she was a lone parent or living in a deprived area. Similarly deprived families are identified whether or not they live in deprived areas. And finally although agencies are working to provide universal affordable packages of childcare that enables people to study and work, there is a very clear belief that:

"there is an assumption that, particularly for lone parents, their quickest way out of poverty is to get a job, but I certainly feel that we should value parenting. And if you are a lone parent with little or no qualifications, then the kind of job that you might get, say in a supermarket, then the money that you come out with at the end of the week is little more than benefits, but the stress level is much higher. Also the children are missing out on building relationships with their parent." (Development Officer)

THE FUNDING OF EARLY YEARS SERVICES IN HIGHLAND

6.76 The distribution of funding for Children's Services, in particular for Early Years, is organised in alignment with the policy and agency framework. The main streams of funding are pre-school education, Childcare Strategy (projects, infrastructure, workforce planning), Sure Start and Health Improvement Fund. However, these funding streams are integrated into a common pool with a trend to devolve as much as possible to area level. The following gives further detail of each of the funding streams with relevance to early years services. As one senior manager summed it up:

"They all come from the Scottish Executive to Highland Education Department (except HIF) and have always been used in a joined up way. What is radical in Highland is that from April 2003, the pre-school budget is left with the education department, but we took the Childcare projects, the Sure Start, and to a large degree, the infrastructure budgets and gave them to Social Work. The rationale is to clearly link accountability to responsibility: people must have accountability for the things they know about and for which they are responsible. The education managers don't have responsibility for childminders, the Social Work managers do. These budgets then come together again at the Area level (ACSF) where decisions about spending are made jointly by the Service Managers, but with clarity about respective responsibilities."

The Pre-school Education Budget

6.77 The education budget for pre-school is currently held centrally in Highland, albeit identified against services in Areas and is currently £6,547,000. But by April 2004, it is intended that the budget will be devolved to the Areas and managed by the Area Education Managers. The budget is based on the ratio of staff to children aggregated up to Area level. Much of this budget is currently committed; there are services in place that need to be paid for. However in Highland, they are about to embark on a review of provision for the 3's and 4's that will identify any changes required to better match provision to need. With the education budget as with all other budgets, there is a top-slice taken to pay for such pan-Highland Services as the Service Level Agreement to Highland Pre-school Services and the Out of School Care Federation.

Childcare and Family Resources Budget

6.78 The Childcare and Family Resources budget brings together the budgets for Childcare and Families projects; consisting of a sum for infrastructure and a sum for the Changing Children's Services Fund. The sum spent on infrastructure is greater than its allocation, and this is because Highland is such a large geographical area and there is a need for local staff in sparsely populated areas. A formula which takes account of rurality, population 0-17 and deprivation is used to allocate funds to the Areas. This is then topped up with a staffing allocation. The Changing Children's Services funding stream came after the Childcare Strategy and it is linked to 'For Scotland's Children'. This portion of the budget is there, in particular, to support after school care developments.

The Sure Start Budget

6.79 This budget is around £997,000 and is currently managed centrally at Highland level albeit again for local services in the Areas. Next year it will be £1.48 million, and the year after £2.1 million. Because of the growth in this budget there is currently a Sure Start review being undertaken in Highland to identify how it can best grow, meet local needs and be equitably distributed across all areas.

6.80 When the Pre-school Education budget and the Childcare and Sure Start budgets are all devolved to Area level, it is anticipated that the Area Education Manager and the Area Children's Services Manager will work together through the Area Children's Services Forum to decide jointly, how the money will be spent in a way that makes sense locally.

Health Improvement Fund (HIF)(children's portion)

6.81 The children's portion of the HIF is managed by the Joint Committee but the money comes to NHS Highland and is integrated with other funding streams.

The Workforce Budget

6.82 The Workforce budget is part of the Childcare Strategy stream and largely goes to Highland Pre-school Services for training programmes, but a small portion is kept back for current training initiatives.

Children's Services Development Fund

6.83 In Highland none of this is used specifically in relation to Early Years services.

New Community Schools Approach

6.84 There is education funding from the National Priorities Action fund (£1 million) which in Highland is added to by a significant portion of the Changing Children's Services Fund to fund New Community School activities. These funds are largely devolved to the Area Children's Services Forums and there could be some pay-off locally for early years services as a result. It is anticipated that in time there will be more integration of pre-school initiatives with new community school initiatives and that wraparound childcare services will be developed.

Well-Being Alliance

6.85 The Local Enterprise Companies and Highland's and Island's Enterprise Company support some central initiatives and some strategic initiatives. For example the companies may wish to ensure there is childcare available to those wishing to train or work in their areas and so will support local initiatives. They have been particularly active in Ross and Cromarty and in Lochaber.

Lottery Funding- New Opportunities Fund

6.86 There are different rounds of NOF money and it gets distributed differently, but recently Highland as an area was allocated £440,000 over 3 years. The Council were asked to indicate how much should go to each area/project. The money is not paid to the Council; their role is simply to co-ordinate its distribution. The Scottish Childminding Association have, for

example, made use of NOF funding in their Project for retaining Childminders in remote rural areas where sustainability is an issue.

Funding Model

6.87 The children's services funding model in Highland is one in which the main streams of funding (once top-sliced for pan Highland requirements) are divided between Highland Council departments of Education, Culture and Sport and Social Work, each with responsibility for delivery of specific services. These funds are then integrated again (or will be in the near future) through being devolved to the Area level for spending in a way that is deemed most appropriate by the members of the Area Children's Services Forum. In making these decisions, the ACSFs take account of the views of the members in the local Area Partnerships.

Summary

6.88 In summary, Highland has seen a rapid expansion of early years' services across sectors that are themselves increasingly working together. They have imaginatively embraced a targeted and universal approach which blurs the distinction between the two, while offering support for vulnerable families and other specific groups. A wide variety of provision is being developed and some of the challenges of rurality are being met, although further developments to support the childcare workforce in remote areas with fluctuating requirements are being considered.

EARLY YEARS' SERVICE DEVELOPMENT IN DUNDEE CITY

6.89 As noted in Chapters 4 and 5, Dundee City was able to build on existing provision to meet the challenges of the range of early years' policies. Again, we see a range of services being developed with a move towards integration and an effort to combine universal and integrated services.

Mapping service development and implementation

6.90 Service development was mapped using a variety of research instruments. A template was sent to agencies to complete (see methodology appendix for further discussion). Information was also gathered through interviews and documents. Geographical mapping of where children live and childcare resources was also carried out by officials in Dundee City, using sophisticated geographical information systems (GIS) to assist with service planning. Their maps have been made available to the Scottish Executive Education Department as an example of good practice in service planning.

6.91 Dundee City has developed new tools for planning and rationalisation of childcare resources. The city has been divided into seven geographical areas which are coterminous with school catchment areas. NHS Tayside uses the same 7 areas as planning zones for health delivery. The geographical profiling of children and childcare provision has been a collaborative venture between NHS Tayside and Dundee City. Within each of the 7 areas the

geographical location of all children under 5 years and childcare resources have been geographically identified, and distribution maps of the location of preschool children in Dundee and the location of preschool resources have been produced for each of the seven catchment areas. These give an immediate visual impression of the extent to which services are located near children's homes.

An overview of childcare provision in Dundee

6.92 Since the late 1990s, there has been a substantial growth in the level of childcare provision in Dundee. About two thirds of childcare provision in Dundee City is provided in either local authority or private sector settings. Dundee City is the largest provider with the private sector a close second. There is pre-school education provision for all three and four year olds across the city for all parents or carers who wish it.[34] The greatest growth in childcare is in private sector provision. Dundee City Council commissions places from the private and voluntary sectors. There were 399 places commissioned in August 2002 from 21 partner providers. The majority of childcare providers are childminders. [35]

The numbers and types of childcare providers

6.93 The number of service providers of early years childcare in Dundee City for 2000, 201 and 2003 is shown in Table 6.3 below. There are currently 285 providers of childcare within the city, a slightly higher figure than in the two previous years. The majority of these are childminders, although their numbers are declining.[36] The four most common types of childcare places, providing over 80% of places, are shown in Table 6.4. The number of providers offering full-day or near full-day places, shown in Table 6.5, is much smaller.

[34] Dundee Early Years and Childcare team Review Progress, February 2003.
[35] Dundee Early Years and Childcare Team Review of progress , February 2003
[36] Dundee Early Years and Childcare Team Review of progress , February 2003

Table 6.3 The Number of Service Providers and Childcare Places in Dundee, 2000 - 2003

Type of Provision	*April 2000*	*April 2001*	*April 2003**	*Total Places available April 2003**
LA Nursery schools/classes	*34*	*34*	*35*	*1510*
Private Sector Day Nurseries	*19*	*22*	*26*	*1137*
Childminders	*173*	*167*	*156*	*567*
Out of School Clubs	*14*	*14*	*18*	*491*
Parent & Toddler Groups			*23*	*163*
Pre- school playgroups	*11*	*11*	*7*	*138*
Holiday Playscheme (not OOSCs)	*10*	*10*	*6*	*84*
Nursery Centres	*0*	*0*	*1*	*45*
Crèche			*1*	*10*
Community Nursery	*1*	*1*	*1*	*0*
Nurseries attached to independent schools	*0*	*0*	*0*	*0*
Child &Family Centres	*9*	*9*	*10*	*300 **
Other: sitter service	*1*	*1*	*1*	*0*
Total	272	269	285	4445

*Estimate

Source: Dundee Early Years Childcare Plan 2001-2004; The Childcare Information Audit October 2003;

Table 6.4 The four most frequent types of childcare provision in Dundee

Type of Provision	Number of Places	As % of total places
LA Nursery schools/classes	1510	33%
Private Sector Day Nurseries	1137	26%
Childminders	567	12%
Out of School Clubs	491	11%
Total	3705	82%

Source: Dundee Early Years Childcare Plan 2001-2004; The Childcare Information Audit October 2003

Table 6.5 Providers offering full day provision in Dundee

Provider	Number of settings	Hours available
LA Nursery schools	13	8:15am to 5:15pm
LA Nursery classes	5	9:00am to 3: 15 pm
LA Nursery classes	16	Half day morning or afternoons
LA Nursery schools	5	Summer and Autumn holidays
Private Sector Day Nurseries	27	7:30am to 6:15pm approx

Source: Dundee Early Years Childcare Plan 2001-2004; The Childcare Information Audit October 2003

6.94 Targeted provision for vulnerable children and families is provided by 10 Child and Family Centres. However other types of service targeted to vulnerable families have been introduced and some of these are now described.

Childcare provision for vulnerable children

6.95 An increasing number of three year olds with special educational needs take up nursery places. A pre-school Home Visiting Service offers guidance on placing children with special needs in pre-school mainstream settings. There is a dedicated specialist early years provision in a Pre-School Centre offering up to 30 places for three to four year olds and provision in 3 other Pre-School Centres across the city. Tayside Health Board provides an assessment centre at Armitstead Child Development Centre which offers a nursery for children with complex medical needs. A multi-agency and multi disciplinary Pre-School Placement Panel considers placements of 3 and 4 year olds with special educational needs. Childcare services for student parents have been developed at Abertay University using Sure Start funding and discussions are proceeding with Dundee College.

Support for families from minority ethnic communities

6.96 The needs of minority ethnic communities have been assessed by NHS Tayside. There are development workers dedicated to integrating families and children from theses groups. Health Visitors are being trained in local languages of some groups. Dundee City operates an interpreter service but this is unhelpful since interpreters need to be booked in advance. Language problems remain and there is a perception that more needs to be done in this area.

> *"We have sent Health Visitors to learn Urdu. ...[The] multi cultural officer does not speak the language... ...[The] Multi cultural officer is Anglicised and Christian. But does her best. We are trying to address this. Translation services through the council are not very satisfactory because you have to book appointments in advance." (health planner)*

6.97 Families from minority ethnic communities are concentrated in the centre of the city and a mother's group is attached to Frances Wright Pre-school Nursery located in this area. Negotiating access to mothers is problematic.

> *"The translation service is particularly hampered because it is a very small ethnic community here and they all know each other. The translator is likely to know their family. Women particularly have huge issues and [in some families] it is very male dominated and very difficult to get access to a mother on her own. Even the mother in law is protective." (health planner)*

6.98 One dedicated development worker commented that language and cultural attitudes created barriers to mothers becoming involved in children's education.

Support for parents experiencing mental health problems

6.99 Post-natal depression and mental illness was a common problem for many parents who attended targeted services. However, planners were concerned about a lack of visibility of more affluent parents with similar difficulties who needed support and similar services but who only had health visitors and GPs as support.

"On mental health we don't know how many ethnic minorities use the service. We found post natal depression a lot. We have 5 post natal depression trainers and they train with mental health staff and others who are involved with hard to reach groups. We carry out the Edinburgh Post Natal Depression Score on every new mum. I can't say we reach every mother. But it has a clinical pathway so it is very robust in Dundee." (health planner).

Family support and centre-based provision

6.100 There are 10 Child and Family Centres in Dundee. The Centres target their resources towards those in greatest need and work with many of the city's most vulnerable children and families. They are the social work's main resource for children from 0-12 and provide a range of family support services (Table 6.6). They provide services to children and families in their own homes, and in outreach facilities. Sessional care is provided for young children for up to 4 half days per week. To accommodate changing population movements and needs Family Centres have extended their services and introduced new services through their outreach workers,[37] in Charleston, St Mary's and Hilltown.

Table 6.6 Some services offered by Child and Family Centres in Dundee

Child and Family Centre	Services available
Ardler	Post Natal depression Group; Healthy Eating Group; Feel Good training; Infant massage; Community Fun days, Mellow Parenting, Mother and toddler Groups
Lochee	PACT; Taie Chi; Smoking cessation; Photograph Project; One meal in a Pot; Little Gym Time; Taste and Try
Douglas	Parenting skills group; Drop-in sessions; parent and Child together group; Infant massage; Play programmes

Parent support services

6.101 Integrated provision for specific parent support projects have been set up. These are located outside city centre provision and are city-wide. Child and family centres feel hampered by the lack of visibility of their services, but are constrained by the need to ensure confidentiality for users. Other Child and Family Centres provide the same or similar services, possibly in slightly different combinations depending of the requirements of local families.

Parenting programmes

6.102 Parenting Programmes operate across the city and the general policy direction is to bring a more universal approach to support parenting. These programmes have prompted a whole raft of networks and groups in which parents can become engaged. As one health planner stated.

[37] Three outreach workers were appointed in 2000 using Sure Start. The Outreach Workers Group chaired by Early Years and Family Support Services within the Department of Social Work.

"People are not born being able to parent. We are not considering the broad ranges of difficulties they all face. Mothers have a common thread. I have yet to find a mother who does not want the best for her child and better than she has. Whatever the baseline is."

Partnerships and voluntary sector involvement

6.103 The voluntary sector makes an important contribution to childcare services in Dundee. Representation of the voluntary sector has been strengthened within the partnership. Funding has been made available to support local playgroups and mother and toddler groups, and voluntary organisations who provide childcare and support services. Some of the projects are provided by the voluntary sector and a few of these are noted below.

- Home Start Dundee
- Dundee Sitter Service – home bases childcare. This service is being extended to two other local authorities.
- Frances Wright Parents Group, a self help group for parents of children aged 3-8 on the autistic continuum
- Services for parents and children affected by substance misuse
- SAYF project which assists vulnerable parents with housing, homelessness and other issues.

The regulation of childcare provision

6.104 The EYCCP have set up structures and procedures to establish minimum standards across the city. Training and quality within the private sector are regulated by a quality co-ordinator. There are 167 registered childminders in Dundee and 21 partners. Childminders and partners can access training and personal development through accredited and non-accredited courses. Partners are required to write and a Development Plan each year. Funding is made available to the private sector to assist with training.

6.105 A range of childcare networks feed into the EYCCP and allow for consultation and planning. There is a Partner Providers Forum and Business Group for information sharing. A city wide Childminders Network and a Linked Childminding project also operate. In addition a "mentoring scheme" is being developed to provide support to newly registered childminders. A Playgroup Network across the city has been aided by Pre-school Playgroups Association fieldworker.

6.106 All these initiatives and mechanisms have strengthened representation within the Early Years and Childcare Partnership.

"The EYCCP has helped to bring members of the private sector together. They are not very good at sharing information because of commercial competitiveness, but the partnership has helped that" (private provider).

Qualifications of staff in the childcare workforce

6.107 The qualifications of local authority and private nursery staff differ. All local authority staff in nurseries are at least HNC and HND trained in a two year accredited training. Nursery staff in the private sector only need to have SVQs. This disparity is however, being re assessed. Family support staff in Child and Family Centres have similar qualifications as nursery nurses However this is also currently under review.

