NHS childcare strategy impact analysis

RESEARCH REPORT

by Robert Frew

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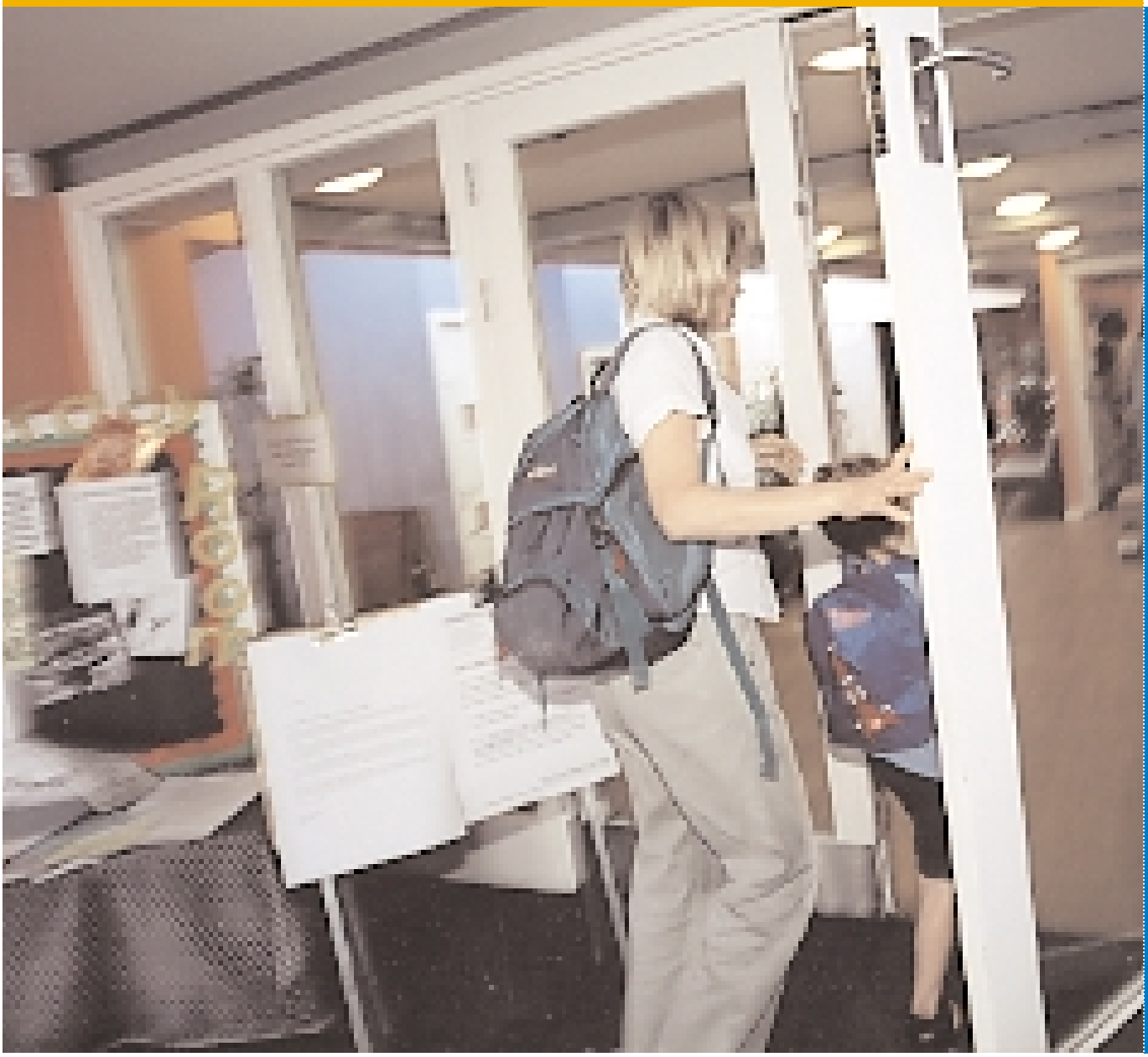

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Description	The purpose of the Report is to assess how successfully the objective of the NHS Childcare Strategy 'to support the needs of staff with children and to encourage the recruitment, retention and return of parents to the NHS workforce' has been met. The analysis focussed on implementation of the strategy in five case study areas. Recommendations for local action are made.		
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Executive Summary

The NHS childcare strategy was launched in 2000 as a key part of the Improving Working Lives (IWL) Standard and the NHS Plan. The objective of the childcare strategy is to support the needs of staff with children and to encourage the recruitment, retention and return of parents to the NHS workforce. The purpose of this report is to assess how successfully the strategy has met this objective. This has been done through a detailed analysis of the implementation of the strategy in five case study areas.

KEY FINDINGS

1. Over 80 per cent of NHS staff members with children in the case study sample have found the strategy helpful in meeting their childcare needs.
2. Many of the initiatives undertaken under the childcare strategy are still in their infancy. Many coordinators have been in post for less than one year and have not yet had sufficient time to make their full impact on meeting parents' childcare needs or improving their working lives.
3. Despite this relatively short period of time, the childcare strategy has made a significant impact on parents' working lives. The biggest impacts have been in helping to retain staff within the NHS, enabling parents to return from maternity leave, reducing sickness and absence levels and in improving the job satisfaction and morale of staff members with children.
4. Insufficient attention has been paid to how the childcare strategy can be used to attain recruitment and retention goals at a local level.
5. The study calls into question the strength of support for the childcare strategy within many PCTs and trusts.
6. The attempts of childcare coordinators to convince local NHS managers about the importance of the childcare strategy are being hampered by their lack of experience in making a business case for childcare and navigating local strategic and financial planning processes.
7. There is some uncertainty and concern about the future of the childcare strategy after devolved funding arrangements are implemented in April 2004.

MAIN RECOMMENDATIONS

1. That much greater importance is placed on using the childcare strategy at a local level to further PCTs' and trusts' strategic objectives on recruitment and retention.
2. That childcare coordinators and Workforce Development Confederation childcare leads give high priority to making a strategic business case to management in PCTs and trusts for continued funding of the childcare strategy, and that a key element of this business case is a demonstration of the benefits of childcare for the development and maintenance of an effective workforce providing high quality care for patients.
3. That the Department of Health continues to provide training to childcare coordinators on how to evaluate and balance the strategic objectives and processes of their employers with the needs of the workforce to make an appropriate business case to local PCT and other healthcare trust managers.
4. That the Department of Health makes further efforts to promote the benefits of the national childcare strategy to NHS organisations.
5. That the childcare leads in Workforce Development Confederations work with PCTs, childcare coordinators and other stakeholders on how to manage the transition to the new funding arrangements in April 2004.
6. That consideration is given to recording basic information on childcare as part of the Electronic Staff Record, most crucially the numbers of children each staff member has and their dates of birth.

Contents

Introduction

1.1 BACKGROUND

The NHS childcare strategy was launched in 2000 as a key part of the Improving Working Lives (IWL) Standard and the NHS Plan. The objective of the childcare strategy is to support NHS staff with children and to encourage the recruitment, retention and return of parents to the NHS workforce. The purpose of this report is to assess how successfully the strategy has met this objective.

The IWL Standard was introduced to provide NHS employers with a performance framework to develop better working conditions for NHS staff. All NHS employers were expected to achieve the Practice stage of IWL accreditation by 2003 with the achievement of the Standard at Practice Plus level expected by March 2006. As part of the NHS Plan the IWL Standard aims to:

- help to improve staff morale by helping them to manage a better work life balance;
- help retain staff;
- improve recruitment and encourage staff to return.

