

Changes in the Characteristics of SSLP Areas between 2000/01 and 2004/05

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Sure Start Local Programmes (SSLPs) were area-based, concentrating on relatively small neighbourhoods. Their aim was to improve the health and well being of young children under 4 years old and their families, so that children will have a greater opportunity to flourish when they go to school. This fifth and final report from the Local Context Analysis (LCA) module of the National Evaluation of Sure Start (NESS) documents change over five years in the characteristics of Sure Start Local Programme (SSLP) areas in Rounds 1 to 4 and determines factors associated with more or less change.

Key findings

- ▶ Over the five-year period, improvements in SSLP areas were detected and often the level of change was significantly greater than that seen in England as a whole. However, few of these changes can be linked in a straightforward way to Sure Start activities.
- ▶ The areas became more concentrated as places for families with children and fewer of these children were experiencing economic deprivation (as measured by workless households and households in receipt of Income Support).
- ▶ Some aspects of crime and disorder in SSLP areas have also changed for the better, notably burglary from homes, vehicle crime and exclusions and unauthorised absence from schools (however violence against the person increased). Children from 11 upwards are demonstrating improved academic achievement, particularly when there are other Area Based Initiatives (ABIs) operating locally.
- ▶ SSLP areas saw substantial increases in the rates of crèche providers and places (larger than increases in England). Full day care (providers and places) also increased but the increases were significantly smaller than those seen across England. There were no significant increases in either crèche provision or full day care in the two groups of areas with more BME residents - 'ethnic diversity' and 'Indian subcontinent'.
- ▶ There were improvements in child health (fewer emergency hospitalisations of 0 to 3 year olds for lower respiratory infections and severe injury). These may indicate that families are accessing more routine health care at GP surgeries or child health clinics, supported by possibly more 'joined-up' working between health and social services.
- ▶ It appears too that increases in the health screening of young children may have occurred in SSLP areas over the period, as evidenced by the percentage of children identified with special educational needs or eligible for benefits related to disability increasing across the period.
- ▶ Other indicators for preventive health (i.e. the rate of breast-feeding or immunisations) were available for a small number of areas and suggested some gains, but without information on all SSLP areas no conclusions can be drawn. Similarly no conclusions could be drawn about child welfare due to the lack of sufficient data over the complete time period from social service departments.

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³ This indicator is based on data indicating the precise area covered by ABIs, available for the following eight initiatives: Aim Higher, Education Action Zones and Excellence in Cities; Children's Fund; On Track; Early Excellence Centres; Health Action Zones; Neighbourhood Nurseries; Neighbourhood Renewal; New Deal for Communities.

Background

Sure Start Local Programmes were area-based, covering relatively small neighbourhoods, the boundaries of which were defined by the programme partnership boards after consultation with local community members. This is the fifth and final report from the Local Context Analysis (LCA) module of the National Evaluation of Sure Start (NESS), with the task of documenting change over time in the characteristics of Sure Start Local Programme (SSLP) neighbourhoods, based on the boundaries specified when SSLPs were first implemented, between 1999 and 2002⁴.

This report provides descriptions of the SSLP areas in Rounds 1 to 4 in the calendar year 2004 or the fiscal year April 2004 to March 2005 (unless otherwise specified) and how they have changed since the calendar year 2000 or the fiscal year 2000/1 (unless otherwise specified). At the point of final data collection (March 31st 2005) programmes in Rounds 1 to 4 had been in operation for between 39 and 83 months (average 63 months). Information about the SSLP areas in the first year of data collection (2000/1; Barnes et al., 2003), their change after one year up to 2001/2 (Barnes et al., 2004), after two years up to 2002/3 (Barnes et al., 2005a) and after three years up to 2003/4 (Barnes et al., 2006) can be found respectively at:

<http://www.ness.bbk.ac.uk/documents/activities/lca/127.pdf>

<http://www.ness.bbk.ac.uk/documents/activities/lca/399.pdf>

<http://www.ness.bbk.ac.uk/documents/activities/lca/987.pdf>

<http://www.ness.bbk.ac.uk/documents/activities/lca/1384.pdf>

The following core questions are addressed:

- Have the characteristics of Sure Start Local Programme areas changed between 2000/2001 and 2004/2005?
- What is the relationship between change in the characteristics of SSLP areas and change in England?
- What factors are associated with more or less change in community characteristics?