6.108 As services develop, the training required of staff also changes. It is thought the roles and nature of family support diverges considerably from nursery nursing roles to the extent that current training is no longer thought to be adequate.

> *It has become very obvious that the roles carried out by our staff in Child and Family Centres and those of Nursery Nurses in Education Department nurseries and nursery classes have become increasingly different… It has also become very apparent that the HNC training which focuses upon childcare and education is no longer meeting the skills needs of our staff providing family support services (social work planner).*

Meeting training needs in Child and Family Centres

6.109 There is no national training at present which is thought to meet the needs of family support staff. Child and Family Centre managers have accessed training from external providers, which is delivered in-house. The training emphasis has been on developing more flexible approaches to family support and have included diverse topics such as First Aid, Food Hygiene, Moving and Handling (e.g. young children!), Little Gym Time, Infant Massage, and awareness training about disability, autism, drugs, alcohol and post-natal depression. Opportunities for joint training and funding have been pursued and their value is recognised. Training programmes also focus on the most vulnerable families, in particular those who are hard to reach.

> *These have been many of the broad based initiatives which have each involved significant numbers of staff from across our centres, often learning together or in multi-disciplinary groups. Some of these programmes have been jointly funded or delivered with other departments and agencies. For instance Hanen training has been provided by the Speech and Language Therapy Department and was partly funded through Health Improvement Fund (social work planner).*

> *Working with the Job Centre Plus is a major plus… We do have free time available for vulnerable families. Even if it is to help them going to unpaid training, it might help lift that family out of poverty…already looking at consulting with parents, travelling families, those that can't access written information [and] also trying to contact all new mothers. (training co-ordinator)*

THE DEVELOPMENT OF EARLY YEARS SERVICES IN DUNDEE CITY: PLANNING, AND IMPLEMENTATION

6.110 Two phases of development of early years services in Dundee can be identified: the first in developing the strategy and planning structures and the second in the implementation of the strategy. The current agency structure is described in chapter 4, here we focus on the development of services under this strategy.

The Child Health Implementation Plan

6.111 The Child Health Implementation Plan (CHIP) sets out SMART objectives.[38] Local Health Care Cooperatives (LHCCs) extract objectives that are relevant for inclusion in local plans. Tayside University Hospitals and Tayside Primary Care also include relevant action within their clinical services action plans. Action relating to joint health and local authority priorities are included in Children's Services Plans.[39]

Early Years and Childcare Team (EYCCT)

6.112 An Early Years and Childcare Team was established in January 2000 and helped broaden the Childcare Strategy. New avenues were pursued in the setting up of the Parents' Services Initiative and The Pre-School Home Visiting Service. A Sure Start Strategy and Implementation Group was established to develop the Sure Start Initiative. It has a multi professional membership and has been influential in facilitating collaboration across agencies.[40]

Establishing mechanisms to gather information for planning

6.113 The importance of gathering and disseminating information for planning purposes was accepted at an early stage at strategic level and such information collection was built into planning structures.

> *That is something the EYCCT has concentrated on since setting up the team—the importance of getting information, using it for planning purposes and the importance of providing it to the users of services. We're lucky to be able to do it in an integrative way. (planner)*

Evidence Based Intervention

6.114 NHS Tayside has sought to develop evidence based policy, using evidence such as needs assessments, reviews, audits and child health population profiles. A Child Health Strategy and various Health Plans have been produced using mechanisms to gather

[38] These are objectives that are Specific, Measurable, Achievable, Realistic and have a Timescale. The Plan also includes milestones, timescales and financial information.
[39] Tayside Child Health Strategy
[40] Dundee Early Years and Childcare Plan 2001-2004

information on child health such as needs assessments for various target groups, surveys, health audits, and monitoring information.

The Dundee Early Years and Childcare Partnership (EYCCP)

6.115 The establishment of the Dundee Early Years and Childcare Partnership, the Childcare Information Service and seven local Childcare Networks promoted wide involvement in the early years and childcare strategy. A Pre-school Quality Co-coordinator enabled standardised reporting mechanisms to be rolled out across all childcare providers. Good practice guidelines for services for children aged 0-5 were developed by an Early Years Curriculum Group.[41] Providers used these centralised resources regularly for updating information, new policies and procedures.

Local Childcare Networks

6.116 There are seven local childcare networks established across the city[42] and also a range of children's multi-agency health planning groups.[43] The local childcare networks agree shared priority agendas and have a direct link to city wide planning and policy through the Early Years and Childcare Partnership. The local networks and joint action planning, and were a useful mechanism for consultation at local level.[44]

The Dundee Childcare Information Service

6.117 The Information Service is an integral part of the Early Years and Childcare Partnership improving quality of information for parents, carers and providers of child care services. The Service aims to provide a "one stop shop" for information about early years childcare. Information is delivered by way of fact sheets, a telephone help line and a childcare web site linked to EYCCP through the Dundee City Wide Information Network PinPoint. [45]Regular audits are carried out and information on changing childcare provision is recorded.

Local Service Provision – Structure of Management

6.118 An Early Years Co-ordinator located within the lead agency makes accessibility and monitoring of implementation more effective There is no such person in the health field and this would be beneficial in cutting through the complexity of health's organisational structures. New structures have brought new management posts where strategic planning, management and operational responsibilities co-exist.

[41] Good practice Guidelines for Services for Children aged 0-5: Assessment in Action, November 2001
[42] Mid Craigie/Linlathen,Kirkton,Hilltown,Charleston,Fintry/Mill O Mains,Broughty Ferry, Ardler/StMarys
[43] Dundee LHCC's Children and Young Person's Working Group, Dundee Child Protection Committees, Local Drug and Alcohol Teams
[44] Dundee Early Years and Childcare Plan 2001-2004
[45] There are 25 locations in Dundee, based in libraries, centres, housing offices and other council buildings.

6.119 There are 10 Child and Family Centres located across the city. There is a City- wide Centre Manager and individual local Child and Family Centre Managers. Though management is fairly structured, each has some autonomy to set up and run local services.

6.120 Policy development moved into the second, implementation phase. A norm of integrated working and a unified approach was accepted. Structures had been reformulated and reporting mechanisms redesigned to bring a more cohesive approach to implementing policies.

As one health planner remarked:

> *"New networks have been formed. Many of the old planning mechanisms did not work with the new integrated structures. New posts and new roles needed new mechanisms to inform planning."*

Political Will

6.121 Political will was there to emphasis the importance of early years policies on the political agenda. There was, it was explained, no competition for early years resources within the Council.

> *"We have been very fortunate in Dundee. We have not had very much competition for the resources that have come to EYCC. Money that has gone to EYCC in Dundee has gone to EYCC. This is quite an achievement and gives some indication of the level of political investment [in EY]. The Director of Education and Director of Social Work have not made plays for that money to sort out other crisis areas. And they could have because there are other crisis areas." (senior official)*

Balancing region-wide and local priorities

6.122 Local authority boundaries and health board boundaries are not coterminous in Tayside. The Strategic Planning Group is a response to this and a mechanism to foster a unified approach. In considering the meshing of region wide priorities to local priorities, the response is positive. It is recognised by all agencies that Dundee has both specific and concentrated problems but that services should reflect this.

> *"Most of the services are delivered in accordance with the local authority boundary, because there was disproportionate need but also a centrifugal effect. The city tended to pull together organisations. That is where the organisational service was as much as where the need was so these would re-enforce each other" (health professional).*

6.123 The differences across Tayside are recognised also.

> *"Tayside is a very diverse area. [I] Worked across in the former Tayside Region and worked in the rural part before coming into the city. The distinction is a very great one. The two rural areas, Perth and Kinross and Angus contrast sharply*

with the urban situation. Can't say there is too much conflict between the two. It is just you have to deliver things in a different way. And there are stronger priorities ... certain greater volume issues. So we have more of certain categories of need" (senior official)

GP Practices and Inflexibility

6.124 There is no sense of any great difficulties in this area at strategic level although problems reportedly exist at local level with the restrictive aspects of GP practices and how health visitors are attached to these, reducing flexibility. GP practices are not evenly distributed across the city. As one health professional stated… "*There are six practices within arms length of here [a health centre] and there are whole areas without any"*. Sure Start Health visitors were created as a response to this inflexibility. There is some frustration at local level about GPs.

"They don't operate as a community service. The reward payments make sure that immunisation rates and other services are provided…GPs are more commercially minded than people think." (planner)

POLICY DIRECTION - ACHIEVING TARGETED PROVISION THROUGH UNIVERSALISM

6.125 The earlier policy direction towards targeting the most vulnerable children began to be regarded as problematic, even though there is general acceptance in education and health that a wide range of children not in touch with services could benefit from them. As one head of service observed:

"Children's Services Planning in Dundee up until now has been about children in need. Now [we are] trying to universalise this and trying to replicate the national picture by having a Dundee's Children's Plan."

6.126 A universal service was considered an essential mechanism for identifying children and parents from both affluent and poor families who would benefit from early intervention. Many vulnerable children and families not in contact with services, but who required them, were arriving at (untargeted) nursery schools and health services. This created a tension in policy direction that permeated policy implementation.

"One of the things that concerns us is that where you go to nursery school, is largely a matter of choice. So[a child] might end up going to a nursery that is on their doorstep that only offers part time pre-school education place. And they may have significant needs, but still only get a part-time place. For that is all that is available in that building. We want to reduce this accident, and ensure that if a child goes into a nursery and only has a part-time place then that child's needs would still be picked up by someone else in that neighbourhood." (planner)

6.127 This tension was also articulated by a nursing service manager:

> *"We are under extreme pressure with our colleagues in social work with a very targeted service, whose policy is to accept referrals from health visitors, who are their key source of referrals, against the development of Education's Early Years policy which is non-targeted."*

The view from a social work planner expresses the difficulties a targeted service has:

> *"[There is] always going to be a tension between universal and targeted so… [we've] got to keep them apart somehow. How are you then going to ensure that children who access universal services are able to get targeted services. That in a nut shell is the challenge we have in bringing family support services to children who are getting a universal service within an education setting or within a health setting."*

Definitions of vulnerability

6.128 Consistent with a move towards greater universalism was a view that the concept of vulnerability itself needed to be broadened, being outdated, too restrictive and tied too closely to poverty and housing indicators.

> *"Health Visitors argue that deprivation by postcode is a waste of time. As is scoring deprivation using Carstairs models of what people do for a living. They are seeing deprivation in the most affluent households." (senior official)*

6.129 Agencies wanted a more flexible definition of vulnerability to include children and families from more affluent households who need support. Both health and education agencies would like to see a greater use of universalism to identify needs.

> *"We still do not have open access childcare for under 3s… affordable and accessible community based resources for families who are not in employment, are not in training but who need a bit of help. …[We are] looking to use Sure Start funding to plug that gap, to offer open and inclusive universal services. So you don't have to be a drug addict or a single mum…,anybody could use these services" (education planner)*

The challenge for targeted services

6.130 Targeted childcare provision is delivered from 10 Child and Family Centres and are embedded within Social Work. Health and education argue however that this mechanism does not fully address the needs of all vulnerable children and families. Capacity and stigma are enduring problems for the service. There is wide understanding of the problem and considerable efforts are being made to address this through outreach and non centre-based services. Confidentiality concerns and the visibility of services limits location. Integrated services operating in school settings were thought not the best places for a targeted service. Though experiences from those involved would suggest that closer links between vulnerable

families and teachers is useful, senior managers are concerned about the risks to staff of the physical presence of aggressive parents in the school.

6.131 In March 2002 the Child and Family Centre Working Group was set up to undertake a review of existing provision in Dundee and to agree a family support strategy for Child and Family Centre services for the future. The aim of the group is to integrate planning for children in need and their families across Children's Services and to develop services which integrate closely with Education, Neighbourhood Resources and other Council Departments, as well as with Health.[46]

> *"Re-alignment of Child and Family Services with voluntary and other organisations or providing outreach services not immediately identifiable with a centre based service are proving helpful in this."*

6.132 The approach of outreach work appears to be bringing about some changes in perception, for example from a health professional

> *"Should we just have one child care provision? Should it be not run by one specific agency? And as education is less stigmatised than social work would it matter whose staff worked there if it came under an umbrella. It would remove that [stigma]. You would also get some mixing across areas and be able to reflect the difficulties all families have."*

Summary of the first phase and looking towards phase 2

6.133 Demographic shifts in population, regeneration policies, the demand for professionals and incoming population have all affected the planning of childcare in Dundee. Rationalisation of services is taking place. A move away from centre-based provision from Child and Family Centres and developing single childcare resource centres is proposed by Education.

6.134 Planning is helped by agreement on funding timetables, geographical zones and comparable databases. These are all progressing, albeit at different rates. Historical traditions relating to the physical arrangements for childcare are significant in Dundee and impinge in future planning. Differences in definitions of vulnerable communities also affect planning. New structures have been planned to take account of these factors. These were outlined in chapter 4.

Phase 2 – Proposed New Structures of Service Delivery

Education

6.135 In each of the seven areas representing non- denominational secondary school clusters across the city it is intended to create a single Early Years Resource Centre. These will use existing premises, cluster areas and network local people to one centre. Using health population data and local authority GIS planning procedures that map the locations of all

[46] Social Work The Way Forward, 2003

children aged 0-5 years and childcare resources (explained in chapter 2), the planning framework is in place. It has been accepted at political /strategic level and is proceeding; it is evidenced based and specialists have been recruited to assist.

Child and Family Centres

6.136 In March 2002 the Child and Family Centre Working Group was set up to undertake a review of existing provision in Dundee and to agree a family support strategy for Child and Family Centre services for the future. The proposed model for Child and Family Centres is to develop new community based services called Community Family Support Initiatives. Social Work proposed to reconfigure existing Child and Family Centre staffing to create 8 Family Support Teams linked into service networks at local level. The intention of this model was expressed as follows by a Head of Service:

> *"Essentially looking at joining up family support services within CFC with child and family support services being delivered within the voluntary sector with a view to reach families who are either too far from CFCs or not coming to CFCs. The initiative involves CFC, One Parent Families Scotland, Youth Link Dundee and Home Start Dundee. The overall aim is to identify where there are gaps in provision in the city and develop community facilities."*

6.137 Dundee City has built its recent early years provision incrementally from a relatively well-developed baseline of service planning and delivery. Drawing on national policy documents and guidance, this has included two phases of development: a planning phase and an implementation phase. The planning phase involved the setting up of planning frameworks and partnerships at various levels that included a wide range of public, voluntary and private sector providers. Innovative geographical information systems techniques have been developed as an input to service planning, which is now geographically organised and collaboratively planned by local and health authorities. New structures for regulating quality and training have also been developed. The implementation phase involved a unified and integrated approach. As in Highland, there has been a substantial growth in the level of childcare provision, principally of near universal pre-school education for three and four year olds whose parents or carers wish to use it. However, growth has taken place across all sectors so that Dundee City has a mixed economy of early years provision delivered by the statutory, voluntary and private sectors, with partnerships developed across and within sectors. Targeted provision for vulnerable families is provided by Child and Family Centres as well as being integrated into more universal services.

Conclusion

6.138 This chapter has described the great diversity and increasing scale of early years services that have developed over a relatively short timescale in both Highland and Dundee. These have drawn on the spirit and substance of various national early years policy initiatives taken as a whole. Despite different starting points, the objective of integrating early years provision has been accepted, although it is still very early days and too soon to judge the extent to which these initial activities and early outcomes at institutional, community and family and individual levels will result in positive long term outcomes for children.

6.139 In both case study areas there has been a substantial growth in system capacity for planning and delivering integrated early years provision, as measured in various ways. Building on the spirit and aims of national policies, organisational change that allows for integrated and collaborative approaches to service planning and delivery has been embraced in both areas, with structures and processes developed on the scale required for the particular area - incremental or fundamental - to achieve a more joined up organisation. The core objectives of national early years policies, as outlined in paragraph 1.31, such as improving children's health, ability to learn and social and emotional development, were the starting point for change and implicitly accepted as the taken for granted rationale, although there was no direct or explicit linkage of core objectives to programme or service objectives.

6.140 Integration of services is not only evident across service areas of education, leisure, health and social services, but also along a continuum of universal/targeted services. Nevertheless concerns and questioning by service planners and providers remain as to whether targeted services are successful in reaching all of their intended targets and as to what is the optimal mix of universal and targeted services to meet the needs of the most vulnerable children and families. Particular challenges remain in developing effective means of delivering services sensitive to local conditions, such as Highland's challenges for service delivery to remote areas where demand fluctuates and accessibility is a major issue.

6.141 Substantial expansion of provision was evident in both areas, although accurate and consistent measurement of provision across the board was not possible due, for example, to differences in the unit of measurement used. Nevertheless there was a clear expansion of places in aggregate, and particularly in local authority pre-school education for 3 and 4 year olds, the most universal of all services.