The NHS childcare strategy is seen as central to achieving the above aims in respect of those staff with children. The strategy has a national target for 150 extra on-site nurseries providing an additional 7,500 places subsidised at an average of £30 per place per week. It also has a target for all NHS staff, including hospital doctors and GPs, to have access to a childcare coordinator, the fulfilment of which is a requirement of achieving IWL Practice Plus status. Over £70 million was made available to meet these targets from 2001.

In addition, the government committed a further £100 million to extend the strategy to other forms of childcare support for pre-school and older children, such as playschemes, after-school clubs and voucher schemes, as well by upgrading and subsidising existing NHS nurseries.

Strategic Health Authority capital allocations for 2003/04 included a further £15 million nationally for building on-site nurseries with £15 million revenue funding allocated to subsidise new nursery places, fund childcare coordinator posts and support other childcare initiatives.

So far at least 140 new nursery schemes (new or extensions to existing nurseries) have been opened or are in the pipeline, which will provide an extra 6,000 new subsidised nursery places for NHS staff. Over 220 childcare coordinators are now in post.

To date funding for the NHS childcare strategy has been ring fenced and the funding at a local level has been allocated by Workforce Development Confederations (WDCs). Local leadership on childcare issues has been provided by WDC childcare leads who have worked with and supported childcare coordinators. From 2004/05 funding for the childcare strategy across the local NHS economy, including the ongoing subsidy for new nursery places is included in Primary Care Trusts (PCT) general allocations and

no longer ring fenced. This is in line with the government policy of allowing NHS organisations to determine their own local needs and priorities as set out in 'Shifting the Balance of Power'. Therefore, from April 2004 it is for PCTs to determine the appropriate investment in childcare provision working in partnership with SHA/WDCs and other local stakeholders. In doing so account will need to be taken of existing childcare strategies and provision within the wider context or recruitment and retention needs and implementation of IWL.

Childcare will remain a crucial element in the IWL programme. In working towards IWL Practice Plus, NHS organisations will have to demonstrate that their childcare strategy feeds into the childcare strategy across the wider health economy and is one of the human resource activities that underpins their Local Delivery plan. All NHS staff, including PCT staff and GPs and their practice staff, must continue to have access to the services of an NHS childcare coordinator and to affordable, accessible and good quality childcare.

1.2 AIMS OF THE STUDY

This study aims to:

- Provide a detailed account of how the NHS childcare strategy has been implemented on the ground, in terms of initiatives undertaken, successes achieved and issues encountered.
- Assess the impact of the NHS childcare strategy in meeting the childcare needs of people working in the NHS.
- Evaluate the impact of the NHS childcare strategy in improving the working lives of staff and in assisting recruitment, retention and return.
- Assess the importance attached by parents working in the NHS to childcare support as compared to IWL initiatives around flexible working.
- Make recommendations as to how to continue and improve the development of the childcare strategy as national funding devolves to PCTs.

1.3 RESEARCH METHODS

The following research methods were used to carry out the study.

- Case studies were undertaken in five areas of the country based on WDC boundaries. The choice of case study areas was partly based on achieving a geographical spread but also on the need to select areas that were furthest advanced in implementing the strategy. Further details on the case study areas is given in table 1.
- Focus group interviews with parents working in the NHS were conducted in four of the five case study areas.
- In addition, parents in all five areas were asked to complete a short survey questionnaire. In total 35 parent questionnaires were completed.
- Focus groups of childcare coordinators were held in all five areas.
- There was also a questionnaire survey of childcare coordinators in all five areas, with 33 forms being completed.
- In-depth interviews were conducted with childcare coordinators, WDC childcare leads, workforce information managers and HR directors, managers and advisors.
- In each area background information was collected in the form of HR data, childcare coordinator caseload data, childcare surveys and childcare strategy reports.

TABLE 1 - CASE STUDY AREAS

Area	Region	Urban or rural	No. of PCTs/Trusts	No. of childcare coordinators
A	London	Urban	15	14
B	Midlands & Eastern	Urban and rural	28	7
C	South	Urban and rural	18	3
D	North	Mostly urban	33	8
E	South	Urban and rural	33	7

Childcare issues affecting workers in the NHS

2.1 MAIN CHILDCARE ISSUES

Before looking at how the NHS childcare strategy has been implemented in practice, it is helpful to get an indication of sorts of childcare issues experienced by parents working in the NHS. The questionnaire survey asked parents about the childcare issues affecting them. Childcare coordinators were asked to cite all the significant issues experienced by parents in their area. The most frequently cited issues from both surveys are shown in the table.

In answering the question childcare coordinators had a wider focus than parents who were asked to think about their own issues. Nevertheless, common themes emerged from both surveys. The cost of childcare was the most frequently mentioned issues for both childcare coordinators and parents. The problem of finding childcare in an emergency also features in both lists. While the difficulty of obtaining a nursery place was not one of the most frequently mentioned problems by parents, those it affected often saw it as a serious problem. Likewise, the difficulty in obtaining childcare for children aged 11 and over was mentioned by a high proportion of parents with children in that age group.

Parents and childcare coordinators mentioned many issues other than those listed in the table. These included difficulties obtaining childcare at or near work or for children age 2 and under, problems in getting childcare of sufficient quality, lack of information on childcare options and problems in obtaining other specific forms of childcare such as breakfast club or after school club places.

2.2 COST

Difficulties in meeting the cost of childcare emerged as the main issues facing parents in the study. Nursery fees were singled out in particular, with costs of places for under 2s mentioned as being particularly high given the higher staffing ratios required. Daycare Trust's Childcare Costs Survey (January 2004) found that the national average cost for a nursery place for Under 2 year olds was £134 per week with costs for some nurseries as high as £338 per week. A number of parents also complained about the cost of holiday playscheme places. Daycare Trust's Holiday Costs Survey (July 2003) found the national average weekly cost of a full time holiday playscheme place was £68 with some schemes charging up to £135 per week.

Such costs were having a significant impact on many of the parents surveyed.

'In the holidays I leave my two older children with my mother. I cannot afford to pay for playscheme places for them' (parent).

A number of parents interviewed felt guilty about having to rely on family and friends to provide informal care. Other parents did not have that option and had been forced to reduce their working hours.

There was some disagreement as to which groups of parents were most

TABLE 2 – MOST FREQUENTLY CITED CHILDCARE ISSUES

PARENTS			CHILDCARE COORDINATORS		
Childcare issues	**No.**	**%**	**Childcare issues**	**No.**	**%**
Affording the cost	17	49%	Affording the cost	32	97%
Obtaining childcare in an emergency	17	49%	Obtaining a nursery place	26	79%
Obtaining childcare in school holidays	14	40%	Obtaining childcare in an emergency	24	73%
Finding a childminder	12	34%	Obtaining childcare at times of day needed	23	70%
Obtaining childcare near home	10	29%	Obtaining childcare for ages 11 and over	23	70%
Total responses	35	100%	Total responses	33	100%

affected by high childcare costs. In one area it was suggested that those on low salaries were most affected, particularly nursing staff near the beginning of their careers. In another area, childcare coordinators took the view that the hardest hit group was middle income earners, particularly those who just missed out on the childcare element of Working Tax Credit. It was generally felt that childcare costs were a particular burden on those working parents with two or more children.

'People are actually planning their families around the cost of childcare. People are only having one child when they might want two or three. They can't afford to work and be faced with those childcare costs' (childcare coordinator).

High childcare costs were also perceived to be acting as a disincentive to take up work in the NHS or to take promotion to a higher paid job.

'I keep thinking I'm working my way out of the money trap by getting promotion, but now I work full time and have to pay more in childcare. There is no one to help me calculate my salary versus expenses' (parent).