Methods

Change in the characteristics of SSLP areas has been compared statistically with change during the same time period in England. A number of factors have been examined to find out if they relate to change, falling into three groups, to highlight the relevance of: the variability between and within areas (area typology, area variability); other activities in the areas (other ABIs); and the SSLPs themselves (time of operation, spend per child, health-led).

Variability *between* SSLP areas is based on five types of SSLP area that were derived from clustering based on their demographic features, at the outset of the evaluation: 54 SSLP areas designated '*Least deprived*' had, in relation to other SSLPs, less average deprivation; 29 '*Most deprived*' had the highest mean levels of all indicators of deprivation; 87 areas were designated '*Typical*' in that their deprivation was close to the SSLP mean for all indicators considered and they had relatively low percentages of residents who were from Black or minority ethnic groups; two further clusters of SSLP area were characterised mainly by larger percentages of residents with minority ethnic backgrounds, 59 were deemed '*Ethnically diverse*' with a varied population; a smaller group of 28 areas had the highest proportion of '*Indian subcontinent*' residents and a high concentration of children relative to adults in the population.

⁴ Some SSLPs amended their original boundaries during their first year or so of operation

Three indicators of within-area variability were constructed, based on the Census 2001, indicators of the variability *within* SSLP areas in terms of the housing (social or owned), the extent of disadvantage of residents, and the ethnic background of residents. The LCA team obtained data on the boundaries of other ABIs to determine the number that overlapped with each SSLP area. Time of operation of the SSLP was studied by comparing change for each Round separately, and by examining the association with months of operation. The average spend per child in the SSLP area in 2004 and whether or not the programme was health-led were determined from other NESS data.

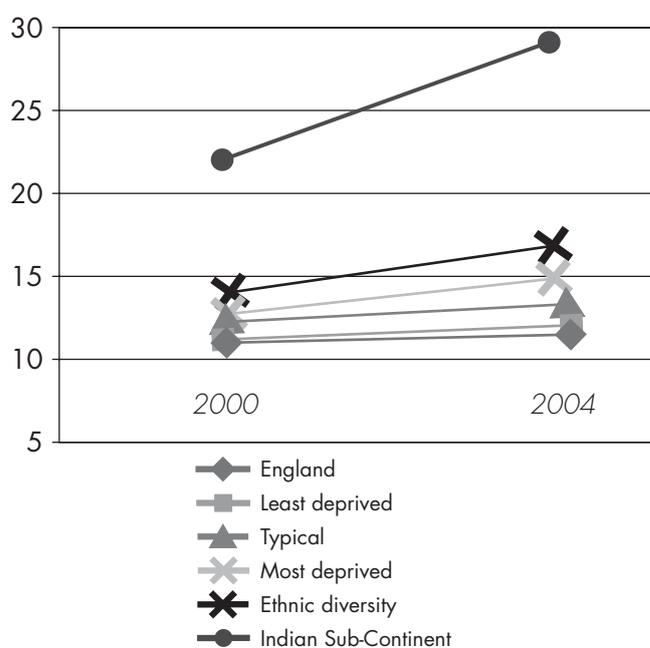
Main Findings

Demography

The SSLP areas were by 2004/5 home to a larger number of children under 4 years old in total (210,058; 773 on average, up from 693), representing a greater average proportion of the population in the SSLP areas (6.6% up from 5.9%). The comparable rate increased to a lesser extent in England and is lower (4.6%, up from 4.4%). The Indian subcontinent areas have the highest number of children per 100 households, and the rate has increased most in these areas (see Figure 1).