6.142 Overall, both areas can be characterised as having a mixed and diverse economy of early years provision in which the statutory, voluntary and private sectors all contribute and work together to an increasing degree. While the overall level of provision has grown, not all types of provision have grown to the same degree. For example, it was reported in both areas that both measuring and encouraging new childminding provision have become more difficult. This was seen to be due to the transfer of responsibility for the regulation of childminders from the local authority to the Care Commission. However, it was observed in both areas that problems in developing childminding provision could be an unintended consequence of Care Commission registration policy, and that a lighter touch in registration procedures for childminders might be beneficial.

CHAPTER SEVEN PERCEIVED IMPACT AND OUTCOMES OF EARLY YEARS SERVICES IN HIGHLAND AND DUNDEE CITY

INTRODUCTION

7.1 The case study approach has enabled the views of a range of service providers and users to be expressed. This in-depth, qualitative approach to evaluation can complement the hard measures obtained through existing data sets or through proposed surveys. It can also provide some evidence on those areas of impact not currently measured in other ways, especially in relation to system capacity/organisation change, children's social and emotional development, as well as in parents' well-being. However, the user perspective in the case study material is limited to the views of a small but diverse group, so our findings must be interpreted cautiously (see appendix one). The first part of this chapter focuses on service users' views about how services benefited their child, and then on how they themselves benefited. The respondents attended a range of early education and childcare and family support services such as pre-school nursery, playgroup, mother and toddler, home visiting, play sessions, childminders, group support, special initiatives such as the Tayside Breast Feeding Initiative. Parents came from a variety of backgrounds, but included young mothers, parents with disabled child, parents with children with other difficulties such as ADHD, mother with depression, those living in deprived as well as less deprived areas.

HOW EARLY YEARS' SERVICES BENEFITED CHILDREN AND FAMILIES

7.2 The views of service users collected during the course of this study suggest that parents (usually but not always mothers) found benefit from accessing services, whether this was attending groups themselves, having a child-care place provided, outreach help or a combination of such services. The service users thus accessed a range of early education and child care services for their children as well as groups for themselves. Similar outcomes were reported in both Highland and Dundee City and related to children's social, emotional and educational development, parents' own needs for leisure or training, and the value of support workers in providing information about or access to services.

How children were perceived to benefit

7.3 Mothers, and occasionally fathers, felt that nurseries or other group based child centred activities fostered independence, learning how to function within a group, taking turns and sharing. The more structured environment of such services was also perceived as helping with transitions to pre-school or school, supporting early educational development as well familiarity with a more structured day, although more informal environments were also appreciated.

7.4 Below are some examples from Highland service users

> *"role play, poetry, colour table, oral hygiene, story time, nature themes like autumn leaves, lots of physical stuff-she's tired out when she comes home, play-do, writing her name, using the computer"*

"she is more self-confident now"

"...has come on so much, she has better social skills and has learnt to control her temper"

"contact with other kids her own age,"

"...has poor concentration but she has really come on well. She is aware of rules, tidying up after play, persevering with tasks. She has help from the speech therapist and communicates so much better now."

"she does role play at home- playing school- things like changing shoes, hanging up coats- preparing for school"

7.5 And some examples from Dundee City Service Users

"I think more than anything it is just learning to play with other children, getting on in a group. Working out that they have to share things. Nursery made a big difference. I went to mother and toddler but the structured system in a nursery was ideal. ... it was excellent preparation for going to school. My youngest one just started primary one and on her first day at school with her, she was absolutely horrified to think I was going to school with her. She kept on saying but I can go myself"

"They do things like posting letters, I remember that. It is very good that they did little projects on things, maybe on butterflies or things like that."

"The fact that they were at nursery and a wee bell was rung, they knew that they then tidied up what they were doing after and everything. This was excellent…"

"Very important for when they go to school. So that they have got a basic discipline of being able to sit in a class."

"Again I think a local nursery [is good]…the majority of children that are in her class, they were all at nursery together. They are all moving together and I think that makes such a difference. Gives them more confidence".

7.6 The social and emotional development of the child seemed to be prioritised here, whatever the reason for the service use in the first place (SEN child, young mother or whatever). Parents (usually mothers) said that they could see a change in their child, so seemed to judge the service's effectiveness on that basis. They could compare their child's behaviour over time and monitor beneficial changes. The desired changes relate to culturally and educationally accepted norms of behaviour for young children: sharing, communicating with others, playing, concentrating and developing confidence. Getting tired was also viewed positively, and impacted on the child's behaviour at home. The respondents also would use the fact that their children had begun to 'play' at home as an example of the benefit the nursery or other group provision was having. On the whole, these seemed to be more important indicators than educational outcomes, although preparedness for school was sometimes mentioned.

7.7 Quality issues seemed to be defined in terms of the friendliness of the staff and how they were with the children, as well as the actual resources provided. The range of resources available in terms of play were identified as good as well as the quality of staff, although some facilities might not be ideal in terms of space available.

> *"Oh yes, they are really great with the kids" (Highland service user)*

> *"It's a happy place, you know that just going through the door?" (Dundee parent)*

7.8 Concerns about young staff suggested quality might be perceived as compromised in some situations:

> *"I'm not having a school leaver practicing on my child (parent). You go in and see these young girls…well it doesn't fill you with confidence" (parent).*

7.9 However, it is important to note that mothers were aware of the needs of their own individual child, and that services had to be tailored to meet these. This sometimes required some negotiation with service providers or advocacy from a support worker. Two examples from the Highland data illustrate this:

> *"I thought there was a choice about how many days you could go. We were offered 5 sessions, but I only wanted 4. By the time we walk there and back she is tired by the end of the week. So I just take her off one day a week if I need to, but I'm worried it affects her attendance record."*

> *"The play leader was not at all sympathetic to …'s needs. …was not fully toilet trained and one day when my younger son was still a new baby, I got a phone call telling me to come and change …'s nappy. I had to put the baby in the car and drive 4 miles there, come home again, and then go back at the end to fetch him home. I was so upset. The community paediatrician was very supportive but they issued a statement saying she didn't have to change his nappy."*

7.10 Affordability was a factor for some parents, in both Highland and Dundee. In Dundee it was reported as a significant impediment to choice for young and lone parents. In Dundee, young parents wanted one half day free childcare each week to allow them to train or take up an activity. They thought the needs of mothers, especially those with very young babies or who are breastfeeding, should be accommodated. The ability to visit at any time or to pick up children early was also thought to be important. All private providers interviewed said that open access was available. Local authority nurseries were perceived as too inflexible in this regard. One parent said:

> *"My sister had to wait outside [a local authority provider] till it opened at 8.45 and you had to be there at 3.15."*

7.11 Services have to work with diverse needs and also within specific local contexts. For example, in a focus group conducted in a small rural town in Highland, issues relating to distance from a service were raised as well as the very limited availability of childminders. Local bus times may not coincide with the service's hours and a long walk might be fine if it

is not raining. Most parents seemed prepared to walk or drive considerable distances to make use of a service that they saw as benefiting their child.

Family relationships

7.12 In a community where parents may have no extended family, as was the case with some of the service users in this Highland community, the early years' services can begin to fill that gap. But in doing so, they have to balance formality and informality in terms of provision for children as well as for parents directly (through advice, advocacy, help in the home). Isolation was noted by a few in the Highland case study, compounding the effects of postnatal depression for example *"We don't have any family here so there was no-one to turn to" (Highland user).*

7.13 In Dundee we found a different picture, where extended family were a strong resource for parents. The challenge for services here is rather different: to provide for children in the context of strong informal networks. In the course of interviews in Dundee City it became evident that grandparents fulfil a number of childcare roles; some informal and others more formalised. Information is, of course, anecdotal, but service providers made the following observations:

> *"Grandparents are often the ones collecting children from nursery and we assume they will often be providing care for the rest of the day" (educational provider).*
>
> *"You only have to stand in the Wellgate [Shopping Centre] for half an hour you'll see lots of grannies and their weans." (planner)*

Service for grandparents are currently being considered by the EYCCT:

> *"We would like to encourage relatives to become registered childminders because parents using these can then access tax credits and because if they are registered childminders we can support them better. Also some areas of the city have no childminders so recruiting people who are already doing the job informally seems like a good place to start" (educational planner).*

In some communities grandparents and extended families play a fuller role in childcare:

> *"I would guess that grans will be more involved in communities where economic prosperity is challenged- but we haven't really got data to support this. (planner) Furthermore, we hear for example from providers who tell us that parents seek information about services in order to make Childcare Credit claims but then never appear to take up the service." (educational planner)*

7.14 The department of Social Work use grandparents in a more formal role in childcare Grandparents often provide alternative care for children who cannot remain in the care of their own parents for whatever reason. Dundee's Social Work Department place children within the care of extended family as a first option. This does not always require formal action or care proceedings through the Children's Hearing, as the approach adopted is underpinned by the 1995 Children (Scotland) Act's principle of minimal intervention.

"The reasons for supporting children to stay with their grandparents can be as much about promoting contact with their parents, as about ensuring that they are looked after appropriately and with the minimum disruption to their lives. However this contact can sometimes be difficult for grandparents to manage, especially when the concerns about the parents' care of their children relate to issues involving drug or alcohol abuse (a significant problem in Dundee) mental health problems or learning disabilities, child abuse, domestic violence etc. In such circumstances and especially where the plan is for the child to return to his or her parents, families often require ongoing support." (social work planner)

7.15 Child and Family Centres provide some respite care for grandparents, but also supervised contact and a range of other support services through PALS or Feelgood groups.

7.16 While there are no particular events specifically geared to grandparents the Pre-School Home Visiting Team have had requests to arrange information workshops for extended families involved with children on the autistic spectrum and are generally welcomed into parenting groups. We did not interview any for this study, although this could be an area for future research.

7.17 Parents also reported how their family relationships could be improved by services, whether this was their relationship with their child or their partner, suggested wider benefits were perceived and valued:

"Once I've got time to recharge my batteries I've got more time to spend on her. More time to play with her and stuff. It is really good. It helps both of us out. C gets time away from me and I get time away from her" (Dundee mother) .

"Let's just say it has worked well. My husband and I are getting on so much better" (Highland mother) .

"It (parenting course) has literally saved my marriage" (Highland parent).

"It (parents' group) helps you be more open with the kids as well" (Dundee mother).

How mothers/parents were perceived to benefit

7.18 Early years' policies link with other policies aimed at alleviating poverty through work and training, which may directly benefit parents and provide indirect benefit to children. Some of our respondents were at work and some were not; a few commented that services should be readily accessible to parents whether they work or not. Positive outcomes for parents are likely to in terms of increased self-esteem and improved relationships (as noted above). Direct interventions for parents (such as parenting programmes) are also likely to have a direct influence on child health and well-being, and we have some examples of this from the Tayside Breast Feeding Initiative. Service users discussed the ways in which early years services and associated groups or home based work benefited themselves as well as their children. They also made links between the felt benefit to themselves and to their children.

7.19 In the Highland case study we have evidence of the value of parenting courses and other types of groups, from one user's point of view:

> *"It was a Webster Stratton course run by the health visitor and school nurse in Room 22 (a family support facility in a secondary school). It was my health visitor who recommended I try it. I was desperate for anything that would help me cope with… (her son has ADHD which has since been diagnosed as Asperger's Syndrome). I didn't drive then so they organised a taxi and my wee girl got a place in a crèche. Meeting with the other parents was a hugely important part of the course. Listening to the others- their stories and experiences, they were dealing with the similar issues. Another mum had a child with ADHD. We shared so much in common and yet had felt so alone before we met. In the course we covered things like managing difficult behaviour, setting clear rules/boundaries, No means no, the power of positive praise, and more understanding of the child's perspective. I thought I was a positive parent, but this course taught me so much…….he (her son) is so much happier, more relaxed. He can still be trying, but he is not really naughty the way he used to be, for example, he still needs time out now then, but when it is over, we have a hug and get on with life, before he used to be in a foul mood for days. Both our Doctor and his teacher are amazed at the change in him. All because of this course. It's wonderful."*

7.20 Both the formal educational component of the course as well as the informal support it engendered amongst the group were valued by this respondent. She perceived change in her son's behaviour, drew on reports from others involved in his care to back up her perception.

7.21 From comments from the Tayside Breast Feeding Initiative we also see mothers benefiting from a specific service, even if this is supporting behaviour that is not necessarily culturally sanctioned as in this example:

> *"I have to go upstairs to breast feed when she (female relative) is there……I just decided I was going to do it and I did. It has been so worthwhile. It's so much easier than bottle feeding."*

This same respondent also commented how infrequently her baby got a cold; this confirmed for her that the benefits of breast feeding were what she had been told.

7.22 Other formal and informal groups were also experienced in a positive way, where meeting others, sharing experiences as well as learning new skills were all reported as positive outcomes, supporting parenting, self-esteem and confidence:

> *"Talking with the other mums, it's reassuring to hear that they have the same problems." (Highland mother, supported parent and toddler group)*

> *"When I saw the advert I thought that's for me, it has been great for the girls and for me. We're all just ordinary mums getting together for a blether. The staff are great and the facilities are really good. You get the chance to talk about 'twins issues' like potty training or sleep problems, you share experiences. , I think I really benefited from watching all the other twins and seeing what they were like. It's really fascinating. Also I made new friends and now, if we are up (to town) shopping, we usually bump into someone we know." (Highland parent)*

"Just feel happier in yourself. No worried about speaking to the kids about anything. You are on the same ground as them now. You know how they feel about things." (Dundee mother, parents' group)

7.23 A combination of reassurance gained from meeting others in similar circumstances, along side receiving some specific interventions seemed to be well received. However, group support does not always result in the formation of friendships and bonds outside the group, and a few respondents, although talking positively about the group they attended, did not report that they had made lasting friendships.

7.24 Other benefits were the learning of skills, or of having time away from children in the knowledge that they were being well looked after:

"Children are in the room next door to us, which is great because we know they are safe and looked after. We are next door and sit and have a chat and then we go upstairs and have our dancing or keep fit. It keeps us active and gives us time to ourselves" (Dundee: Very young mums' group)

7.25 In the Dundee City case study some of the mothers' interviewed described benefits to themselves. Many parents felt able to extend themselves after joining groups and activities. They became more confident and more able to try something new or make changes in their lives. One parent moved to a better job while others were able to train and feel they were not too old to learn .

7.26 Barriers to participation were also noted in the Dundee case study. The importance of having crèche facilities available to allow mothers to attend groups and activities was by far the most mentioned by facilitators, mothers and organisers alike. This was a particularly problem when encouraging mothers from ethnic communities to become involved in English classes or local groups where childcare difficulties were a barrier to take-up. Barriers in Highland were related more the distances and availability of services.

Home visits

7.27 As well as participating in group support, several of the parents also received individual home visiting support, reported in the Highland case study interviews. Home visiting support is provided to meet a wide range of needs and can be arranged through referrals, mostly from a health visitor, but also through social workers, GPs, CPNs, friends and family, as well as self referrals. Generally, a local area co-ordinator meets with the parents to discuss the issues or difficulties they are facing and the type of support that they would find helpful. They then meet again with a volunteer that the co-ordinator has 'matched' with the family. The types of support offered is also very varied ranging from household tasks, social contact and friendship to some one who is socially and perhaps physically isolated, a child sitter service to give respite for parents.

"I get home visits, 2 ladies (they take it in turns), come and look after my son, take him out for an hour or two, like today he was taken to a coffee morning and there were other children there for him to play with. Some days they stay indoors and play with him…….Because I'm a single parent he was with me all the time.

He was very clingy. Now he is much more self-confident. At the nursery he plays with other children his own age he has made lots of friends and gets asked to lots of birthday parties. Also because of my (illness) I can't do a lot of physical things with him so they try and help there too, they take him to the park." (Highland)

"I feel very isolated. Not just because we live some distance from anywhere, but also because we have no family near by. It can be very hard when my husband is working away. The home visiting has been a god-send." (Highland)

"I also get home visits. Someone comes out to the house and plays with the wee one and it gives me a break. I can wash my hair or have a sleep. After my partner and I split up I had the kids 24/7, I never got a break, never got nothing. I was stuck at home with no other family. I feel like I can cope a lot better now, I'm not on my own anymore. There is always someone on the end of a phone (not that I've needed to right), but they are there if you do. I can ask for help if anything bothers me." (Highland)

7.28 As noted earlier, the local family context is important here, with lack of extended family in the area being compensated for by home visiting for the most vulnerable. Interestingly, home visiting is also described as supporting the caring responsibilities some may have for older relatives, in this case an ill mother, suggesting that a community based approach focussing on individual families supports informal networks of support.

7.29 Others managed their children better. "*I don't shout at her as much now and she comes and sits by me now*". This was positive experience and as one parent said, "*felt I was a better mother*". Communication with children and families improved, generally parents felt happier with themselves.