2.3 FINDING A NURSERY PLACE

In many areas private nursery places were available but not at a cost that most NHS parents could afford and, in some instances, not providing the quality of care that parents desired. NHS workplace nurseries were regarded as much more affordable and generally of better quality, but in almost every area this was creating a high demand for places and resultant waiting lists. One childcare coordinator reported two-year waiting lists in some settings. In another area, where the nursery had been substantially extended with funding under the NHS childcare strategy there was already a waiting list for baby places. Two parents interviewed in this area stated that they might well have to delay their return from maternity leave until a baby place becomes available. The particular shortage of places for under 2s was a problem common to many areas.

In some areas shortages of and waiting times for nursery places were being exacerbated because families from outside the NHS were using a significant proportion of NHS on-site nursery places. This was most likely to occur as a result of long-standing agreements in nurseries that pre-dated the childcare strategy, often on-site nurseries run by private companies. In other cases it was the location of the NHS nurseries that was the problem.

'I didn't realise that NHS nurseries were a lot cheaper but I don't have one near where I work or live' (parent).

One parent reported an entirely different problem in accessing a nursery place for his child. He had found a place at a local nursery run by another government agency; not one connected with national security as far as we are aware.

'We started there but after 9/11 we were told that they would no longer have children of parents who were not based on site, as they were a government building that could be subject to terrorist attack' (parent).

2.4 OBTAINING CHILDCARE AT THE TIMES OF THE DAY NEEDED

Another frequently mentioned issue was that the childcare available was not appropriate to the working patterns of many health service workers. For example many nurses worked a shift from 7 a.m. to 6 p.m. Many nurseries or breakfast or after school clubs would not provide this extended hours cover. For many private companies it was simply not profitable for them to do so. This included private nurseries operating on NHS sites. A number of parents criticised the inflexibility of private nurseries.

'I was in a situation where I was sprinting down the road to collect my child at the end of the working day, in order to avoid the 'late fee'. In the end I thought, 'this is just not worth it' and I gave up my job' (parent).

Several other parents who were working irregular hours also reported a lack of flexibility among childcare providers in being able to accommodate their needs. In particular, parents were unhappy about being made to pay for a full day or session, when they were only using part of that session.

'I work 8.45 to 2.45, but I need to pay for full day care and for something I don't use' (parent).

'Flexible hours are great, but can create more problems around needing flexible childcare' (childcare coordinator).

In a number of cases parents working more normal hours said that there was no breakfast or after-school club near where they lived or near their children's school, forcing them to change their working hours or rely on informal support.

'I changed my hours to be able to drop my son off at school and I had to lose an hour per day. I had to lose the pay and delegate some work to my full time junior' (parent).

Another issue is where childcare is needed at unsociable hours such as weekends or evenings. It was reported that nurseries were rarely open at these times and that childminders who would be willing to provide care during those hours were often hard to find. The only solution that could be found in one scenario was for the Childcare Coordinator to be on call herself during unsocial hours one week in every three to cover an on-call A&E consultant.

2.5 OBTAINING CHILDCARE IN AN EMERGENCY

This was a issue reported by many parents who needed emergency childcare because of work commitments or because their normal childcare arrangements had broken down. For example, one parent needed childcare because her husband, the normal carer, had gone into hospital with a heart attack. She could not get an emergency place from either an NHS nursery or a childminder.

'I tried to get my child into an NHS nursery. They said they were full. There were probably places available that day, but the parents don't tell them the place won't be needed until the last minute. It's the same with childminders. Twice I tried to access the system. Twice I failed and had to take time off work. I don't feel optimistic about accessing it in the future. I hope I have a kind neighbour in future' (parent).

2.6 OBTAINING CHILDCARE DURING SCHOOL HOLIDAYS

This can be a particular issue for parents working in the NHS given that many more of them have school age children than have children of pre-school age.

The issue here is not necessarily that external holiday schemes do not exist but that they may be too costly or are not open for the entire holiday period, outside of the summer holiday or at the times of day needed. In some cases it was reported that the schemes were not in the right location or that the quality of childcare provided failed to meet parents' standards. An additional problem for working parents was of having to find childcare, often at relatively short notice, on teacher training days.

The difficulties in accessing childcare in the holiday period had a significant impact on parents' lives. Some had to change their working hours or take large chunks of their annual leave to look after their children.

2.7 OBTAINING CHILDCARE FOR CHILDREN AGED 11 OR OVER

Accessing appropriate holiday care for children in this age group was reported as a problem in almost all of the case study areas visited. Many parents were understandably reluctant to leave older children to their own devices in the holiday period.

'I don't like to leave my 13 year old at home. I'm not prepared to do that. This summer I had activities arranged for him like a military programme' (parent).

There was often perceived to be a dearth of holiday activities for children once they reached the age of 11. Parents commented that by age 11 the children had out grown the sort of activities for younger children normally associated with playschemes.

What activities were available tended to be sports based organised by leisure centres. Such activities were not always regarded as appropriate because not all children are sportingly inclined. The activities were often provided on an open access basis where the children were free to come and go as they pleased. Most leisure centre staff did not have the background or training needed to provide proper day care. In addition, it was pointed out that the costs are not eligible for the childcare element of Working Tax Credit, as leisure centres are not accredited for this purpose.

2.8 ACCESSING CHILDCARE IN RURAL AREAS

Parents living or working in rural areas faced some additional issues in accessing childcare. Registered childcare provision was often very thin on the ground because demand in a local population or in a given workplace did not justify nursery provision. In consequence parents had to travel greater distances to access childcare.

One childcare coordinator talked of a parent travelling in one direction to drop her child off with a childminder before turning back in the opposite direction to go to work. In some cases rural travel problems could be exacerbated by poor public transport and even severe winter weather.

Childcare coordinators

3.1 CHILDCARE COORDINATOR'S ROLE

Childcare coordinators in the case study areas were asked about the kinds of activities they carried out in the course of their job. The results are shown in the Table 3.

The table shows that almost all coordinators spend a significant amount of their time providing advocacy and advice to parents and publicising and promoting childcare initiatives. However, the percentages that were heavily involved in the more strategic activities of developing new provision and securing funding were lower.

In practice, most coordinators' jobs involve a combination of strategic and hands on advocacy or administrative work. However, the balance between the two aspects of the job varied significantly from coordinator to coordinator. Partly coordinator's territory and partly by job descriptions and salaries. It was reported that there were quite wide differences in salaries between coordinators, some being paid around £30,000 per annum, while others received nearer £20,000.

There was a widespread view among coordinators that the demands of the job were changing, and the strategic element of the job was becoming ever more important, particularly given the need to influence PCTs to continue funding childcare from April 2004. Many childcare coordinators had prepared or were preparing childcare strategies for their local area and in some cases for individual PCTs and trusts within that area. Local childcare strategies varied quite widely in terms of style and content. Features that were common to most strategies included a statement of strategic objectives or underlying principles, an account of existing childcare initiatives, proposals for new childcare initiatives to be undertaken and a statement of the financial implications of these proposals. Some strategies also contained background HR or workforce data, an overview of childcare provision in the local area, childcare survey results and targets or indicators against which the success of the strategy could be measured.

Some coordinators were of the opinion that their role should primarily be a strategic one and that they should not become too heavily involved in providing detailed advice, particularly if help was available from other sources such as the local CIS.

'Some coordinators think it is like they are trying to run a playgroup, but they do have a strategic responsibility. You should help staff find their own solutions. It is too easy to try and do everything for them' (childcare coordinator).

However, the majority of coordinators saw making personal contact with parents as a crucial aspect of their role. They felt that while some of their work duplicated the role of the CIS, childcare coordinators would often give parents more in-depth advice and support. There were also perceived to be advantages to providing support to NHS parents 'in-house.'