There was a significant increase in the average number of births per area (201, up from 188) and the birth rate in SSLP areas between 2000 and 2004 increased, but at a similar level to the increase in England. In addition births to lone mothers⁵ were significantly higher in 2004, both in SSLP areas (25.8%, up from 25.0%) and in England (15.2%, up from 14.5%). The proportion of births to young (under 18 years) mothers was significantly lower in SSLP areas in 2004 (3.9%, down from 4.3%), a reduction similar to that across England (2.1%, down from 2.3%) though the average rate in SSLP areas remained higher.

Figure 1: Change in the mean number of children per 100 households in the five types of SSLP community and England



Source: ONS2000, 2004

Economic deprivation

Less economic deprivation was being experienced by families with young children in SSLP areas in 2004/5 than five years earlier. The proportion of young children in SSLP areas in 'workless' households⁶ was significantly lower in 2004/5 than it was in 2000/1, representing a significantly greater reduction than in England overall. The proportions of children aged 0 to 3 and 4 to 17 in Income Support households are also significantly lower in SSLP areas in 2004/5 than in 2000/1, and the overall rate of working age adults in receipt of Income Support (see Table 1). The reductions are significant in all types of SSLP area.

⁵ Registered solely in the mother's name, or registered jointly where the parents live at different addresses

⁶ Households dependent on means-tested benefits

Table 1: Change between 2000/01 and 2004/05 in children experiencing economic deprivation in SSLP areas in Rounds 1 to 4 and in England

	SSLP average 2004/2005	Range in 2004/2005	Change in 2004/2005	England average 2004/2005	England change from 2000/01
% 0 to 3 year olds in workless households	40	15 - 70	-4.6*	22	-1.2
% 0 to 3 year olds in households receiving Income Support	34	12 - 65	-5.5*	18	-2.3
% 4 to 17 year olds in households receiving Income Support	31	8 - 60	-5.1*	16	-2.3
% working age adults receiving Income Support	14	3 - 31	-1.4*	6	-1.0

Source: DWP 2001, 2005.

*Change significantly different to England change

Child health

The rate of emergency hospitalisations of children aged 0 to 3 years for severe injury and respiratory infection were significantly lower in SSLP areas in 2004/5 than in 2000/01, significantly greater decreases than in England (see Table 2). Emergency hospitalisations for gastroenteritis have not changed significantly, in SSLP areas or in England.

Table 2: Change in rates of emergency hospitalisations of 0 to 3 year olds between 2000/01 to 2004/05 in SSLP areas in Rounds 1 to 4 and in England

Per 1,000 0 to 3 year olds	SSLP average 2004/2005	Range in 2004/2005	Change in 2004/2005	England average 2004/2005	England change from 2000/01
Lower respiratory infection	22	1 - 62	-2.3*	19	+0.7
Severe injury	12	0 - 50	-3.3*	11	-0.1
Gastro-enteritis	14	0 - 51	+1.2	10	+1.0

Source: *Hospital Episode Statistics 2001, 2005, DWP 2001, 2005.* *Change significantly different to England change

There was a significant increase in the percentage of children aged 4 to 17 in SSLP areas in receipt of Disability Living Allowance (DLA)⁷ (4.0%, up from 3.2%), significantly greater than the increase in England (3.0%, up from 2.4%).

Infant weight and mortality data are based on calendar years. There was no overall change in the rate of infants born with low birth weight (less than 2500 grams), either in SSLP areas or in England. Within the 260 Rounds 1 to 4 SSLP areas, the rate of low birth weight decreased significantly in the 'Indian subcontinent' SSLP areas, but also remained highest in those areas on average. Infant mortality was reduced significantly in SSLP areas and in England to a similar extent. Again, dividing the SSLPs into the five types, the reduction was significant only in the 'Indian subcontinent' areas.

Data from Child Health Systems were incomplete, but the available evidence suggests there may have been increases in rates of breast-feeding in some SSLP areas, with an average in 2005 of 46%. However rates are substantially below the rate for England (78%). Immunisation rates for the Triple

⁷ Paid to anyone aged 3 years or over that has severe difficulty walking, or aged 5 years or over and needs help getting around

vaccine⁸, MMR⁹ and Polio appear to have fluctuated from year to year, but this may be an artefact of the data, with different SSLP areas represented in different years. Rates of the Hib¹⁰ immunisation have risen.