Sustaining parental involvement

7.30 The following aspects were described as important in sustaining participation; we have more information on this from Dundee, perhaps relating to the different context within which services operated, with a stronger culture of female participation both in work and community life:

- Parents became increasingly self confident after joining activities. This made them more likely to try other things
- Development workers were important instigating involvement, providing information and expertise and broadening interest and scope –this was evident in Highland as well as Dundee.
- The timing of activities was crucial and had to fit with childcare arrangements and shift working. In Highland we had examples of other factors being relevant, such as other caring responsibilities or health related appointments
- Companionship was important for moving on to other things; groups could encourage this, but it did not always happen.
- Open access was important and allowed parents to move back and forth between activities.

Health professionals and development workers

7.31 The Dundee City case study highlighted the particular importance of health professionals (health visitors and development workers) in the context of locally accessible, universal services, and also of the felt importance of continuity. The reassurance that mothers had of seeing a health visitor regularly was expressed over and over again.

> *"I had the same health visitor since my eldest child was born. I have had the same health visitor all that time. She is fantastic. Anything that has ever worried me, I would phone her and if she could not come up, she would phone you. She was fantastic." (Dundee parent)*

7.32 Continuity was important for sustaining contact, lessening concern among mothers but also facilitating positive relationships in their children towards health care and other health professionals.

> *"Have 2 or 3 friends who have had a lot of different health visitors, changed every 3 or 4 months. And they have not kept up seeing their health visitor because they said there wasn't any point because they did not know their kids. My health visitor knows my children and they see her in the shops and everything. And they are not frightened to go and have their screenings and that because they know the person. It makes such a difference to the kids." (Dundee parent)*

7.33 Health visitors and development workers were often key to providing information about or access to services:

> *"The midwives and health visitor have given me lots of information too" (mother Highland)*

> *"It was my health visitor who recommended I try it. The school nurse might also have mentioned it too. I was desperate for anything that would help me cope with" (mother, Highland)*

7.34 Finding out information on a range of issues was important to parents. Finding out about employers responsibilities to breastfeeding mothers was the most important thing that three mothers mentioned when joining a group.

> *"I would never have known about what employers responsibilities were had I not joined the group (Breast Feeding Initiative) I had made arrangements about working in the evening after I had my baby, but if I'd know about this maybe I wouldn't have done that. When I took the leaflet to my boss, I think they were a bit shocked at first at what was required. But they were fine about it. They got everything, a fridge, a room and everything." (Dundee mothers, Breast Feeding Initiative)*

7.35 These data, although limited, give a sense of the perceived benefits of a range of early years' services. The experiences of service users, as reported here, suggest a range of short term benefits that could be measure more systemically. In relation to the well-being of the child, the parents noted positive changes in behaviour across a range of areas, both at home and elsewhere. Sometimes their views were reported as being corroborated by others in

contact with the child. The parents also reported wider benefits in terms of family relationships, which in themselves could impact on their child. Indicators focussing on these impacts could be used on a wider sample of service users. Parents' reported benefits to themselves, in terms of parenting and other skills, opportunities for a break and leisure, and seemed to value both group and individual support. Although we do not have much data on wider community level benefit, if groups develop and extend their activities into other community initiatives then impacts at this level might also be seen. There was some limited evidence of that in our case study.

7.36 Although the two case study areas were very different and the small sample of users whom we interviewed make any resolute conclusions inappropriate, there was remarkable similarity in the ways users' perceived and conceptualised benefit, suggesting that the search for universally applicable indicators, especially if measuring short term impact, may be possible.

EVALUATION ISSUES FROM THE SERVICE PROVIDERS' PERSPECTIVE

7.37 The inclusion of service users' views is crucial to any formal evaluation of early years' policies and services, and consultation strategies form part of the rolling out of children's services. Informal feedback from service users and observations by service providers also contribute to informal assessments of effectiveness. The challenge to those concerned with monitoring and evaluation is to systematise such feedback without losing the informal processes that are essential to providing a responsive, dynamic service. The case studies revealed concerns about measuring effectiveness that must be addressed if service providers are to feel included and empowered by evaluation processes. Each case study is addressed in turn.

Highland case study

7.38 In Highland 'evaluations' vary from feedback forms at the end of a staff development course through to independent researchers monitoring and evaluating service planning and delivery across Highland. There are numerous examples of both this internal form of evaluation of a service or course as well as more independent external assessments.

7.39 The early education sector is regulated by quality assurance standards, enforced by the Care Commission through regular inspections. HMI also undertake regular inspections with a focus on curriculum. Pre-school education services are more heavily scrutinised than either the primary or secondary sectors. They are supported by the early education workforce at pan-Highland and Area level in meeting these standards and in preparing for inspection. The Care Commission also carries out regular inspections of the childcare sector and centres are supported by the Childcare and Family Resource Officers at a pan-Highland and an Area level in meeting the standards.

7.40 Voluntary agencies each have their own internal system of monitoring their service. Service Level Agreements require a regular system of reporting to be in place. They collect data about the children and families receiving their service, the type of work carried out with each child or family, time spent with children or families etc. This may be reported monthly, quarterly, 6 monthly or annually.

7.41 In some cases funding requires an external evaluation conducted by independent researchers. The local authority has employed individual consultants and organisations to evaluate aspects of their work.

External evaluations

7.42 Some comments suggest the importance of integrating evaluation into service planning and delivery, so that the workforce can directly benefit from evaluations.

> *"NCH were evaluated by CAF but we never received a final report, we commented on a draft, the staff involved ask me about it but we feel unable to action the findings."*

> *"University of Highlands and Islands has been commissioned to evaluate the Joined Up Agenda. A range of threads are to be evaluated including the rollout of NCSA, including more integrated ways of working, including multidisciplinary teams,-Youth Justice and so on. It is at an early stage as yet, but 2 researchers are working out of Edinburgh University. It will be an iterative kind of process, when they uncover examples of good practice they will reflect it back and give the opportunity to change tack."*

> *"The Play at Home Programme is being evaluated by C.A.F, Strathclyde University. I do my own sort of monitoring through feedback from health visitors."*

Internal

7.43 Internal monitoring and evaluation is often part of the service provided, with reviews or regular feedback. This is likely to vary from service to service.

> *"We have 5 year plans and in these we have to demonstrate that we are working towards aims, meeting objectives. We also have bi-monthly and 6 monthly reports."*

> *"The person doing the baby massage instructor training asks for detailed feedback when people have done the course. The first tranche of those completed is in and we have analysed them, it will be put into a report. And it will help inform how and if we will do further training."*

> *"We get feedback during our support visits of what staff courses they have been on, courses they like, courses they might like for the future."*

> *"My responsibility is to listen to everybody, through questionnaires, through the evaluations, any way we can gather information."*

Needs Assessment

7.44 Needs assessment reports from the local authority or health services were not offered as evidence of the planning and delivery of services in Highland. Rather 'For Highlands Children' is seen as the document detailing children's services plans. However that does not mean that parents and communities have not been involved in identifying need:

> *"At the beginning of my work (nearly 4 years ago), we questionnaired widely contacting parents using the school bag for delivery. Since then we have done more targeted questionnaires (at specific groups/communities). We are aware of current gaps in provision. We work with parents in identifying what services are needed: through people contacting myself or through school boards." (Area Development Officer)*

> *"I would question the value of questionnaires alone for measuring demand for services because you can get an inflated and under statement of actual demand. It is only when the provision becomes more tangible that people commit to being involved.*

> *"When someone approaches me to ask for a service development, the process is: to talk with them about what they want. Meet with representatives from the community, the school and interested parents. To send out a questionnaire via the school. To talk to relevant voluntary agencies. To report back to the community via a public meeting. To set up a steering group of parents. To put an application for funding together. If it is successful, to go back to the community through school bag to set up a committee and to appoint a board of directors. Collaboration with statutory and voluntary or private agencies and parents is essential at every step."*

Dundee City case study

Assessing effectiveness

7.45 Service providers measured the effectiveness of their service by the responses they got from parents. This often confirmed more formal mechanism of feedback.

> *"People ask us if they can come back. Parents drop in and say hello. Parents let us keep visiting them. Send card to the staff and telephone us. They say they feel comfortable with us." (service provider)*

This was confirmed by parents who said they went back to groups because that is where it all began for them and to show to themselves how far they had come. Service providers stated also that they were not so much preparing women for training as increasing their confidence to allow them to do what ever they wanted to do. This was confirmed in interviews. Some parents were involved in formal training but by far the main reason parents changed aspects of their lives came from a stronger belief in themselves and an increasing sense of worth.

Indicators

7.46 Waiting lists were not viewed as useful indicators. Some services did not operate waiting lists because they wanted to capture the motivation of individuals who wished to change (e.g. Drug & Alcohol services). Furthermore

> *"...It is very difficult to tell. If you produce a good service, then you will have waiting list because people want to access it. So waiting lists are not a good indicator of effectiveness." (service provider)*

7.47 For some services being in treatment was better than not. So that in itself is an achievement and measure of effectiveness. *"If people are in treatment, they tend to be better in treatment than not"*. Cutting the numbers of children on CP register is not necessarily a measure of effectiveness. "*Perhaps it would be more effective to take children into car*e". This was a common response among those who dealt with families with complex needs. How to measure untapped need was a concern also. Health visitors and early intervention workers have increased the number of vulnerable children and families being identified at an earlier age and coming forward.

Evaluation

Agency Level

7.48 Databases across agencies were not compatible. Some progress has been achieved in this area in development planning where databases were amended. Concerns still remain, however.

> *"[We] Need standardised data sets to make equitable comparisons across the population of Scotland. Don't have that. Some are being developed. Problems is datasets are all different. ISD is looking to co-ordinating them now. The way that data was fed in from different health boards was slightly different and they way they collected it. In some areas it was post coded populations and in others it was done differently. So that we can make comparisons and improvements. "*

7.49 Baseline data was collected by health and education [psychological services] and structured evaluation profiles were in place for children. Nursery schools were required to developed weekly, monthly and yearly plans for measuring progress of the service and of individual children. Transition records were completed and passed to primary schools.

7.50 Health measures and initiatives were criticised for their wrong emphasis:

> *"More importance should be placed on changing attitudes to sustain changes in behaviour rather than count the numbers breastfeeding...it is easy to boost numbers at the beginning of a project, but how do you change attitudes.. This was echoed by other service managers."(service manager)*

Service Level

7.51 External evaluation was conducted by education, health and Social Work. Parenting programmes and Children's Development Programmes were externally evaluated. There is structured integrated assessment of SEN children in integrated settings. The Childcare Information Helpline evaluates calls.

7.52 However, evaluation came far down the list of priorities when responding to bids on tight time frames or on tight budgets. On a major rationalisation of service one senior manager explained that "*We are still discussing resources for evaluation".*

7.53 For others, speed in the bidding process meant that:

> *"...Evaluation is not always built into projects. Depends on what questions you ask. If you ask people if they like coming here. They will say yes because they don't want to offend you. You're looking at robust evaluation that asks the right questions and gets the right responses and not did you like it or not."*

7.54 Some organisations had amended guidelines and developed more concrete measurable parameters for initiatives. [47] One provider had amended national guidelines to develop robust and tangible measures that would benefit a child. These included:

- school attendance,
- nursery attendance,
- Centre attendance,
- contact with a significant adult around,
- involved in peer group activity,
- level of emotional well being.

> *"It has been shown that if you put these in place for children they are better able to cope with whatever is happening for them So whatever the outcome of the work here, children hopefully will benefit."*

7.55 Another suggestion came from a health professional:

> *"One way could be by taking randomised life stories. Although that is dialogue. You could tie that into satisfaction studies and statistics around that."*

Community Level

7.56 There were a lot of locally based surveys and questionnaires for individual groups. These were developed by individual project co-ordinators, nursery head teachers and development workers or child and family centre managers. All agreed that evaluation was important, however, evaluation was not standardised across agencies. Those interviewed found difficulty when addressing long-term aims particularly in public health and education.

[47] The Drug & Alcohol Framework from Aberlour uses six domains to map the resilience of children.

CONCLUSION

7.57 Across both Highland and Dundee City, it would seem that a range of monitoring and evaluation is being carried out, although often these relate to individual services or including feedback from individual families. Although some consideration of medium to long term effectiveness is being made and tied into planning, evaluation tends to focus on rather shorter term goals or identifying areas for service development or enhancing delivery. Parents are clearly involved in such monitoring and evaluation efforts through surveys and individual assessments.

CHAPTER EIGHT CONCLUSION

INTRODUCTION

8.1 We broadly adopted a theory of change approach to this evaluation, along with a consideration of specific indicators available from national data sources. The theory of change approach helps evaluators to address complex interventions by focusing on processes and systems. It explores the relationship between context, activities and outcomes. Early years' policies should be considered complex interventions: They have broad and multiple objectives, cut across sectors, and allow for local diversity in implementation. Accounts of key stakeholders can be understood as attempts to link developments to specific policy objectives – for example in terms of integration of children's services in the early years.

8.2 This approach demands detailed descriptive understanding of strategic and operational processes and objectives in order to make analytical and interpretive evaluations as to the effectiveness of change. However, we have only been able to take the theory of change approach to its first stages, as the processes under investigation are themselves fairly new and the intermediate and longer term policy objectives are yet to be identified locally and embedded in planning, delivery and outcome evaluation at community, institutional, family and individual levels. The case studies were able to focus on the initial activities (which have been rapid and numerous) and issues relation to attempts to assess effectiveness at the early stages.

8.3 The data from the two case studies comprised detailed review of service provision and development using local documents and a specially developed service template; interviews with key stakeholders, a range of service providers, a range of service users, attendance at various meetings and service visits. The two case study areas were contrasting both in terms of geography, socio-demographic profile and historical context of service provision prior to 1999. The nature of the investigation within each area was also determined by that context, so although the broad parameters of the fieldwork approach were the same, the resultant data reflected local organisational structures so are not strictly comparable. The rich description obtained provides a first stage for evaluation, where issues of system capacity (organisational change, service delivery) and impact on families and communities

SYSTEM CAPACITY

8.4 Both Highland and Dundee can be considered 'success' stories in managing nationally driven but locally enacted early years' policies. Starting from very different levels of existing provision and using different approaches to change (incremental in Dundee and comprehensive in Highland), both areas, in a short time frame, have increased capacity in provision and created organisation structures to promote integration and collaboration at both planning and service delivery level.

Evidence of the expansion of system capacity

8.5 Increase in overall provision which combines universal services (such as pre-school education which has been the largest area of expansion) with provision to meet the needs of minorities (for example Gaelic medium provision in Highland) and of vulnerable groups (for

example children with special educational needs, the needs of very young mothers). The extent to which services are now able to meet the needs of vulnerable groups cannot be thoroughly assessed. Although there has been an expansion of provision, evidence of a reduction of time from referral to assessment and a range of services from groups to home visits, it is likely that unmet need remains and further development will be required to reach such groups. The service template we used could be developed to enable more systematic mapping of services; however, this would required an additional study to develop and pilot the framework.

8.6 From the case study fieldwork, we found an enormous energy and commitment to developing provision to meet the new early years' agenda. The tone of the service providers' accounts were very optimistic. Much has been achieved in a short space of time and national policies and funding streams seem to have released energy and imagination at local level. Although the relationship between such developments and specific outcomes for children, families and communities remains to be thoroughly explored, in terms of system capacity, rapid and enthusiastic development of diverse services certainly marks the implementation of early years' policies. Of course, difficulties and barriers remain (for example, retention of staff in rural areas, aspects of joint working), but the workforces in both areas seemed committed to integration and collaboration and the provision of high quality services that would make a difference in people's lives. Staff training, often of a collaborative nature, was also being put in place.

8.7 The tension between universal and targeted provision identified in the Sure Start Mapping Exercise (2002) had been moderated by the approaches taken within these case study areas. A more complex picture emerged of the relationship between targeted and universal provision. A commitment to provided increasingly targeted provision within a context of a universal service was present in both areas, and a distinction made between universal provision and universal access. Universal access to services, even if they are aimed at meeting the needs of particularly vulnerable groups was described as one way of removing the stigma of accessing targeted services, especially if they were social work based. A categorical approach to identifying vulnerable groups cannot be taken, and staff worked with a sense of diversity and change amongst families. Vulnerable families are thought to derive benefit from universal services, and both areas used funding streams as a way of supporting an imaginative mix of services on a universal/targeted continuum.