'Because we are within the NHS parents will often call us first to check that talking to an outside organisation like the National Childminding Association is okay. They can trust us because we work

TABLE 3 - ACTIVITIES UNDERTAKEN BY CHILDCARE COORDINATORS

Activities constituting a large part of the job	No. of Coordinators	%
Providing advocacy and advice to parents	28	85%
Publicity and promotion of childcare	30	91%
Administration (e.g. of discounts, placements)	16	48%
Developing new provision within the NHS	22	67%
Developing new provision with other providers	14	42%
Securing funding	24	73%
Total coordinators	33	100%

'We as childcare coordinators offer a personal service and build up a relationship with staff'
(childcare coordinator).

for the same organisation, but we're not their manager and we're not HR' (childcare coordinator).

The value of the personal touch that most childcare coordinators could provide was echoed by a number of parents.

'It relieved a crisis when I was unhappy with my childminder. There was somebody on the end of the phone who was very calm and responded very quickly to help me find a new childminder' (parent).

'Without the childcare coordinator I wouldn't have known anything. Yes, you can get advice from other sources but it was more helpful for me getting advice that was work related from someone who understands the stresses' (parent).

Parents also emphasised the value of childcare coordinators' advice on issues such as leave entitlement and the coordinator's ability to act as an advocate where the parent was having difficulties with their line manager over a childcare issue. A number of childcare coordinators pointed to the difficulties of trying to combine strategic work with personal advice and advocacy.

'You can't do a strategic plan and come back to 15 phone messages and deal with them all individually and effectively' (childcare coordinator).

'I don't have the time to be strategic because I have 500 subsidy forms in front of me with no admin support' (childcare coordinator).

Most childcare coordinators worked on their own but in some of the case study areas childcare coordinators had received funding to appoint an assistant. This was particularly the case in one area where many of the coordinators operated subsidy schemes, which were requiring increasing amounts of time to administer as they grew in popularity.

Some of the childcare coordinators in the case study areas had expanded their role to cover staff with other caring responsibilities, such as those with elderly parents or a terminally ill partner. Where this happened, the role was generally one of providing advice and support, and signposting to other services. In some areas a carers' forum had been set up.

Views as to whether this was a good model for all childcare coordinators to follow were mixed. Some coordinators argued very strongly in favour of dealing with other caring issues on the basis that it was important that they were seen to be providing a service that was relevant to a wider group of staff and not just those with children. Other childcare coordinators argued that they did not have the capacity to take on these extra responsibilities. Also, many childcare coordinators had been employed in their posts because of their background in childcare. They did not necessarily have the experience or skills required to provide support to other carers and to help them with the often complex and painful issues they faced.

'I've started to deal with other care issues, but only in the last couple of months. It's like re-branding myself. I feel slightly uncomfortable about my new role because I come from a childcare background. I don't feel comfortable that I know where to signpost people. I need to do some research' (childcare coordinator).

3.2 CHILDCARE COORDINATOR TERRITORIES

As has been noted a key element of the NHS childcare strategy has been the funding of childcare coordinators to implement the strategy on the ground. To date over 220 posts have been created across the country. However, many childcare coordinators are only very recently in post. The survey of 33 childcare coordinators in the five case study areas found that 57 percent had been in post less than one year. A few coordinators, notably some of those based in acute trusts, are long standing with their appointment predating the strategy.

There is a wide disparity between childcare coordinators in terms of the areas they serve. Some coordinators' territories in the case studies were geographically based around a local health economy typically incorporating a couple PCTs, an acute trust and a mental health trust. Others served only a single PCT or trust. Yet other territories covered a very wide geographical area, taking in several different PCTs and trusts. Some coordinators had responsibility for specialist trusts such as ambulance trusts. One

'In the end it comes down to each childcare coordinator having to prove their own worth before they are accepted' *(childcare coordinator).*

coordinator in the case studies had a national remit, being responsible for NHS Logistics.

The overall impression is that the creation of childcare coordinator areas has been somewhat piecemeal, influenced by historic factors, self-interest and the timing and availability of funding. For example, some acute trusts whose childcare initiatives predate the national strategy were keen to hang on to a coordinator for their particular trust rather than switch to a geographically based coverage. In one case study area consisting of two counties there are 2.5 coordinators in one county and eight in the other.

One consequence of this piecemeal development has been the differences in the sizes of childcare coordinator territories, not just in terms of geographical area, butalso, as the table demonstrates, in terms of numbers of staff served. In some cases the distribution of territories had led to a duplication of responsibilities. For example, in one of the case study areas two coordinators were serving the same PCT and in another, different coordinators were serving different groups of staff based on the same site.

There was a feeling expressed by some coordinators that such overlaps were both confusing and unnecessary. The view was also expressed that the creation of large numbers of childcare coordinator posts in some areas had not represented the best use of resources.

'It feels like lots of dead money has been invested into unnecessary childcare coordinators rather than into providing childcare places' (childcare coordinator).

TABLE 4 - NUMBER OF HEALTH SERVICE WORKERS IN COORDINATORS'S TERRITORY

Number of staff	No. of Coordinators	%
Under 500	1	3%
501-1,000	2	6%
1,001-2,000	6	18%
2,001-5,000	9	27%
5,001-10,000	10	30%
10,001-15,000	2	6%
Over 15,000	3	9%
Total coordinators	33	100%

The size of the territory also had implications for the childcare coordinator's role. Some of those with large territories felt they were more able to take a strategic view over the childcare needs of the health economy or an entire county, which coordinators in the smaller territories were less able to do. The downside was that it was much more difficult to provide advice and assistance to individual staff when there were so many members of staff to cover.

'My role is much more strategic because of the numbers of staff we cover, but the problem is that I am not there on the end of the phone as an advocate' (childcare coordinator).

3.3 CO-OPERATION FROM PCTs AND TRUSTS

The level of co-operation received from the trusts they were serving was a big issue for childcare coordinators. The normal procedure is for a childcare coordinator to be employed and managed by a host trust but to provide services to all trusts in their territory. In many cases childcare coordinators were located within HR departments. However, many were left largely to their own devices and had to be cases where a childcare coordinator turned up for work and there was no desk or telephone provided for them. In one instance the childcare coordinator was employed by a local authority and located within the Children's Information Service (CIS). This had not appeared to help her develop close relationships with the trust she was employed to serve.

On the other hand, a number of coordinators reported good relationships with their host trust and said that they felt supported by their line managers. Even here relationships with other trusts could be more difficult.

Childcare coordinators cited many instances of lack of co-operation from the trusts that they served. These included not being given access to HR data, not being allowed to circulate childcare publicity as a payslip attachment, not being given a slot on new staff inductions, or by HR or line managers failing to pass childcare information on to front line staff. There was a widely held view that many trust managers did not really see the childcare coordinator role as an important one.

'I feel that management only accept my presence because they have to. I sit there at the meeting and they talk down to me. They don't value the role' (childcare coordinator).

Some coordinators felt that getting co-operation from PCTs could be particularly difficult. This was partly because PCTs had less of a tradition of providing childcare support than many acute trusts. It was also partly attributed to the newness of PCTs and the associated organisational teething problems that were inhibiting the flow of information. However, many coordinators stressed that the level of co-operation they received varied considerably from organisation to organisation and between different individuals within an organisation.

'The main barriers we face are often personalities and what their personal priorities are or are not' (childcare coordinator).

The lack of support and co-operation received from many PCTs and trusts, contrasted very strongly with the very strong links that childcare coordinators in the case study areas had with each other and, with one marked exception, with their WDC.