The percentage of school aged children living in SSLP areas and identified with minor special educational needs (SEN, school action/school action plus) increased between 2002/3 and 2004/5¹¹ (22.2%, up from 20.1%), another change significantly different to change in England (16.1%, up from 14.5%). There was no change in the percentage of children with statements of SEN.

Child Welfare

No firm conclusions can be drawn about change in the levels of social service activity in the SSLP areas over time due mainly to the large amount of missing data, the result of resource limitations of Social Service departments and inadequacies in the geo-coding of data in some areas. While no significant changes were identified there was a trend for rates of referral of under fives and under 16s to Social Service departments to show an upward movement in SSLP areas, set against a national decline in referrals.

There were different patterns in the five types of SSLP area. Referrals of children under five had some fluctuation but no overall change in the 'least deprived' and 'typical' areas; there was more fluctuation year on year in the 'most deprived' areas and those with 'ethnic diversity'. However rates of referral for under fives and under 16s declined significantly (and were the lowest in 2004/5) in the areas with more Indian subcontinent residents. Thus, while there appears to have been more social service activity in some types of area, this was not the case for all SSLPs.

Academic achievement

There were no marked improvements in the academic achievement of younger children in the SSLP areas based on assessments made at age 7. However, achievement at Key Stage 2¹² was significantly higher for all three English tests (final, reading and writing) taken by 11 year olds living in SSLP areas, greater than improvements in England. For example, in Key Stage 2 English final, the percentage achieving level 4 or above increased by 6.1% to 67.7% (in England it increased by 4.2% to 78.8%). The percentage of SSLP pupils achieving level 4 or higher in reading increased by 6.7% to 74.4% (in England the increase was 4.6% to 84.1%).

The percentage of young people obtaining five or more GCSEs¹³ grade A*-C increased significantly for pupils from SSLP areas (by 5.5% to 38.5%), compared to a lesser increase in England (by 2.4% to 55.5%).

Child benefits paid to youngsters at 17 indicated that more were staying on in full time education in SSLP areas (an increase of 8.7% to 67.7%) which was significantly greater than the national increase (up 5.2% to 75.8%)

Local child care provision

Data from Ofsted were available from 2001 and from that time until 2005 there were on average substantial increases in the rates of crèche providers and places in SSLP areas, larger than increases in England with the rate of crèche provision in SSLP areas in 2004/5 almost twice that for England (see Table 3).

There were also significant increases in SSLP areas in the rates of both the providers of full day care and the places available, but the increases were significantly smaller than those seen across England and mean rates of provision remained substantially lower in SSLP areas than England rates.

⁸ Diphtheria, Pertussis and Tetanus

⁹ Measles, Mumps and Rubella

¹⁰ Haemophilus Influenza b

¹¹ Data from earlier years could not be compared due to changes in the definitions of SEN

However, looking at the five types of SSLP separately, there were no significant increases in either crèche provision or full day care in the two groups of areas with more BME residents - 'ethnic diversity' and 'Indian subcontinent'.

Table 3: Change in places at childcare providers per 1,000 0 to 7 year olds between 2000/01 and 2004/05 in SSLP areas Rounds 1 to 4 and England

Per 1,000 children 0 to 7 years old	SSLP average 2004/2005	Range in 2004/2005	Change in 2004/2005	England average 2004/2005	England change from 2000/1
Child-minders	34	0- 110	+2.8*	69	+1.3
Full day care	66	0- 286	+18.6*	113	+26.7
Sessional day care	22	0- 107	-7.5	54	-9.7
Out of school care	42	0- 214	+9.0	74	+6.6
Crèches	15	0- 142	+5.8*	9	-0.4

Source: Ofsted 2001, 2005.