8.8 Changes in organisational structures to promote integration and collaboration. In Highland this is involving four phases of development moving to increased integration, with a jointly funded post of Head of Children, Young People and Families for strategic leadership. This is operationalised through the Childcare and Early Education Service, with Area Officers providing strategic lead at local level through the Area Children's Services Forum. In Dundee this involved the setting up of the Dundee Early Years and Childcare Partnership and a Strategic Planning Group, suggested a more centralised integrated planning process. At local level, co-located centres are a feature of collaborative service delivery, where education and social work services are delivered from the same facility. Other collaborative services have also been developed such as Sure Start Health Visitors. Existing structures were felt to be already meeting the challenge of integrating services. Again in both areas challenges and barriers to collaboration and integration were identified – different philosophies of different agencies, different areas of responsibility and different definitions of vulnerability were all mentioned. However, in their different ways, both areas were taking integration and collaboration seriously.

8.9 Few interviewees spoke explicitly about early years' policy objectives, although those wide objectives clearly underpinned approaches to service development. A strong sense that such services did bring benefit to young children and their families was evident, but services did not seen to develop with specific outcomes in mind. In other words, they were not criterion based in their approach. Clearly, more emphasis on monitoring and evaluation at local and national level will help with measuring impact and outcome. This current study again reveals the complexity of that task, given the diversity of provision, the broadness of the policy objectives and the lack of defined indicators which meaningfully measure impact.

SERVICE USERS' VIEWS

8.10 Our small sample of service users' views provides illustrative material that can help in the development of further indicators, especially for measuring short and medium term impact. The data suggest that:

1. It is important to consider impacts on child, parent and wider family and community. By this we mean that each family exists within a social network, that includes both formal and informal relationships.
2. Parents were particularly well able to identify short term change in their child's behaviour as well as in themselves. Subjective indicators of such changes, along with self-perceived changes in levels of confidence and self-esteem could prove useful for future attempts to measure short and medium term impact
3. Parents sometimes reported how others had perceived changes in their children, suggested that a robust evaluation could include a degree of triangulation of results, with service providers, such as teachers, also providing an assessment of change in the child.
4. Parents, on the whole, seemed more concerned with the development of social skills in their children than educational attainment, although preparedness for school was also mentioned. Again, such subjective measures might be important in estimating the impact of early years' support.
5. Health visitors and development workers seemed to be important in providing information on and access to services, and an evaluation of their developing role might form the basis of a separate future study. Service users in this study did not talk about integrated services or collaboration between agencies. This could suggest seamless delivery, but further investigation is required.

THE INDICATOR STUDY

8.11 One way in which we have been able to consider effectiveness of the first few years of early years policies has been to measure change from 1998 to 2002 across a range of agreed and available indicators. These indicators are broad and were not in themselves likely to be sensitive to the changes in outcomes that might be experienced by those receiving early years' services, whether a parent or child. In addition, for some areas, such as system capacity or organisational change, no indicators were available in existing datasets. The data from service users provides a contrast to the evidence from the indicator study. The latter is suggestive of small degrees of change across narrow indicators, except in the area of service expansion.

8.12 Twenty-nine indicators were considered although the data were not considered robust enough for analysis for all of them. It is important that data can be broken down by at least deprivation and by rural/urban dimensions in order to ascertain whether targeted groups are being particularly well served. The results of the indicator study are, on the whole, disappointing in terms of what they can tell us about the effectiveness of early years' policies. This is not a surprise, given that early years' policies are recent, need time to bed in and develop, are unlikely to be associated with clear and rapid change in broad indicators of health, social and emotional development or education. However, small change in a positive direction was identified for some indicators and more importantly there was some evidence that the greatest change had taken place amongst the most deprived categories. As noted in the feasibility study that preceded this report, it is impossible to attribute causality here. The indicators that suggest such positive change are: primary immunisation rates and numbers of babies being at least partially breast fed at 6-8 weeks. Both of these suggest that early health related interventions might be having some effect, especially an enhanced health visitor role. Breastfeeding initiatives, for example, are one of the developments associated with early years' interventions. However, this trend is not identified in the data on dental caries or low birth weight, both of which might be expected to improve as a result of the integration of services across sectors for both children and mothers. However, there appears to have been some improvement in maternal smoking.

8.13 There has been a dramatic increase in the proportion of three year old children receiving pre-school education and a smaller rise among those aged 4 –5 (from a higher baseline in 1998); such intervention is the backbone of early years' policies and our case study research reinforces the efforts that the local authorities have made to increase their pre-school provision. The data also suggest that provision is higher in more deprived areas. Although overall numbers are small, the proportion of children attending family centres (that may also be providing services for mothers/parents) have increased; attendance varies in relation to type of area people live in, with those in deprived areas being more likely to attend than those in less deprived areas. Those in the most deprived areas were also more likely to access a wider range of services in family centres. There has also been a notable increase in staff numbers and improvements in child/staff ratios.

8.14 In chapter 3 we made recommendations about the use of indicators and the need to have in place a robust set of indicators and reporting mechanisms that are consistent and fit for purpose. Current reviews of the CHSP-PS may result in improvements in this area as would the commissioning of a longitudinal study with additional cross-sectional surveys.

8.15 Similar concerns about the value and consistency of monitoring and evaluation processes were identified in the case studies.

CONCLUSION

8.16 Without a doubt, Early Years policies have resulted in considerable change in the planning and delivery of services. In Highland this change has been intensive and rapid, suggesting a maximalist approach to change, driven by policy objectives, funding streams and historical context. The picture of early education and childcare and family support is very different today compared with the mid 90's. In Dundee, the changes have also been substantial within a context of restructuring that has been incremental rather than maximalist.

Most integration in Dundee occurs at planning level, whereas in Highland, devolved management at area level has resulted in more vertical integration.

8.17 In Highland a huge amount of energy has gone into developing the policy framework; into restructuring and into creating children and family specific workforces. This is only now coming to fruition across the whole of Highland. The full success of their vision will only become apparent over the next few months and years. Only once the redefinition of the community nurse's role and the NHS Highland restructuring of Community Health Partnerships have bedded in will all the pieces of the jigsaw be in place. A jigsaw is a useful analogy because in their creative efforts to integrate services, the links have been forged across geographies, across agencies, across services, both horizontally and vertically. In an ever-changing policy framework, one can only speculate on how the way in which agencies organise their services around 'Joint Futures' will impact on children's services.

8.18 In Dundee, a central planning structure has been modified through the new Strategic Planning Group, alongside the development of a more integrated approach through new posts, synchronised funding periods and joint bids. In both areas there is no doubt that, whatever the agency structure or degree of integration and collaboration, there has been a rapid expansion in system capacity and range of early years provision.

8.19 Key stakeholders accept the value of an integrated approach and are trying to put this vision into practice. From the case studies it would seem that this is currently most effective at the top planning level (through new planning groups and structures) and at service delivery level (through joint bids/projects and good co-operation across staff and sectors), but that more can be done at the middle management/operational level. Another significant barrier to developing effective services is staffing, where high turnover or difficulties in recruitment are likely to affect quality of service, joint working practices, morale and workload. These system issues could be more closely monitored as a possible dimension of effectiveness, but also demand specific attention in terms of training, pay and job satisfaction in order to ensure that expanded capacity is indeed achieved consistently across areas and over time. Short term funding can also limit the development of services.

MEETING POLICY OBJECTIVES

8.20 In terms of the broad policy objectives of the early years' policies, our case studies have identified activities and impacts across all of them.

To improve children's health

8.21 There are examples of initiatives across early education and childcare and family support provisions, such as Sure Start Health visitors (Dundee) and Health Development Officer (Highland). The indicator study suggested small improvements in levels of breast feeding and maternal smoking during pregnancy, but not in other health related indicators. The service users in the study did not report on specific health related changes in their children (with the exception of some breast feeding mothers); although specific support services did sometimes improve maternal mental health. It is likely that broader measures of child well-being (such as sleeping behaviour, concentration levels etc) will more accurately represent parents' concerns.

To improve children's social and emotional development

8.22 A range of services have been developed which meet this aim – from centre based and outreach work as well as pre-school nursery provision. The indicator study gives evidence of a marked increase in the numbers of children attending family centres as well as the number of staff in pre-school education. Soft indicators of improvements in children's social and educational well-being were reported by parents, suggesting the short term benefits are quickly perceived and felt. These in turn improve wider relationships

To improve children's ability to learn

8.23 The expansion of pre-school education is the clearest example of rapid change. There is not specific evidence to support improvement in children's ability to learn, but this is likely to be the case where such a universal service is provided. Related support services may help in terms of 'school readiness' and the service users certainly considered aspects of improvements in their children's behaviour as important in this respect. Learning to play was considered as important as ability to learn and should feature as an indicator in any future evaluation

To strengthen families and communities

8.24 The range of centre and outreach services, especially groups and initiatives that involve parents in shaping and delivering services (support parent and toddler groups for example) could all be considered to strengthen families and communities. Our qualitative evidence for this is limited: some parents had derived great benefit from group support and became involved in their communities; families were strengthened through improved relationships; services developed taking family context into account (presence or absence of extended family for example). The indicator study can only be suggestive here through measures of increased capacity. Further evaluations could include measures of family functioning and community involvement (paid and unpaid work and care)

To reduce barriers to unemployment especially for lone parents and to reduce number of children living in workless households

8.25 Expansion of childcare and education services can help support parents into and in employment, although wider economic trends continue to define accessibility of labour markets. We had some limited evidence that paid work outside the home was not necessarily the best option for all parents with young children, and provision should allow real choices for parents about whether or not work would improve their situation and parenting capacity.

MEASURING IMPACT AND EFFECTIVENESS

8.26 When early years' policies were introduced there appears to have been little foresight about the collection of baseline data to measure the change that would ensue. To have comparable data across Councils there would need to be a database which would count different types of provision, centres of provision, capacity in terms of places and uptake in

terms of service users. There may be scope to then link this information to a data set compiling information with regard to local outcome agreements. Detailed work on outcomes and indicators for the range of children's services is currently underway with the aim of issuing revised guidance on Children's services Plans by June this year.

8.27 Although we identified local internal and external evaluation studies, further work is needed to establish mechanisms for defining and measuring outcomes. Additionally training in evaluation techniques need to be rolled out to include service providers who are currently trying to incorporate feedback into their own working practices around service delivery.

8.28 Integrating funding streams is one indicator of the success of joint planning. However, it also means that is has become difficult to link particular funding streams with particular interventions or outcomes. Accountability is now driven by function not funding as integration may lead to blurring of professional boundaries, changing the skill mix of the workforce or creating new integrated posts.

8.29 The Sure Start Mapping exercise highlighted a perceived tension between universal and targeted services. In both case study areas, targeting within universal provision was being attained. We saw more complex organisation of services, where the distinction between universal and targeted became more blurred. In Highland, the triangle of tariff approach required a range of service provision with a broad base of universal provision, with a preventive role. There were then increasing services up to the point of the triangle. Targeted services, in either case study area, could be delivered from within a universal service, although they can also be delivered as a targeted service. Universal access to targeted services is one way of overcoming the tensions between separating targeted and universal provision yet still meeting the needs of the most vulnerable families. Some services are regarded as most appropriate for general delivery and some for targeted delivery a judgement based on cost as well as appropriateness. We saw this same tension in the two case study areas with a common view being that the best approach is a universal one, with targeted provision being best achieved through a universal service. It would seem this allows maximum flexibility, is less likely to be stigmatising and more likely to be inclusive in terms of meeting the needs of diverse groups.

RECOMMENDATIONS

8.30 The case studies highlighted certain issues that could be developed into indicators relevant to the evaluation of early years that can still take into account local variation in organisation and delivery.

8.31 We suggest that some standardised template is used by service providers in order to provide relevant information on service provision; service use; where on the continuum of universal/targeted the services lies; who is served; nature of the workforce (extent of joint working). Our preliminary attempt to use such a template would suggest that more development work needs to be done to make this a robust method and we recommend that further development work on the tool is conducted.

8.32 As we noted in the feasibility study, the transition record may provide a useful intermediate measure relating to children's social, emotional and educational development. Clearly a standardised set of measures is required for these dimensions for all children. It is

important that these also take into account the parent's perspective as they are often able to judge short term behavioural change, so indicators could be developed to tie into service use and employed at intervals during and after an intervention.

8.33 Involvement in training, work or other formal and informal activities could also provide a measure of success of some of the parent centred interventions. We had limited evidence from our qualitative work, but would also recommend that measures of parental self-esteem, self-reported change in parenting behaviour, self-reported change in relationships, self-confidence and community involvement.

8.34 System capacity could be mapped through the use of the templates above at strategic level to identify structures and planning processes. The provision and uptake of joint training, the provision for joint posts and the extent of joint bids could all be used as measures of degree of implementation irrespective of local authority structures.

8.35 However, all providers spoke of the limits of hard measures and any programme of evaluation should incorporate the perceptions of those working on the ground and the clients they do or hope to serve.

8.36 Mapping service development, provision and use across all local authorities would be a long task. It would, however, provide a detailed picture of the implementation of early years' policies across the country. Geographical information systems could be used to analyse this information and present it in an accessible format. Service use needs to be monitored locally, with nationally defined, but locally agreed, criteria. Future research could support the creation of a monitoring and evaluation framework to meet local and national needs, and support training in evaluation at local level.

APPENDIX 1 CASE STUDY METHODOLOGY

A1.1 The case study methodology appendix describes its design, the development and administration of the data collection instruments, negotiation of access to data sources, sample description and data analysis. The methodology of the indicator study is presented in chapter 3.

A1.2 The rationale for a case study approach was outlined in chapter 1. This particular case study aimed to complement the indicator study with evidence where the data from the indicators was weak or incomplete. It was also intended to produce evidence of the direct experience of a service providers and users, evidence about how objectives on social and emotional well-being, health and education are being met, evidence of how local contexts and institutional frameworks shape the implementation of these policies, and the perceived impact of early years' policies from the perspectives of both service providers and users.

METHODOLOGICAL ASPECTS OF A THEORY OF CHANGE APPROACH

A1.3 A theory of change approach has informed this evaluation study in order to better understand why and in what circumstances stakeholders consider particular interventions will lead to specific outcomes. The theory of change approach was developed in the late 1990s in the United States, notably by Connell and Kubisch (1998), to evaluate complex, comprehensive interventions in community initiatives (CCIs), which they define as "a systematic and cumulative study of the links between activities, outcomes, and contexts of the initiative.[48].

A1.4 An evaluation based on a theory of change approach consists of three stages:

1. 'Surfacing and articulating a theory of change
2. measuring a CCI's activities and intended outcomes
3. analyzing and interpreting the results of an evaluation'.[49]

A1.5 Stage 1 requires the identification of the intended outcomes and the contextual factors likely to influence implementation processes and outcomes, such as the policy environment and the social and historical characteristics of the setting. Articulating a theory of change is a collective process that involves seeking a consensus, or at least an understanding, from stakeholders as to how the interventions will achieve the intended outcomes. This theory of change makes the intended outcomes and the means of achieving them explicit and agreed. It needs to be plausible, feasible and testable and will draw on a variety of data sources and stakeholder perspectives. Stakeholders need to identify not only long term outcomes, but also early and intermediate outcomes, a set of initial activities leading to early outcomes, and how all of these are linked to long term outcomes.

A1.6 Early years' policies display many of the features that characterise complex community initiatives. They have clear but broad and multiple long term objectives which relate to organisational issues, child health, educational and emotional development and

[48] Connell, J. P., & Kubisch, A. C. (1998). Applying a theory of change approach to the evaluation of comprehensive community initiatives: Progress, prospects, and problems. In K. Fulbright-Anderson, A. C. Kubisch, & J. P. Connell (Eds.), New approaches to evaluating community initiatives, Volume 2: Theory, measurement, and analysis (pp. 15–44). Washington DC: The Aspen Institute.
Also at http://www.aspenroundtable.org/vol2/connell.htm

[49] Ibid. p. 15.

strengthening families and communities. They operate at various levels: institutional, community, family and individual. They have been developed collaboratively by diverse stakeholders and have evolved over time. Goals are locally determined, and therefore geographically variable. The implementation of early years' policies is complicated by the need to respond to changing policy requirements at national level, and these can lead to inconsistencies across the life of the policy.

SAMPLING AND ACCESS

Choice of case study areas

A1.7 Our remit was to select two contrasting case study areas, one rural and one urban, for an in- depth analysis of the operation of early years' policies. In a complex, devolved and evolving policy environment such as this, which features both partnership working and integration of services, we aimed to identify in what ways local factors influence implementation. In order to do so, we chose two case study areas, contrasting along a number of important dimensions, including: rural/urban and geographic spread, different socio-economic and political circumstances, different institutional frameworks and histories, and the requirement of being able to complete fieldwork and reporting within the short timescale of the project. The two case study areas selected were the Highland and Dundee City local authorities. As discussed in chapter 2, these two areas contrast in a number of significant respects.

Choice of respondents for interviews

A1.8 Once the selection of case study areas was made, and in accordance with Scottish Executive protocol on research access, contact was made by the Scottish Executive research project manager to key senior officials in each area to outline the study and to request their assistance in facilitating access to respondents.