It was common practice for the coordinators in each WDC area to form a childcare coordinator network. The network meetings provided the opportunity for the coordinators to share good practice, discuss issues of common concern and for the WDC childcare lead to provide advice and guidance. In consequence, childcare coordinators in the case study areas were very supportive of one another and often worked in a co-operative and strategic manner. For example, it was common for a project developed by one childcare coordinator, such as a playscheme, to be open to parents living or working in another coordinator's area. There was a perception amongst childcare coordinators that within their networks there was less of the rivalry that sometimes characterised relationships between different trusts.

'Because we meet together in our network we feel we are part of the one NHS' (childcare coordinator).

3.4 COMMUNICATION WITH STAFF

The survey of childcare coordinators asked about the ease or difficulty in communication with parents in their areas who had childcare needs. The following table shows that 45 per cent of the coordinators in the survey said that they found it generally difficult to communicate with staff with childcare needs. In addition, 76 per cent of coordinators said they had difficulties reaching particular groups of staff. It is clear that many coordinators were being faced with barriers to effective communication with staff in their areas.

One of the major barriers was that few if any coordinators knew or could even accurately estimate the number of parents in the workforce with children. This information was not recorded on HR systems. The majority of coordinators had undertaken staff surveys. However, response rates were low and tended to come only from staff with childcare needs. The surveys were useful in helping to gather information about the nature of people's childcare needs but not the total numbers with children. Nor could they provide a comprehensive listing of staff with children that coordinators could then use to target childcare publicity material. Childcare publicity currently had to go to everyone, which could cause annoyance for those members of staff without children.

Just under half of the coordinators in the study had set up a computer database to log details of those accessing the various childcare services. Many of these databases were in their infancy. Other coordinators were looking to set up databases in the near future. There were two database packages currently on the market, but a good deal of dissatisfaction was expressed with both, one on the basis of cost and both on the basis of not being entirely relevant to coordinators' needs. Some coordinators were looking to develop their own databases in-house, but it was recognised that this could be costly and involve an unnecessary duplication of effort.

The size and organisational complexity of some childcare coordinators' territories could also make communication difficult, as could the necessity (for most coordinators) to rely on the support of managers in the various trusts to get their message across. In practice the support received was variable.

'You are very reliant on other people to get your message out. This is not only dependent on communications methods and distribution lists, but on individuals in HR in the various trusts

TABLE 5 - HOW EASY OR DIFFICULT TO REACH PARENTS WITH CHILDCARE NEEDS

Ease or difficulty in reaching parents	No. of Coordinators	%
Very easy	2	6%
Fairly easy	16	48%
Fairly difficult	15	45%
Very difficult	0	0%
Total coordinators	33	100%

to take back the messages that you need to get across. Some are great and some are not so great' (childcare coordinator).

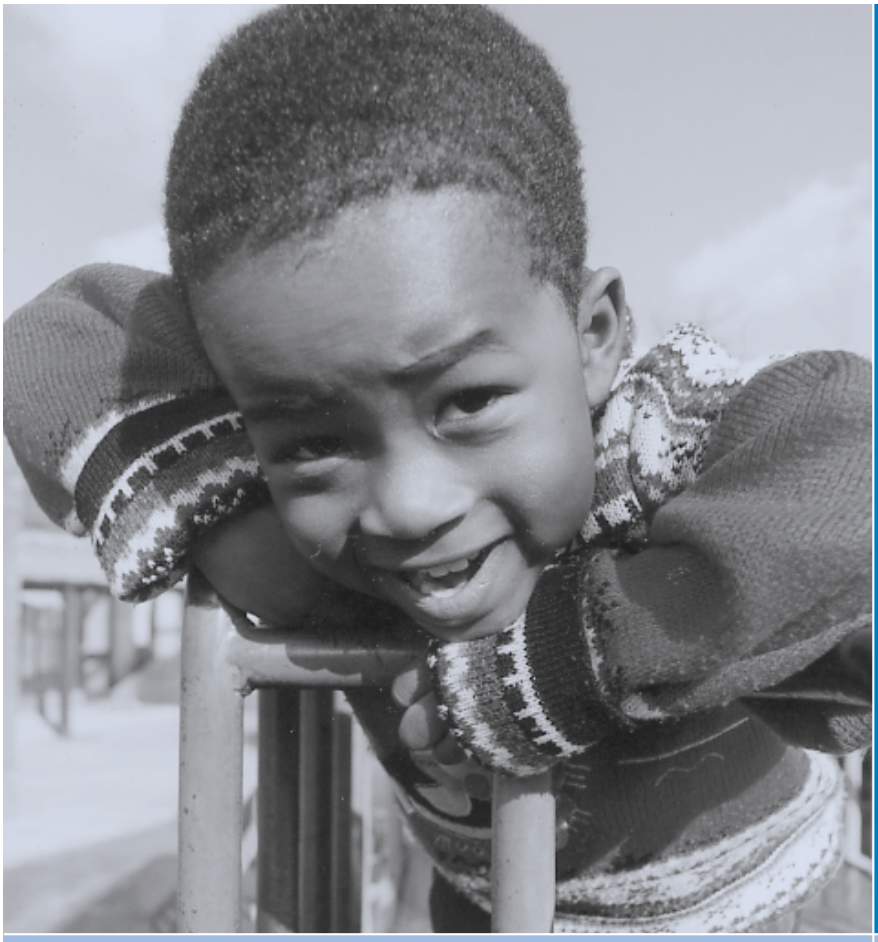
The most frequently cited difficult to reach group for childcare coordinators were GPs and GP practice staff. Part of the difficulty is that GP practices are dispersed in many locations, but many coordinators also had encountered an unsupportive attitude in many GP practices, notably from practice managers.

'It's generally down to practice managers. Their attitude is 'if the PCT won't do it for us then why should we,' particularly if it means extra work for them' (childcare coordinator).

'I sent out some information to GP practices. I had a practice manager ring me and give me verbal abuse, saying it was a waste of funds' (childcare coordinator).

GPs and their practice staff are not NHS employees. Childcare coordinators effectively had to convince small businesses to take on an initiative that they might not regard as relevant to them. The situation was exacerbated, said some coordinators, by the fact that GPs and their practice staff could not access some of the childcare benefits available to PCT staff such as voucher schemes or maternity rights. In addition some coordinator's believed that their work was being hampered by a traditional animosity between GPs and other parts of the NHS.

'At first GPs don't want to know because you work for the NHS. Then they want to know if you are working for them only or for everyone. Everybody here gets the same service. GPs don't like that. They want special treatment.



But GPs don't actually need special treatment when I've talked to them' (childcare coordinator).

Staff members working in the community, such as district nurses, were identified as another difficult to reach group, given that they had no regular office base or access to email. Staff without access to a computer was the other major hard to reach group. This group included domestic staff and front line ambulance staff. Other difficult to reach groups mentioned included staff working in rural or outlying areas, night staff, bank staff and NHS employees working in other organisations such as social services departments.

Childcare coordinators in the case study areas had used a whole array of methods to communicate with staff including mailshots, emails, newsletters, information packs, posters, roadshows and attending staff meetings and inductions. The most effective methods were regarded as email, mailshots/ attachments to payslips and newsletter and magazine articles.

The first two methods had the advantage of being addressed to individuals while the third had the advantage of regularity.

'The newsletter is regular. It goes out to everyone. It's not just there one day but it lingers' (childcare coordinator).

A number of childcare coordinators also stressed the importance of making face-to-face contact and becoming known personally by staff, particularly by those in difficult to reach groups. However, it was recognised that this was not always an option given the size and geographical spread of some coordinators' territories.

The value of word of mouth contact was also emphasised. Several coordinators said that the uptake of initiatives in their area such as playschemes and subsidy schemes had increased as staff members got to hear about it from colleagues who had used a scheme and been happy with it.