* Change significantly different to England change

Community Disorder

The extent of poor behaviour and poor attendance in schools with children resident in SSLP areas showed some improvement, greater than changes seen in England. The average rates of both permanent exclusions and unauthorised absences from primary schools with pupils from SSLP areas declined significantly from 2000/1 to 2004/5, whereas in primary schools across England exclusions rose marginally and unauthorised absences dropped only minimally. Unauthorised absences of secondary schools with SSLP pupils were also reduced on average to a greater extent than all schools in England. Exclusions dropped, but at a similar rate to the reduction in England. Thus, taken in conjunction with the improvements in achievement of older children in SSLP areas, a culture of valuing education may have been promoted in SSLP areas.

A mixed picture of changes in crime in SSLPs emerged across the period 2001/2 to 2004/5 (data were not collected from all areas for 2000/1). Burglary from dwellings, other burglary and vehicle crime declined significantly in all types of SSLP area, with the reduction in burglary from dwellings significantly greater than the decrease in England. This improvement was more likely if there were several other ABIs in the area, if the SSLP was led by health and if there was little variability in the economic deprivation of the population. Reduction in vehicle crime was also predicted by the presence of more ABIs.

Somewhat in contrast, there was a significant increase in violence against the person in SSLP areas, greater than that which took place in England. This was more likely in areas with more variability in the ethnic background of the population, and with few ABIs. This was also evident in all types of SSLP areas. Criminal damage and drug offences increased significantly in SSLP areas and in England. However, separating the types of SSLP area, there was only a significant increase in drug crime in those with ethnic diversity.

Conclusions

Over the five-year period covered by the NESS analysis of the local contexts in which SSLPs operated, some improvements in SSLP areas were detected, though few could be linked in a straightforward way to being areas where the Sure Start activities were located, if only because many changes simply reflected national trends. Consistent with this interpretation changes were generally not related to the amount spent per child or to the length of time that the programme had been operating. The only associating between the SSLP being health led and a positive outcome was for a reduction in burglary from dwellings, not for a health outcome.

Nevertheless, even as the SSLP areas became home to more young children over time, the proportion living in households totally dependent on benefits, or in receipt of benefits indicating a job seeker or someone on a low wage decreased markedly. For instance, the average proportion of children under 4 living in 'workless' households in SSLP areas dipped just below 40%, having started out at 45% in 2000/01. One third were living in a household in receipt of Income Support, down from 39%. These average levels are still much higher than the England rates (22% and 18%) but show important improvements.

Some aspects of crime and disorder in SSLP areas have also changed for the better, notably burglary from homes and exclusions and unauthorised absence from schools and children from 11 upwards are demonstrating improved academic achievement, particularly when there are other ABIs operating locally. While infant health has not improved, the reductions in emergency hospitalisations of young children for severe injury and for lower respiratory infection are indicators that families in SSLP areas may be accessing more routine health care within the neighbourhood, at GP surgeries or child health clinics, supported possibly by more 'joined-up' working between health and social services. It appears too that increases in the health screening of young children may have occurred in SSLP areas over time, as the percentage of children identified with special educational needs or eligible for benefits related to disability increased across the five-year study period.

Other important data may be available to document potential health benefits such as increases in the rate of breast-feeding or greater take-up of routine immunisations. Where these data were obtained from local child health systems some gains were suggested. However without information on all SSLP areas no conclusions can be drawn. The LCA team has slightly more success

in obtaining information from social service departments, but the lack of data year on year for more than half the areas made it impossible to draw any conclusions about child welfare.

Documenting changes in neighbourhoods over relatively short periods of time is not straightforward; many factors need to be taken into account that might explain any change that is detected. Data sources need to be available at the small area level, available annually, and recorded in the same way at each time-point. Many comments in this report indicate that this was not always achieved, even when data were extracted from national datasets. However, in addition to contributing to the body of knowledge about SSLPs, hopefully this work will be useful in pinpointing ways forward for collecting and analysing neighbourhood data, to evaluate other similar area-based initiatives designed to enhance children's well-being and family functioning.

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Further information

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