A1.9 The study was required to include a policy analysis that identified the approaches used across sectors in relation to early years' policies and their implementation, their common aims and areas of conflict. This involved a review of relevant local documents, at least 5 interviews with stakeholders across sectors, and at least 2 focus groups of existing partnerships or planning groups. It also aimed to include a review of current monitoring data at local level and any existing evaluations, using information supplied by service providers. The research brief that required that 50 in-depth interviews should be carried out, 25 with a range of service providers across health, education and social work sectors, and 25 with a range of parents of young children, including representatives from target groups, with the potential to explore specific issues in more detail in additional focus groups.

A1.10 We aimed to get as wide a cross section of stakeholders as possible to represent key constituencies in each area, within the time and resource constraints of the study, to include service providers at both planning and service delivery levels, and service users. The criteria for selection of respondents were guided by the following considerations.

- spread across different service areas and sectors, e.g. health, education and social work, and statutory/voluntary
- include examples of partnership working
- include different types of activities, e.g. work with families/ parents as well as those focused on children
- include a mix of types of services, e.g. centre based, outreach, one-off vs. sustained interventions.
- include services targeting particular groups of interest as well as universal services
- include a mix of sizes of projects (could be in terms of clients / funds)
- include a mix of area types within which projects located e.g. urban/ rural/ remote/ deprived/ affluent
- include services felt to be struggling as well as those thought to be thriving
- include services that existed before early years policies began and services that are new
- include services focused on one policy and those addressing a combination of early years' policies

A1.11 In the end, the total number of interviews carried out exceeded the target in order to ensure adequate representation of all key stakeholder perspectives in each area. We were greatly assisted by several key individuals in each area in who facilitated access to the wide range of respondents contributing to this study.

The study sample: Dundee

A1.12 The study sample in Dundee is summarised in the tables below. A total of 28 interviews were carried out, 3 in excess of the target number, with 7 group interviews and 8 service visits. These were distributed across all relevant sectors and levels, and included a range of service users and providers. A greater number of interviews than originally planned were carried out both in Dundee and in Highland because of the need to capture the range and complexity of services and their organisation, and the range of parents' experiences.

Table A1.1 Number of interviews and service visits

Type of Interview	Number
Individual	28
Group	7
Service Visits	8

Table A1.2 Interviews by Sector

Sector	Number
Health	5
Education	5
Social Work	3
Integrated	3
Voluntary	2
Private	2
Users	8
Total	28

Table A1.3 Service Visits

Sector	Number
Health	1
Education	1
Social Work	1
Integrated	4
Voluntary	1
Total	8

Table A1.4 Group Interviews

Sector	Number
Health	1
Education	1
Social Work	1
Integrated	2
Voluntary	1
Users	1
Total	7

Table A1.5 Group Interviews by level

Sector	Number
Strategic	2
Operational	4
Users	1
Total	7

Table A1.6 Parents Interviewed

Sector or service	Interviewed
Parents using private sector	2
Teenage mothers	3
Mothers involved in BF video	3
Mothers with looked after child/cfc referred	2
Mothers with SEN child/ ASDD	2
Mothers relating experience of Child Development Review	1
Mothers relating experience of child transition to nursery	1
Mothers involved in training/running groups/in work	4
Total number of interviews with parents	8

Note: some parents were in more than one category

The study sample: Highland

A1.13 The study sample in Highland is summarised in the tables below. A total of 31 interviews were carried out, exceeding the target number by 6, with one parents' focus group and one service visit. These were distributed across all relevant sectors, areas within Highland and levels, and included a range of service users and providers. In the light of the integrated cross-sectoral organisation of services in Highland, it is not meaningful to classify service providers or users into conventional service sectors such as health, education or social services, but respondents came from a range of these backgrounds.

A1.14 The parents who contributed to the study lived in various parts of the Highland area (Table A9) and included teenage mothers, lone parents, parents living in deprived areas, parents of children at nursery in an affluent area, parents whose children had special needs, parents with disabilities, parents of large families, parents who were users of positive parenting programmes, parents who had received services such as home visits, play sessions, health promotion and free nursery places.

Table A1.7. Number of interviews, business meetings and service visits

Type	Number
Planning Meetings	5
Individual interviews with service providers	21
Individual interviews with service users/parents	10
Focus group with 4 parents	1
Service Visits	1

Table A1.8. Interviews with service provider by type of respondent

Sector	Number
Strategic/planning with responsibility across the Highland area	110
Strategic/planning with area responsibility	5
Fieldworkers with service delivery responsibility	6
Total	21

Table A1.9. Parents Interviewed by area in Highland

Sector	Interviewed
Caithness	2
Sutherland	2
Ross and Cromarty	2
Inverness	3
Skye and Lochalsh	2
Badenoch and Strathspey, Nairn, Lochaber	0
Total number of interviews/focus groups with parents	11: 10 + 1 focus group

DATA COLLECTION INSTRUMENTS AND FIELDWORK

Service mapping in the two case study areas

A1.15 The research remit required a mapping of service development and implementation of early years' policies in each of the case study areas. In addition to the information on mapping services that was obtained from local documents and interviews, we sought to collect information more systematically. We developed a short and easily completed service mapping template which was intended to be completed for each service. This instrument would allow us to carry out an inventory of services, build up an aggregate profile of all early years' provision, and to make comparisons across areas. It might also have provided a means to survey service development elsewhere and monitor changes across time and differences across areas. Attached as Figure 1 is the service mapping template.

A1.16 We collected a large number of completed forms from both areas, but were unable to complete a robust analysis of these returns due to deficiencies in the coverage, quality and consistency of the data we obtained. This was due in part to the very short timescale available to complete the information gathering, an absence of returns from key sectors, insufficient guidance from the research team on completing the form, a lack of common understanding about the unit of measurement, most significantly on what constituted a service. For example, is it every individual playgroup, or playgroup services organised in a particular area? If the latter, which area? Therefore we were unable to supplement the mapping of services from other data sources with information from the service mapping template. However, we consider that further thought might be given to the use of such a uniform instrument, but more fully developed and piloted than was possible in this study, to collect information on all early years' provision in a common format capable of analysis at an aggregate level.

Data Analysis

A1.17 The interviews were tape recorded, selectively transcribed and notes were also taken in some interviews. They generated a wealth of rich material which was analysed along thematic lines, drawing on the key themes in the topic guides, themes that emerged in the course of the interviews, and bearing in mind the overall rationale of the study. In line with the theory of change approach to evaluation, we attempted to identify underlying assumptions, perceived early, intermediate and long term outcomes, and develop our understanding of processes, systems and perceived impacts of policies.

Figure A1.1 Service mapping template

MAPPING EARLY YEARS SERVICE PROVISION IN HIGHLAND AREA AND DUNDEE CITY

A separate sheet to be completed for each service.
Service name:
Address:
and phone number:
Contact name (if used):
phone number (if different):
and email (if available)**:**

Information sources used to complete this form

Web search (include URL)
Interview/telephone conversation/letter (specify who if not the contact person)
Documentary search (specify document name and where obtained)
Have we obtained a copy of documents or information about the service?

When was the service set up?

Pre-1999 and still the same
Pre-1999 and changed by Early Years Policies
New since 1999

Type of services offered (tick as many as apply)

Childminders [area based aggregate]
Parent and toddler groups [area based aggregate]
Day nursery (private, offering full-time care)
Day nursery (local authority, offering full-time care, not pre-school education)
Health visiting [area based aggregate]
Holiday playschemes (for under 5s)
Out of school clubs (for under 5s)
Special needs groups
Health intervention (e.g. tooth brushing, breast feeding)

Playgroups/partner centres [area based aggregate]

Educational provision for 3 and 4 year olds
Local authority
Private/partner centres
Other (including voluntary sector)
Family (or child) centres
Parenting (stand alone)
Home visiting/befriending
Resources (e.g. toy library or book scheme)
Other (including strategic posts) (specify)

Funding sources (tick all that apply)

Fees from users
Scottish Executive (specify source)
Local authority (specify source)
National Health Service (specify source)
Voluntary sector (specify source)
Other public body
Independent fundraising or Community Fund
Employer (specify source)
Sure Start
HIF
Child care strategy funding

Changing Children's Services Fund/Children's Development Fund
New Opportunities Fund
Other (specify source)
Information not available

Funding level

Less than £10K per year
£10K but less than £50K per year
£50K but less than £100K per year
£100K per year or more

Is service targeted? (if service is both universal and targeted then record both)

Yes
No
Both

If yes, to whom? (tick all that apply)

Inner city	Lone parents
Other urban/ suburban	Young parents
Rural	Special needs
Remote rural	Mental health
Deprived	Drugs and alcohol abuse
Affluent	Ethnic minority
Vulnerable families	Other groups (specify)

Principal agency responsible for service (tick all applicable if an equal partnership)

Health service
Social work
Education
Leisure
Voluntary sector (specify agency, informal group etc)
Employer service to employees
Private company providing a service to the public
Other statutory agency (specify, e.g. housing, police)
Other (specify)

Any other partners? (tick all that apply)

Health service
Social work
Education and Leisure
Voluntary sector (specify agency, informal group etc)
Employer service to employees
Private company providing a service to the public
Other statutory agency (specify, e.g. housing, police)
Other (specify)

Age ranges of children served

0 up to 1 year
1 up to 2 years
2 up to 3 years
3 up to 4 years
4 and 5 year olds

Number of paid staff (FTE, best guess):
Number of voluntary staff (FTE, best guess):

Number of children's places available (best guess) :
(when relevant, distinguish between number of places the building serves at any one time and the number of children receiving the service)
Are all the places taken?
Yes – if yes, is there a waiting list?
No

Number of families involved/served in the previous year :
For Highland only: services available in :English : Gaelic

Topic Guides

A1.18 The principal data source for the case studies were in-depth qualitative interviews of service providers and service users. The interviews were carried out using a topic guide as a means of framing the interview. A further distinction was drawn between service providers working in a policy, planning or strategic capacity and those involved in direct service delivery, where it was decided that slightly different topic guides were appropriate. A third topic guide was developed for service users.

Figure A1.2 Topics Guides for Service Providers and Users

IMPACT AND EFFECTIVENESS OF Early Years POLICIES

A1) Service Providers: Policy/strategic/Planning Level

By the term Early Years Policies we include the following policies:

- Sure Start Scotland
- The Childcare Strategy for Scotland
- The Health Improvement Fund (as it affects young children)
- Pre-school education, including the Standards in Scotland's Schools etc Act 2000

Policy/Agency Context

Can you tell me about how Early Year Policies have impacted on policy development in your agency? (which policy(s) has/have had the biggest impact on your work?)
And what about agency structures? (opportunities for change/difficulties encountered)
In Highland, would you say that any one policy (or combination of policies) has been more or less effective in tackling issues of child poverty?
(Documentation - collect evidence of local policies and strategies relating to Early Year Policies)

Intra and inter agency collaboration/integration

What has been your experience of joint/partnership working?
(What have the barriers and opportunities been?)
Which combinations of people and agencies have worked best? Why?
Explore here the role of the voluntary sector, whether it is an equal partner in planning and funding decisions, rather than just service delivery.

Service development

Moving on to service planning, what impact have Early Year Policies had?
What is new/what has been reorganised? (Where has there been a real growth in services?)
How did you decide what to provide? (Any assessment of need? public consultation, user participation, –examples)
In what ways have you involved grass-roots staff ,parents and children in the planning and design of services?
Which initiatives have been successful and which have not? (Any models of good practice?)
Can you identify any current gaps in provision that you would like to address?

Policy/Service evaluation/monitoring

Can you tell me about any policy or service evaluation/monitoring that you have undertaken?
(What sort of data is collected, how, by whom, how is it used, where is it published– examples)

Targeting of resources

Early Year Policies have identified the need for both universal and targeted services.
Can you tell me about how you have approached this in Highland/Dundee, and why you have done it this way?

How did you decide on the appropriate balance in Highland/Dundee? (Who decided?)
Can you give me examples of services in Highland that have been developed to reach the following target groups?
Ethnic Parents?
Young parents?
Lone parents?
Children with disabilities?
Children living in deprived areas?
Children living in remote rural areas?

Which combinations of Early Year Policies have been most successful with each of these groups?
Is any group of clients particularly difficult to work with? Why?
How have you tackled the issue of difficult to reach client groups?
Has this been successful?
Are any of the services provided in the Gaelic medium? –Is there any unmet demand for this?

System Capacity
To what extent do you feel you have the capacity to provide services to those who need them?
To what extent do you feel the workforce has the appropriate knowledge and skills to deliver these services and what steps have you taken to provide training (staff training, multidisciplinary training, networking etc.)?
Can you tell me about any activities in the voluntary sector and community which compliment your approach to early years service delivery? In what way?

Rural Issues Highland (and Dundee if appropriate)
Can you tell me about how rural/remote issues have influenced your service planning and delivery?
(Economies of scale, infrastructure, human resources, available local labour market with appropriate skills (including IT skills), distance, time, cost of travel to provide a service, IT systems/communications)
Can you give me some examples of services specifically designed to address remote rural issues.
(out-reach, mobile/peripatetic, internet, NHS24, community initiatives etc)

Scottish Executive Early Years Policies Frameworks
Early Year Policies provided frameworks for planning and delivery of services. What has been your experience of the adequacy of
guidance for implementation
funding
resources
time scales
Would you say that these policies have provided an effective framework to 'modernise' the delivery of services to young children and their families?
Has it been possible to make sense of the waves of policies and initiatives at a local level in terms of planning and delivering services?

Conclusion
In your opinion, what mix of interventions appear to be the most effective over time in improving outcomes for young children and their families, particularly the most vulnerable?

A2) Service Providers: Service Delivery Level

By the term Early Years Policies we include the following policies:

- Sure Start Scotland
- The Childcare Strategy for Scotland
- The Health Improvement Fund (as it affects young children)
- Pre-school education, including the Standards in Scotland's Schools etc Act 2000

Policy Context
Can you tell me which of the Early Year Policies your service or project is linked to? (Sure Start, Childcare Strategy, pre-school Education, Health Improvement Fund)

Service delivery/Target Groups
Is this a new or a long-standing service?
(If long standing, has it been reorganised to be delivered in a different way, and why? (e.g. as a result of any Early Years Policies?)
Can you tell me about the range of services you offer to young children and their families? (collect any documentation/publicity leaflets)
Some Early Year services are universal to all children, others are aimed at target groups. Which is yours and how does any targeting element work?
(If targeted, then at whom?
Ethnic parents
Young parents?
Lone parents?
Children with disabilities?
Children living in deprived areas?
Children living in remote rural areas?)

Is there any group of clients that is particularly difficult to reach? In what way?
Is there any group of clients that are particularly challenging to work with?
How do you deal with this?

Early Year Policies are aimed to address issues of
children's health
children's social and emotional development
children's ability to learn
strengthening families and communities
reducing barriers to employment
reducing the number of children living in (workless households) households with no-one in paid employment

Can you tell me which of these does your service address? (In what way?)
Are any of the services you offer available in Gaelic medium?
Do you feel that your service has adequate and secure funding, staffing and resources? If not, what is needed?
Can you tell me about any improvements to the service that you would like to see?

Agency Context and Intra and inter agency collaboration/integration
Who are your other partners in this service?

How do you work with other agencies to integrate the service you offer to clients?(How easy has this been? What have been the difficulties?)
What do you do if you are not able to meet the child's or family's needs yourself/ in the project?
What is your perception of your value as a partner (an equal partner?) (To be asked if the service provider is from a voluntary organisation)
Are you involved in planning and funding decisions?

Service design/development/capacity
Can you tell me if you have been involved/consulted in designing/ redesigning of this service? (In what way?)
Are you aware if your clients/ patients/pupils/parents were involved in the design of this service? (In what way?)
Can you describe for me how it is different now? (What is better? What is not?)
Can you describe any knowledge or skills training you have received in relation to early year service development? (IT, counselling, health promotion etc)
How confident do you feel that you have all the necessary knowledge and skills for the service you are providing?
Do you feel your workload allows you sufficient time to work adequately with each client or family?

Service evaluation/monitoring
Can you tell me about any evaluation or monitoring of your service? (What sort of data is collected, how, by whom, how is it used, where is it published– collect any documentation)
(If any evaluation or monitoring is done) What has the evaluation demonstrated?

Rural Issues (Highland)
Some parts of the Highlands are both rural and remote.
Can you identify for me any issues that you experience as a result? (distance, time, cost of travel to visit clients/patients; isolation – from resources/colleagues; availability and cost of resources to lead healthy life style: food choices, sport/leisure choices)
Does your service aim to directly address these issues?
Can you describe for me the sort of social networks there are for children and parents of young children in you area? (support/self-help groups, mother and toddler etc)

In Conclusion
Overall what impact do you feel your service has had on the lives of young children, their families and their communities as a result of Early Year policies?
Do you try to measure this in any systematic way? If so, please elaborate.