Childcare initiative

4.1 INITIATIVE UNDERTAKEN

Table 6 below shows the range of NHS childcare strategy initiatives undertaken in the case study areas as ascertained from the childcare coordinators' survey.

The table reveals that all coordinators in the study were providing some advice on finding childcare and most were helping parents to claim the childcare element of Working Tax Credit. The vast majority of areas were also providing holiday playschemes, many of which had only been set up in the past year. It was also common to provide parents with financial help towards the cost of childcare, whether via a voucher scheme or some other subsidy method. In just over half of the case study areas an on-site nursery had been provided under the strategy. It is worth remembering that in many areas some NHS nursery provision already existed prior to the strategy. In some cases strategy money had been used to extend or improve the provision or widen the opening hours. Table 7 give some examples of how the childcare strategy has been implemented 'on the ground' in selected childcare coordinator territories.

TABLE 6 - CHILDCARE INITIATIVE UNDERTAKEN UNDER NHS CHILDCARE STRATEGY

Initiatives undertaken	No. of Coordinators	%
General advice on finding childcare	33	100%
Help parents to claim the childcare element of Working Tax Credit	27	82%
Holiday playschemes	26	79%
Financial help/subsidised childcare places	19	58%
Childcare vouchers	17	52%
NHS on-site nurseries	17	52%
Childminders/childminder networks	16	48%
Extended nursery opening hours	13	39%
Improved facilities/quality of childcare	12	36%
Emergency childcare	12	36%
Other nursery provision	9	27%
Increased provision for aged 2 and under	8	24%
Increased provision for aged 11 and over	6	18%
Breakfast clubs/after school clubs	5	15%
Provision to meet cultural or religious needs	4	12%
Other help	7	21%
Total coordinators	33	100%

4.2 MOST EFFECTIVE INITIATIVES

Childcare coordinators and parents in the study were both asked for their views on the most effective initiatives. Parents were asked about what they found most helpful personally while coordinators were asked about their area as a whole. Note that the childcare coordinator percentages are higher as they could give several answers whereas parents were asked to identify the one most helpful initiative affecting them.

A significant percentage of parents in the survey nominated on-site NHS workplace nursery provision as the most helpful form of support. Additionally, others who were using NHS nurseries although they didn't work on the site also identified these as being the most helpful form of provision. Holiday playschemes were also identified as being among the most effective initiatives by both parents and coordinators. Financial help comes lower down the list but it is worth noting that in most cases parents' NHS nursery provision and holiday playscheme provision also came with a subsidy attached.
It is also important to note that views on what constitutes the most helpful or effective initiative will partly be influenced by what is available in a given area. In addition, what Table 8 does not reveal is that almost every type of initiative was identified as the most important form of help by at least one parent in the survey.

TABLE 7 - EXAMPLES OF CHILDCARE INITIATIVES IN SELECTED CHILDCARE COORDINATOR TERRITORIES

Area	Provision pre-dating strategy	Current initiatives under the strategy	Planned initiatives
1	None	■ Childcare coordinator Reserved up to 40 places in holiday playschemes	■ Reserved 25 places in 2 neighbourhood nurseries from Feb 04) ■ Producing stork pack
2	Childcare coordinator (one trust only) 2 on-site nurseries Holiday playscheme	■ Childcare coordinator and link assistant (shared by all trusts) ■ Existing nursery opening hours extended ■ Bought 10 places in other nurseries ■ Expanded playschems by 24 places ■ Voucher scheme ■ Maternity contacts ■ Childminding scheme ■ Nanny scheme	■ 100 place day nursery and creèche (from march 04)
3	2 on-site nurseries Holiday playscheme	■ Childcare coordinator ■ 2 new playschemes (50 places on total) ■ Reserved 10 places in holiday playscheme ■ 2 voucher schemes	■ 60 place day nursery (Jan 04) ■ 2 further voucher schemes
4	3 on-site nurseries	■ Childcare coordinator ■ 35 new nursery places ■ Reserved 10 places in holiday playscheme ■ Holiday playscheme ■ Emergency childminding scheme ■ Voucher scheme	■ Arranging priority access to 10 further holiday playschemes (summer 04) ■ 4 further vouchers schemes

TABLE 8 - MOST EFFECTIVE CHILDCARE INITIATIVES

PARENTS **Childcare initiative**	**No.**	**%**	CHILDCARE COORDINATORS **Childcare initiative**	**No.**	**%**
NHS workplace nursery place	9	26%	Holiday playschemes	19	58%
Holiday playscheme place	6	17%	General advice on finding childcare	19	58%
Flexible working	4	11%	NHS on-site nursery provision	12	36%
General advice on finding childcare	4	11%	Subsidised cost/financial help	9	27%
Subsidised cost/financial help	3	9%	Childcare vouchers	8	24%
NHS nursery place – not on site	3	9%	Help to claim the childcare element of Working TaxCredit	5	15%
Total responses	35	100%	Total responses	33	100%

4.3 NHS NURSERIES

Both parents and childcare coordinators were very positive about NHS nurseries. They were generally perceived to offer high quality childcare at a cost that was much more affordable than that associated with most external nurseries.

'I've had experience of one other government nursery, one private nursery and the NHS nursery. The NHS nursery is best. My child feels much better there. As parents we're extremely happy with the care delivered by the NHS nursery' (parent).

'I was paying £660 a month to a private nursery and I was finding it difficult to continue in my job. Then I got a place here and, along with the other financial help I got, I am saving £230 a month. I now feel there is light at the end of the tunnel' (parent).

NHS nurseries often also offered associated benefits such as emergency places and extended opening hours. For example, in one case study area the NHS childcare strategy money had helped to fund an extension in a nursery's opening hours to allow it to open until 9.30 pm on weekday evenings and also to open Saturdays.

Having a workplace nursery not only created a platform that extended services could be built on, it also provided a focal point for parents.

'An on-site nursery creates a community of people with children and enables them to form their own support network' (HR director).

Many parents said that they preferred to have childcare provided at their place of work, particularly because if there was an emergency or their child was sick they could get there quickly. However some parents, especially those with school age children, felt that it was more practical to have childcare near home. Those with younger children also acknowledged that their preferred location might change as their children got older.

While the advantages of having a workplace nursery were widely recognised, some coordinators said that in their areas it this was simply not a viable proposition, because the workforce was dispersed both in terms of where they lived and where they worked. This was especially the case in PCTs and in rural areas.

'We had a workplace nursery opened in a rural area. Only three NHS staff members put their kids in. They had to open it up to the local population. It was costing the PCT too much money to help just three staff' (childcare coordinator).

In some areas rather than develop their own nursery facilities, childcare coordinators had put their energies into securing discounts with other nursery providers.

It was argued by some that the current childcare strategy funding structure was skewed towards the acute trusts because they were much more likely to be in a position to benefit from the capital and revenue funding for new nursery development. On the other hand, childcare strategy funding had encouraged acute nurseries to open up access to local parents working in other parts of the NHS, and the study found several examples of this practice.

Nevertheless, the study still found considerable disquiet among childcare coordinators that many NHS workplace nurseries were not opening up their places to NHS staff from other PCTs and trusts. In some cases, particularly where the facility was being run by a private company, the on site nursery was not even fully accessible to the staff from the trust in which it was based.

'My PCT would rather give places to members of the public than to other PCT staff' (childcare coordinator).

'Workplace nurseries managed by others need to change their culture to meet NHS needs. The places in these nurseries should be going to NHS staff' (childcare coordinator). 'We need to work in wider health communities more. Trusts need encouragement to be less parochial and to work more in partnership' (WDC childcare lead).