B) Service Users: Children aged 0-5 and their Families

By the term Early Years Policies we include the following policies:
Sure Start Scotland
The Childcare Strategy for Scotland
The Health Improvement Fund (as it affects young children)
Pre-school education, including the Standards in Scotland's Schools etc Act 2000

Perception of the service generally and how it helps
Can you describe for me what 'the service' offers to you/your child/your family? ('the service' substitute the name of the service)
And how do you feel you/your child/your family has benefited? (impact on children's health, children's social and emotional development, children's ability to learn, strengthen family and community, reduce any barriers to employment, improving chances of getting a job?)
What do you feel about free pre-school places for 3 and 4 year olds? (good, bad, suggested improvements)
Do you currently benefit from free part time pre-school education?
If so, is there any childcare provision available outwith free part time pre-school education times? (so you could work if you want to)
If so, do you use childcare at these time? If yes, what are your views about the childcare you use?
If you use childcare, were you aware that the childcare element of the New Working Families Tax Credit could help to meet any costs? If so, have you received this support? What has your experience been?
Have you been offered opportunities to attend any training to increase your chances of obtaining paid employment?
Has anything been unhelpful/made life more difficult?
Can you tell me how you first heard about/made contact with 'the service'? (universal/referral/publicity/ word of mouth)

Satisfaction with service generally
I'd like now to ask you about how satisfied you are with various aspects of the service: (accessibility, flexibility, convenience, costs and affordability, information about the service and help with costs, quality of service/staff)
How keen are you to attend? (any stigma/waste of time/love it?)
Does the service provide you with the information/advice you need? (Parenting, child development, child health, financial advice etc).
How easy was it to understand? Was the information available in variety of forms? (written, visual, verbal, one to one, group sessions)
How well do you get on with the staff? (feel well treated/respected)
How does this service compare with what was available before? What was available before?
Is there any service you no longer receive because of this service?
Overall, what difference, (positive or negative), has the service made to you?

I would like to ask you now to think about one specific initiative or activity and focus on your particular experience of that, including.

- access, information and understanding of the initiative
- The experience of attending: place/ timing/ travel/ costs./other child arrangements. What it was like/ how they and their child felt/ expectations.

- Understanding and ability to ask questions/ given help with problems. Would they go back/ changes that would be helpful. Benefits to them and their child.

Some possible examples of a specific initiative or activity might be:

- experience of induction of child/parent into nursery education/day care/creche/family centre services etc
- experience of home visiting service
- experience of child health developmental review
- experience of transition from nursery to school (transition form etc)
- experience of post-natal depression support]

Information and expectations

- How did you find out about local projects and groups (referred/word of mouth/literature)
- If information is available, how accessible/informative/ widely available is this? Could this be improved, and if so, how?
- Was the service what you expected?
- Were you able to find any information on community activities or training activities for parents

The Experience of attending a service

- Where is the service held and are the facilities adequate (Overcrowded/noisy/good/bad area/busy road)
- Are you made to feel welcome /able to ask questions /have confidence in the people running the service?
- Are there enough teachers/nurses/helpers for the number of children?
- How do you get on with other parents you meet? (enjoy/feel intimidated)
- Would you go again?
- What range of activities is your child involved in? (views on this)

Benefits to the Child

- How do you feel this service has benefited your child? (positive attitude, self confidence/emotional development /mother-child communication)
- Can you give me a specific example of how your child has benefited? (more aware of rules/tidying up after play/persevering with tasks/ taking their turn/ more curious generally)
- Have you noticed if your child is more able to express their feelings through storytelling/ role play/ singing songs?
- Does your child have opportunities to listen/enjoy music, ask questions and talk about stories?
- Has your child developed a love of stories/books/drawing/dance/music since attending the service?
- How has their ability in counting, sorting, recognising their name changed?

Benefits to the parent

- How do you feel this service has benefited you? (time to myself/ respite /met other mothers/met people like me/ increased self-esteem/better parent-child communication/gained new skills /voluntary work).
- Are you less concerned about your child/children?
- Do you feel better able to cope?

Returning now to your experience of family and child services generally, I'd like to ask you about:

Range of Professionals/staff
How many staff are working with you/your pre-school children/your family? (Health education, social work)
How well co-ordinated are the services they offer to you? (key contact?)
How well do you feel the staff work with you as the parent?

Support
Can you tell me about any forms of support you/your child/your family have been offered or receive? (Professional/self-help groups/other)
How has this helped?
If nothing is available, what would you find helpful?

Involvement in design and planning and operation of service
Were you or other parents or your children consulted in designing or planning the service? (In what way?)
Are you or other parents involved in running/delivering the service? (If so, in what way and what has this been like?)

Rural Issues (adapt for Dundee, if applicable)
What (if any) difficulties do you feel you experience because of living in a rural/remote part of the Highlands? Do you feel you lose out on service provision?
(education services, childcare services, health care, availability and cost of resources to lead healthy life style: food choices, sport/leisure choices)

In Conclusion
What suggestions can you make about ways in which services to you/your children/your family could be improved?

Are there any types of services that you would find helpful that are not currently available?

Thinking about services you/your child/your family have received, to what extent would you say they helped you as a parent; with your relationship with your child; with building confidence (parent's and child's)?

APPENDIX 2

ISSUES RELATED TO THE USE OF INDICATORS ON DEVELOPMENTAL DELAY AND SPEECH AND LANGUAGE PROBLEMS FROM THE CHILD HEALTH SURVEILLANCE SYSTEM (PRE-SCHOOL)

A2.1 The pre-school system includes many opportunities for the recording of possible problems. These problems are noted in free text by health care professionals and are later coded by Read coders. Read codes are extensive and can be used to describe many facets of health care. Over 7,500 Read codes have been used in the Pre-school system. It is quite possible within the Read system for two identical patients with identical conditions to be correctly coded using different codes, by different practitioners. Often a child may have signs and symptoms and may need further examination by a specialist before a condition can be diagnosed. In these cases, health care professionals may or may not highlight their concerns by including an "examination" type code.

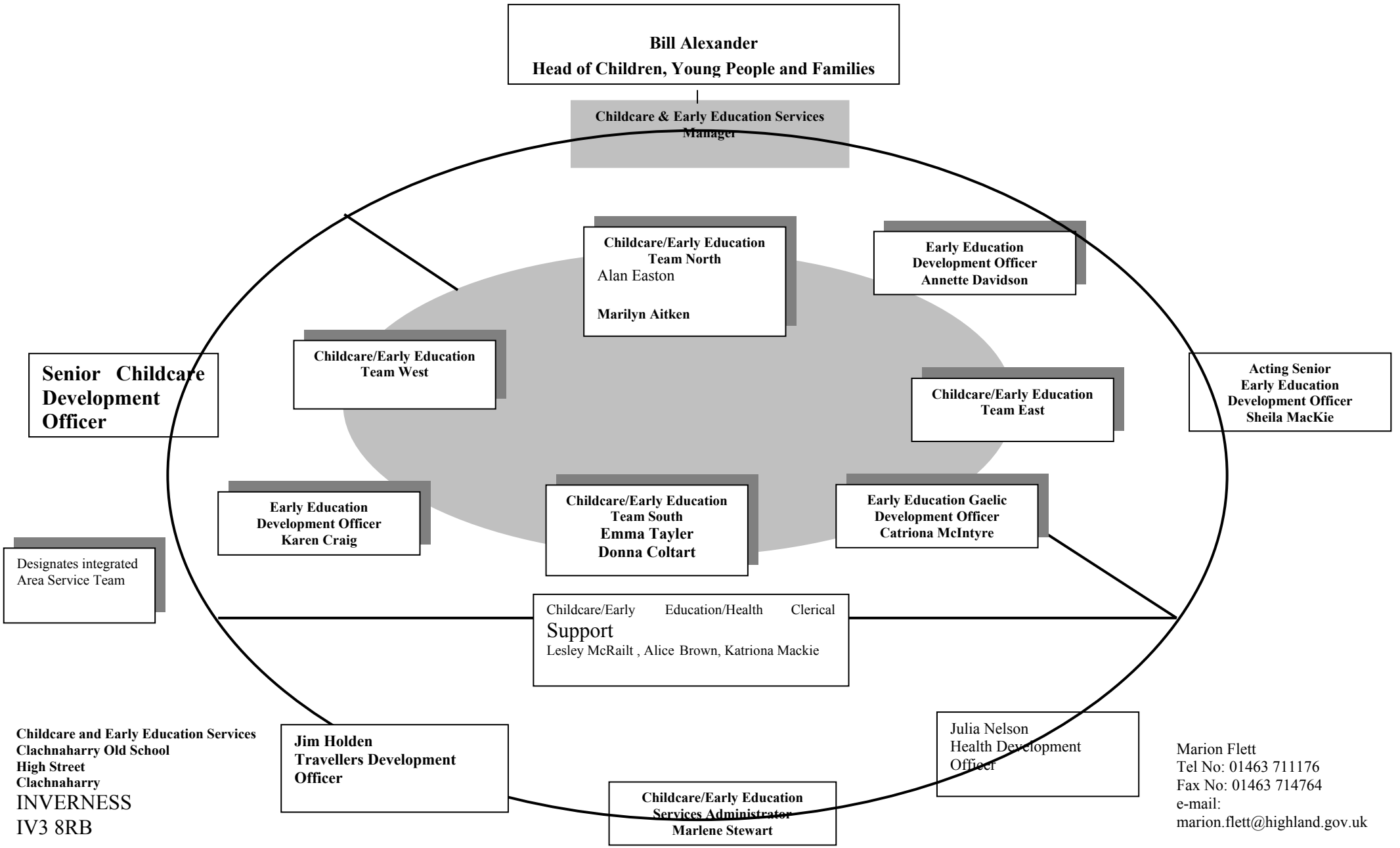
A2.2 It is worth noting that there is large variation in coding practices across NHS Boards. One of the aims of the National Read Code Review Group is to raise awareness of Read code issues and standardise coding practice throughout Child Health Surveillance Pre-school, School and the National Special Needs System. It is recognised that coding practices vary significantly throughout the service and that the coding of problems/diagnoses will presumably differ depending on the clinical terminology used by individual clinicians. The National Read Code Review Group intends to compile a set of clinical guidelines for terminology. These guidelines will clarify what type of information is required for Read coding and will enable clinicians to complete forms in a consistent manner.

A2.3 Provisional analysis of this type of information shows large variation across NHS Board rates. It is possible that any variation may be due to differences in recording practices which may have changed overtime. Further work is required to investigate and the derived groupings have yet to be authorised by the Read Code Review group.

APPENDIX 3 DIAGRAMS

The Highland Council
Comhairle na Gaidhealtachd
SERVING The Highland Community

Diagram H2 Childcare and Early Education Services



Childcare and Early Education Services
Clachnaharry Old School
High Street
Clachnaharry
INVERNESS
IV3 8RB

Marion Flett
Tel No: 01463 711176
Fax No: 01463 714764
e-mail:
marion.flett@highland.gov.uk

Diagram H2 Agency Structure of Children, Young People and Families Services in Highland