4.4 HOLIDAY PLAYSCHEMES

The holiday playscheme initiatives undertaken as part of the strategy were also judged to have been a big success by most parents and childcare coordinators. Again there was praise for the quality of the provision and for the fact that places were generally provided to parents on a subsidised basis.

'There was a scheme near my home, but I don't trust it so I wouldn't send my kids there. The childcare coordinator found me another scheme on the way to work and the NHS paid for half of it. That gave me peace of mind, and I was able to do my job properly knowing that the kids were stimulated and safe' (parent).

'I was very grateful to find out about the hospital play scheme. The quality of care was much better and the price was much better at under £4.00 per day. I have to travel to access it but it's better than the play scheme near my home' (parent).

'In the past when I have found childcare myself, I have found the

'I was very grateful to find out about the hospital play scheme. The quality of care was much better and the price was much better at under £4.00 per day. *(parent).*

children, bored, not happy and not supervised well. With the scheme the childcare coordinator has since found for me the quality has been a lot better. I know a lot is talked about cost but quality is important too. No matter what you pay, you want to be absolutely certain that the children are being looked after' (parent).

Around two-thirds of coordinators with playschemes in their area had developed some in-house schemes. One coordinator who had done this reported that the scheme was a great success with parents but that it had been very hard work to set up in terms of recruiting staff, getting Ofsted registration and so on. Other coordinators had decided against setting up their own schemes for that reason.

A number of coordinators reported that the schemes, while well received by the parents and children that used them, had experienced low take up. A number of explanations were advanced. One coordinator felt that the cost of the scheme had been a disincentive. Also, in many cases the schemes only started running in the 2003 summer holidays and a number of coordinators felt that the word had not got around parents as yet. It was also felt that in some cases news of the schemes had come too late for parents, who had already made their own holiday care arrangements. In another area where the playscheme was longer established its 74 places were full to capacity every day. The childcare coordinator was of the view that such schemes needed a lead in period of about a year before they were full.

'If you offer a service that is not already available locally and it is good, then it should build up quickly and the children will return' (childcare coordinator).

It is possible that in some cases the number of staff served by a scheme was too small to make it financially viable. Some coordinators had addressed this problem by getting a consortium of PCTs and trusts to fund a scheme or schemes. This had the added advantage that staff working in one area but living in another could access any of the various schemes funded by the consortium.

4.5 HELP TO MEET THE COSTS OF CHILDCARE

The study identified a number of different ways in which the NHS childcare strategy helped parents to meet the costs of their childcare. One of the main ways is the revenue subsidy of on average £30 per week attached to new nursery places provided through the strategy. Some childcare coordinators felt that other forms of financial help, such as childcare vouchers, were fairer as the assistance was available to parents using a wider range of childcare and not just to those with an NHS nursery place.

The voucher schemes in the case study areas operated on a salary sacrifice basis where the financial benefit to the parent was in not having to pay national insurance contributions on the cost of the voucher. Parents and childcare coordinators were mainly positive about voucher schemes.

'It's not that much money but it's an acknowledgement from the trust that it costs you money to come to work for them' (parent).

However, there were also a number of criticisms of voucher schemes. Take up was low in some of the areas surveyed. In one area it was claimed that out of 3,000 employees only eight or nine were using childcare vouchers. Among the reasons given for the low take up was that the financial benefits to parents were perceived to be quite small and that the salary sacrifice concept and its implications for other benefits such as pensions was confusing to parents.

'Parents think it's like Marks and Spencer's gift vouchers. When you tell them they are going to have to use part of their salary to pay for them, they're not interested' (childcare coordinator).

Some coordinators also reported problems in getting voucher schemes approved by local Inland Revenue offices. In one case there was no scheme because the local tax office would not allow it.

'I can't move on voucher schemes in my area because our tax office is biased against it. They feel the guidance is unclear' (childcare coordinator).

A number of coordinators had used childcare strategy revenue funding to provide parents with childcare at a discounted rate, most notably in holiday playschemes. In many cases the discount, of £5 per place per day for example, was paid to the scheme provider who then offered the place to the NHS parent at an equivalent reduced rate. However, one of the problems of this arrangement was revenue sum towards the discount was also often used as a retention fee to reserve the place which would be forfeited to the provider if the place was not taken up.

In one of the case study areas most of the coordinators operated subsidy schemes, where the parent paid the fee up front to provider and then claimed a subsidy of £5 per place per day back from the NHS. The subsidy schemes were generally used for holiday playscheme provision but one coordinator had set up a pilot scheme providing a £2.50 per place

per day term time subsidy for 0–3 year olds.

Coordinators using subsidy schemes compared them favourably to vouchers. It was argued that the subsidy scheme could subsidise a wider range of unregistered care for children over the age of 8 than vouchers. In the case study areas the subsidy was available for holiday schemes for children up to the age of 16. The subsidy scheme was also felt to be simpler and more tangible than voucher schemes.

'Parents get it after the event. We need a receipt from them so they can see they are getting something' (childcare coordinator).

Take up of the subsidy schemes had been good. In one area the coordinator had reported that take up had grown in six months from ten parents claiming to 160 claiming.

'There has been a really good uptake. Initially take up was slow. It was as if staff were saying, 'why is the NHS giving us this?' Then the floodgates opened' (childcare coordinator).

Administration was becoming a burden as the schemes became more popular. Administration of subsidy schemes is done in-house, unlike voucher schemes where the scheme is administered by the voucher companies, albeit for a fee. Coordinators also suspected that some parents were trying to abuse the system with, for example, both parents trying to claim a subsidy for the same child. In addition the subsidy is liable to tax and national insurance, unlike vouchers which are exempt from national insurance.

There was a danger of the schemes becoming victims of their own success and consuming too much revenue funding. In one area the coordinator had just changed the eligibility rules so that the subsidy was only payable to those parents earning less than £52,000 per year but not receiving the childcare element of Working Tax Credit. It was this middle-income group, she felt, which was most in need of the subsidy.

Another way that the childcare strategy helped parents to meet their childcare costs was by assisting them to claim the childcare element of Working Tax Credit. Over half of the parents in the case study sample, including most of those on lower incomes, were receiving this tax credit.

Opinions varied as to how helpful the childcare element of Working Tax Credit was. Some coordinators argued that it was very helpful, especially to those staff members on low incomes who could have up to 70 per cent of their childcare costs met.

'Tax credit is a brilliant thing to have. It's a big bonus on top of wages' (parent).

Some coordinators agreed that the credits were helpful but the process of claiming was too long and complicated. In at least a couple of the case study areas the feedback from coordinators was quite negative.

'It's embarrassing. You promote them loads and then people come back to you complaining about delayed payments, wrong payments and not getting through to the helpline' (childcare coordinator).

'You spend a lot of time promoting them, but at the end of the day we have had lots of negative feedback from staff as most people aren't eligible' (childcare coordinator).

4.6 EMERGENCY CHILDCARE

The provision of childcare to parents in an emergency was an area where less had been done compared to some other childcare initiatives. Childcare coordinators explained that surveys often identified the provision of emergency childcare as a priority, but in practice the take up for emergency care initiatives was often low. In an emergency, parents often preferred to take carer's leave. This was particularly true if their child was sick. There was also a reluctance to leave a child with a childminder that the child did not know.

'I rolled out a pilot scheme offering three days free childminding in emergencies. It was not taken up' (childcare coordinator).

In some areas emergency care was attached to an established nursery, with one or more places held vacant to accommodate children in emergencies.

'Parents feel safer when their children are in a nursery. It's more public and the children feel comfortable' (childcare coordinator).

However, even this provision was often not well used. In one childcare coordinator's area four emergency places were set aside and these were used twice in one year. This was felt to be 'a waste of money' so the emergency places were subsequently reduced to one. The coordinator was also looking to use vacant places in an external nursery on an ad-hoc basis to deal with emergencies in future.