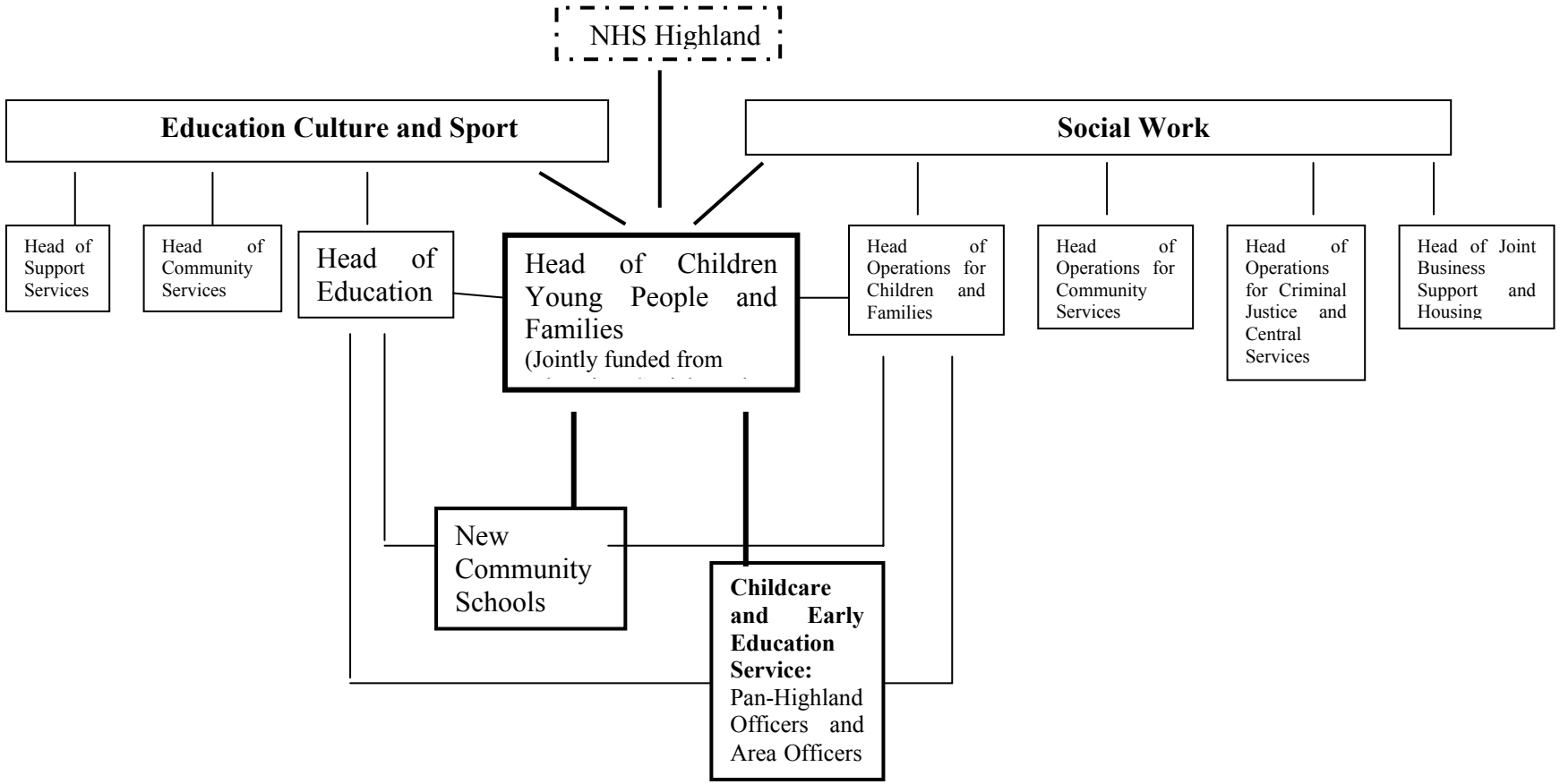


Diagram H3 Highland Childcare and Early Education Service

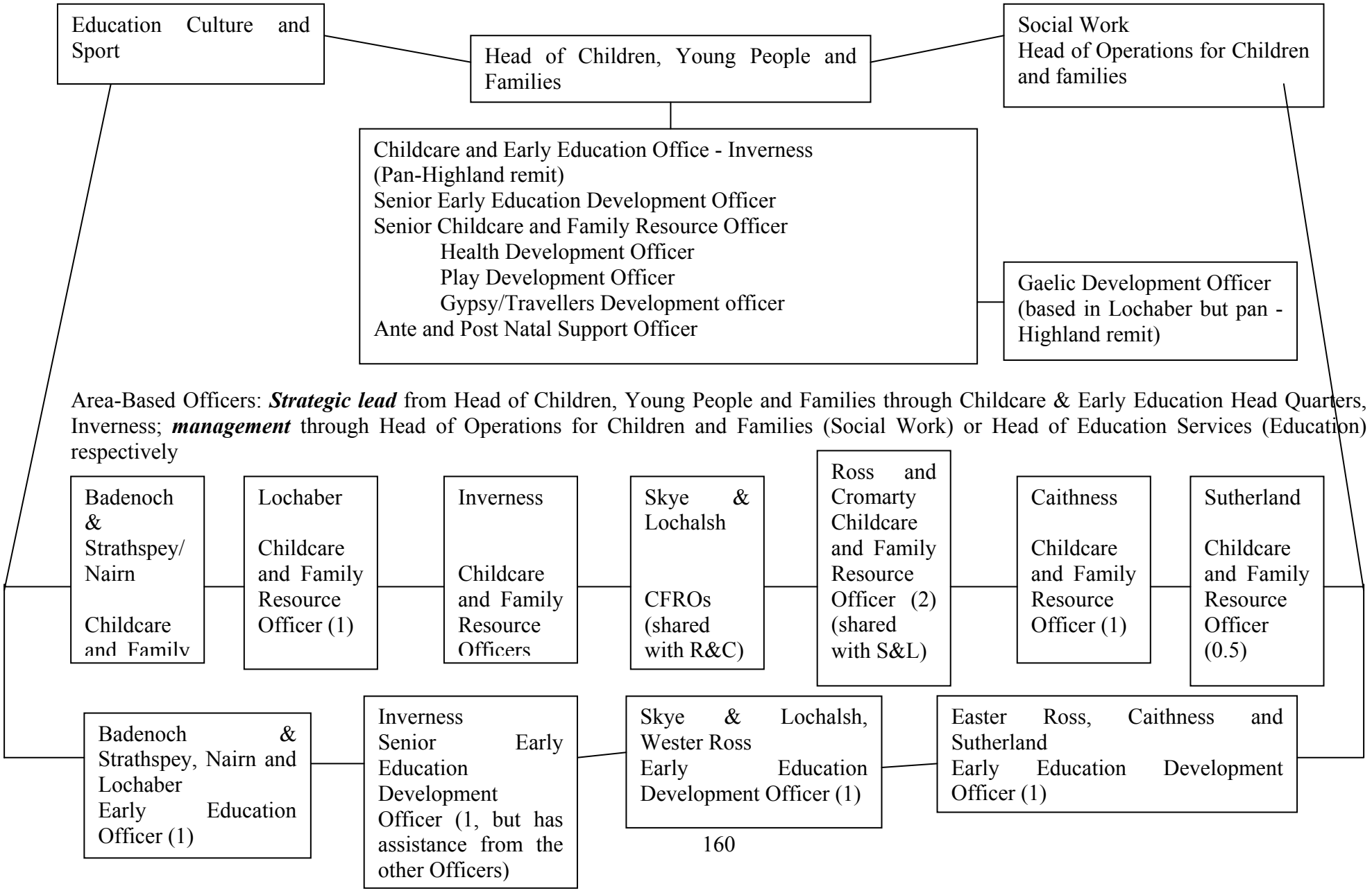


Diagram H4.Strategic Framework for Highland's Children

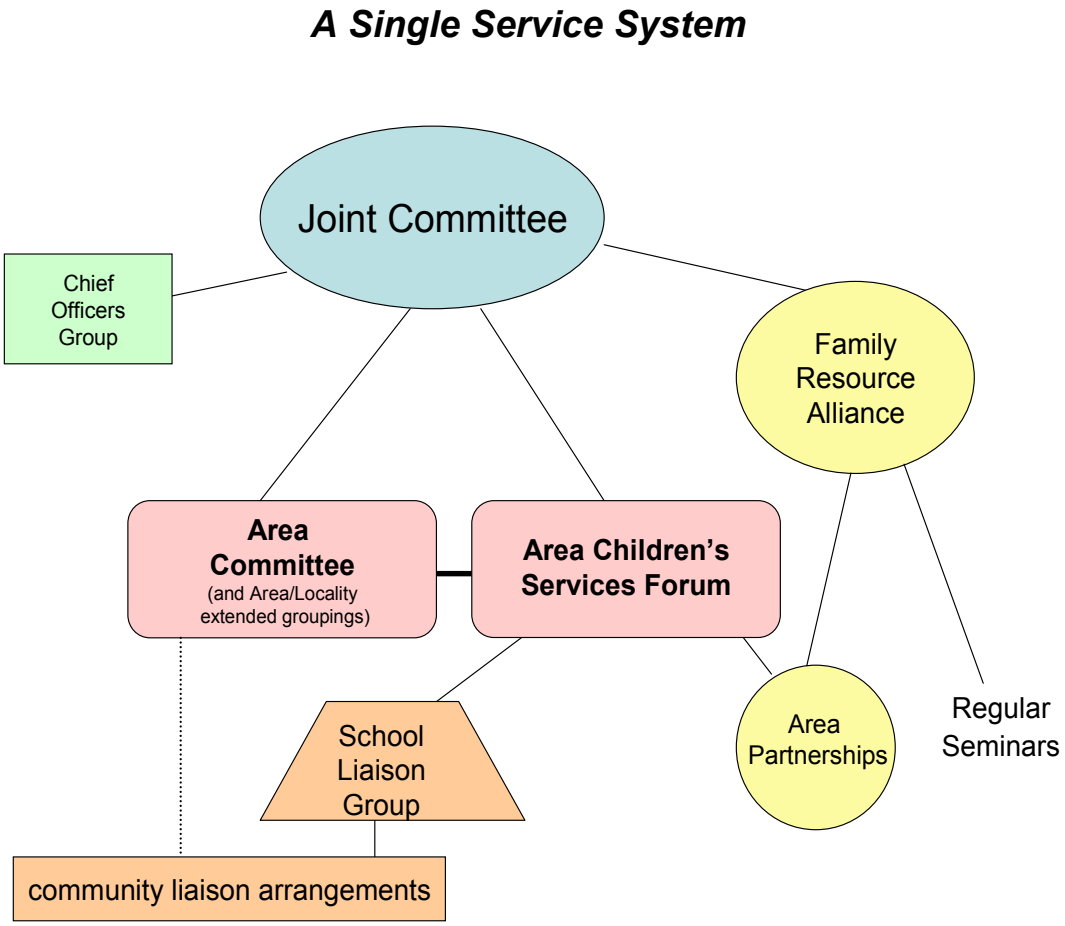
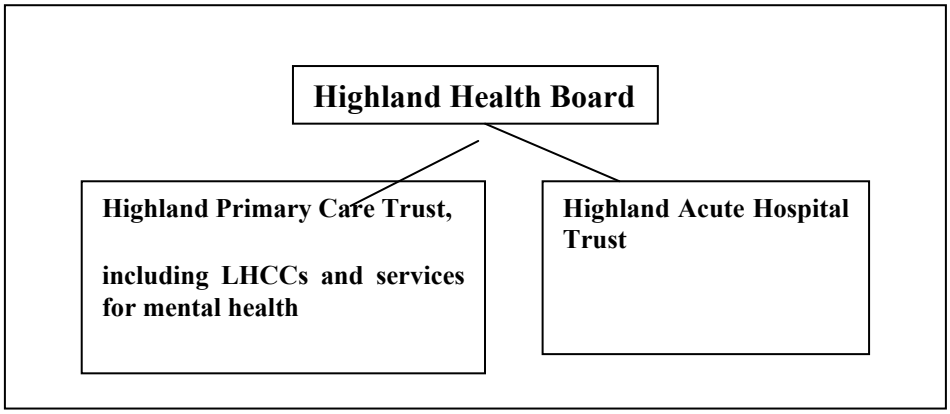


Diagram H5 Changes in Highland Health Structure

NHS Highland outgoing structure



Outline proposal for new NHS Highland structure

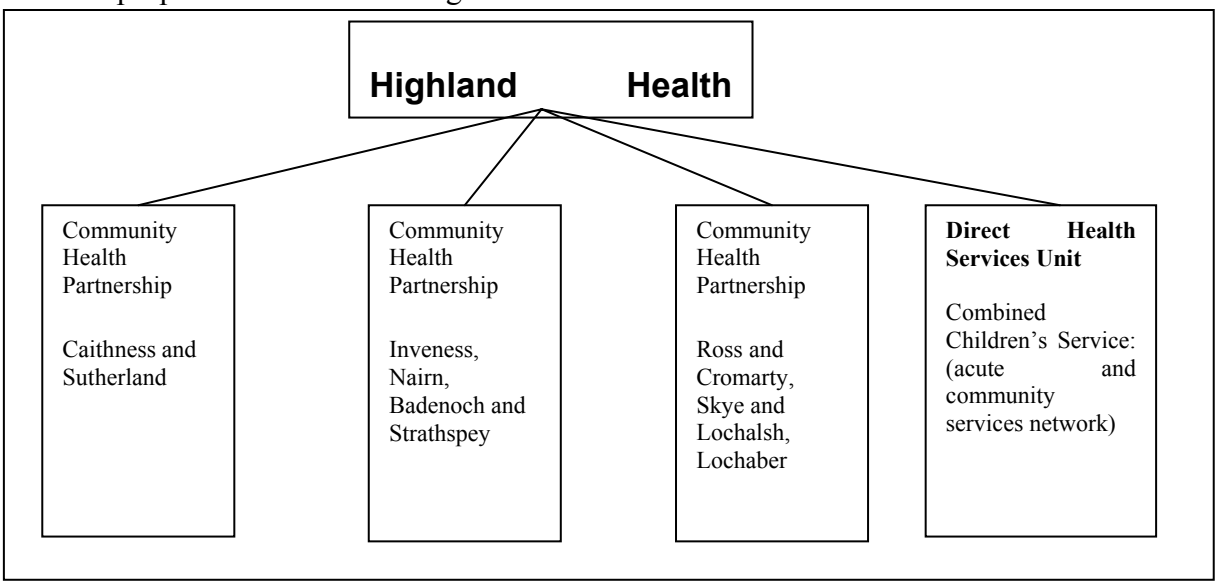


Diagram D1 Dundee City Council Organizational Structure of Early Years

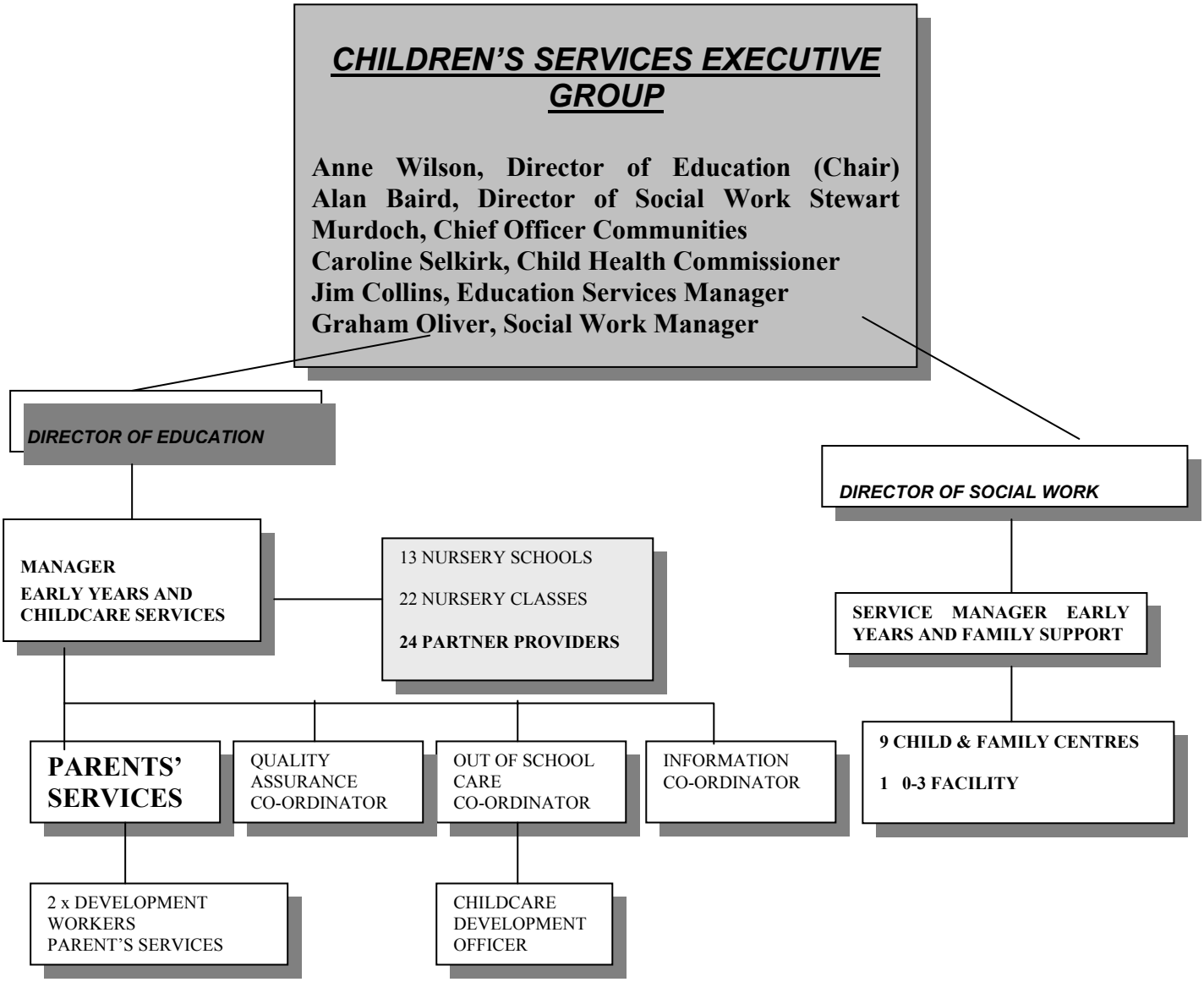
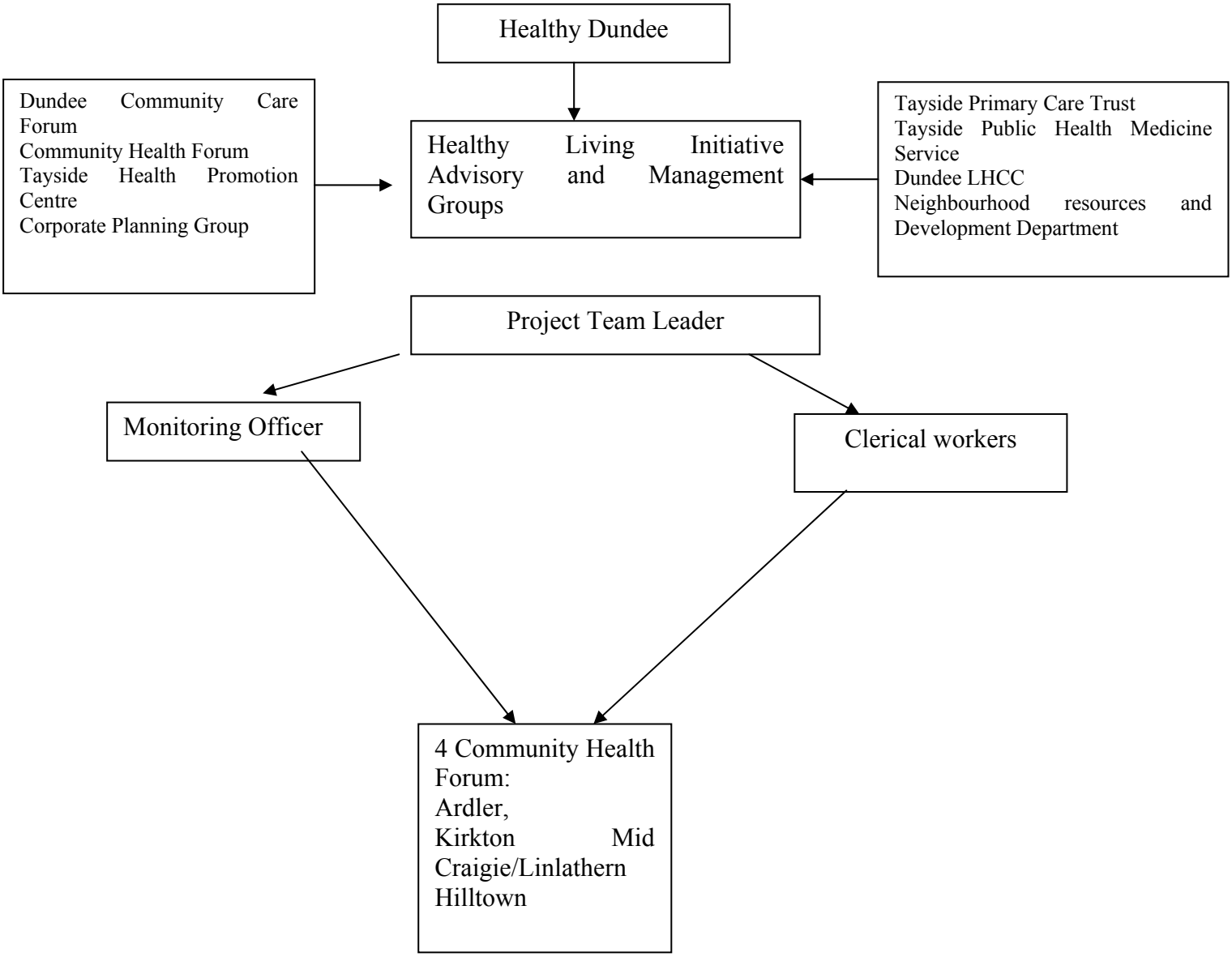


Diagram D2 The Structure of Dundee Healthy Living Initiative.



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