In another area the childcare coordinator set up a home sitter service where one of the nursery workers was available to provide emergency care for a fee of £2.50 per

hour. The uptake for the service had not been high, but a consultant anaesthetist had used it for one continuous week.

'The sitting service paid for itself in that week considering the cost to the NHS in cancelled operations if she had not been able to go to work' (WDC childcare lead).

4.7 FLEXIBLE WORKING

Although not strictly part of the NHS childcare strategy, flexible working has been promoted heavily within the NHS as part of the wider IWL initiative. Many parents in the focus groups spoke of how their working arrangements had helped them to look after their children. For example, some parents had been able to come back from maternity leave part-time. Some had been able to reduce their hours or work more flexibly. Others had made use of carer's leave when their child was sick.

'Flexible working to let me pick up my daughter and take her to school is very important to me' (parent).

Parents were divided as to whether childcare provision or flexible working was more important to them personally. Many would not opt for one over the other saying that both were essential.

However, from the point of view of the service it was acknowledged that there were times when providing childcare for parents was preferable to giving parents more flexibility to look after their children themselves. The childcare option could be less disruptive to the service. Also, allowing staff with children too much flexibility sometimes created resentment among their colleagues.

'You can only allow flexibility for a small number of staff. You set a precedent by giving it to someone, then someone else who doesn't get it gets hacked off and they leave' (HR manager).

'The attitude of other staff is 'why should we always have to do the rubbish shifts? " (childcare coordinator).

It was the widely held view that attitudes towards flexible working had improved within the NHS in recent years. Parents reported that most of their line managers had been supportive of requests to reduce or change hours or to take leave for childcare reasons. However, there also had been a number of cases where managers had been extremely unsympathetic to requests for flexibility around childcare. This was identified as a particular problem in areas of the NHS where there traditionally had not been a large female workforce, but in most cases the problems were perceived to be down to the attitudes of individuals whether male or female.

'My manager and colleagues don't know anything. He doesn't even include me in the headcount just because I'm pregnant. I'm the only female working in a male environment. I've had no support from my colleagues, only resentment. They are worried that they will have to carry my workload while I am pregnant. I'm anxious about what's going to happen in the future related to breast feeding and when the child is sick' (staff member).

'I don't ask for carer's leave, because I don't want to put my manager in the position of having to turn me down' (parent).

4.8 LINKS WITH EYCDPs

A number of childcare coordinators reported having forged close relationships with the Early Years Development and Childcare Partnerships (EYDCPs) in their area. These links had been used to assist strategic planning, as a source of information and advice and to access or develop childcare provision.

In one area the childcare coordinator was provided with a regularly updated detailed database of childcare provision from one of the CISs in the area. This was unusual as most CISs would not release this information to childcare coordinators. In another area some childcare coordinators had bought places in EYDCP playschemes and neighbourhood nurseries rather than develop this provision in-house.

'It was easier to do it through the EYDCP. You know you are going to get good quality childcare' (childcare coordinator).

However, some childcare coordinators reported that they had encountered problems in developing provision in partnership with EYDCPs. There were difficulties in joint funding schemes from different funding streams, each with their own criteria, rules and targets. There were also issues around who employed the staff, took ownership of the project and assumed the risks. In one area this meant that partnership schemes had to be divided up into different spheres of responsibility with the NHS funding a playscheme and the EYDCP funding the breakfast club on the same site as it had proved too difficult to joint fund both together.

'This doesn't make sense when you think that all the money is coming from the government in the end' (childcare coordinator).

4.9 OUTSTANDING NEEDS AND ISSUES

Just over 30 per cent of the parents surveyed said they had outstanding childcare needs. The most frequently mentioned need was for childcare for children aged 11 or over. Other needs mentioned included a pick up service for children after school, childcare help on teacher training days and support for a child with special needs. Not all of the needs identified are currently unmet. In some cases parents were anticipating a problem arising as their child got older.

The case studies also helped to identify areas where there may be gaps in provision. The difficulties faced by parents in accessing appropriate emergency childcare has already been mentioned, as has the lack of suitable provision for children aged 11 and over. Another area where there seems to be a shortfall in provision is before and after school care during term time. Not all schools provided after-school or breakfast clubs which forced parents working in the NHS to changetheir working hours or to rely on informal support. It was recognised that this issue was a difficult one for the NHS childcare strategy to address. Staff members were often drawn from a wide area and there was a need for thisform of provision to be located near their home or their children's schools.

TABLE 9 - VIEW OF OVERALL HELPFULNESS OF CHILDCARE STRATEGY IN MEETING CHILDCARE NEEDS

	Parents		Childcare Coordinators	
View of helpfulness	**No.**	**%**	**No.**	**%**
Very helpful	19	54%	14	42%
Fairly helpful	10	29%	18	55%
Fairly unhelpful	5	14%	0	0%
Not at all helpful	1	3%	0	0%
Not known	0	0%	1	3%
Total	35	100%	33	100%

4.10 OVERALL SUCCESS OF CHILDCARE STRATEGY IN MEETING CHILDCARE NEEDS

Parents and childcare coordinators in the case study areas were asked for their views on how successful overall the NHS childcare strategy had been in meeting parents' childcare needs. Parents were asked the question in relation to their own needs, while childcare coordinators were asked to look at the issue from the overall perspective of parents in their area.

Table 9 shows that over 80 per cent of parents and almost all of the childcare coordinators in the case study survey perceived the NHS childcare strategy to have been helpful in meeting parents' childcare needs. Over half of parents said that the NHS had been very helpful in meeting their needs. The survey finding underlines the fact that, despite particular problems and criticisms, the overall view of the strategy is that it has had considerable success in addressing the childcare needs of parents working in the NHS.

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Impact on working lives

5.1 MEASURING THE IMPACT

While it is clear that the childcare strategy has proved helpful in meeting parents' childcare needs, the question remains as to how big an impact the strategy has had on parent's working lives. In particular, what benefits have there been in terms of the recruitment, retention and return of people to the health service workforce?

The evidence from the case studies is that the impact of the strategy on recruitment, retention and return has proved difficult to measure. Trusts routinely gather a range of HR information on issues such as vacancy levels, staff turnover rates, reasons for leaving and sickness and absence levels that could potentially be used to measure the impact of the childcare strategy on recruitment, retention and return.

In practice however the usefulness of such HR data in this regard is limited. This is in large part because a whole range of factors, of which childcare support is only one, can affect measures such as vacancy levels and turnover rates. It is not generally possible to isolate the impact of childcare on any of the key HR variables, especially as existing HR systems cannot identify and permit a separate analysis of those staff with children.

The situation is further complicated by the fact that existing data collection systems have not been designed with childcare issues in mind. For example, codes on leavers' forms often may not allow a lack of childcare provision to be identified as a reason for leaving the service.

Moreover, in many trusts the HR data gathering and recording systems were not always functioning well. For example, exit interviews were not carried out in significant numbers in any of the trusts visited. Many trusts' IT systems were in a state of transition and development, particularly where trusts had recently merged or new PCTs had been created. One consequence of this is that in most case study areas it proved impossible to obtain data going back further than a year or so. Where such time series data is not available it becomes difficult to measure the impact of the childcare strategy due to a lack of historic baseline statistics.

A different problem is created by the fact that in many areas much childcare provision is fairly new on the ground. It has already been noted, for example, that in the case study areas many of the childcare coordinators had been appointed and much of the provision established in the last year. There simply has not been the time for many of these initiatives to make their full impact on recruitment, retention and return.

Having said this, the study found many different examples as to how the childcare strategy had improved working lives. However, much of the evidence was anecdotal. The difficulties in gathering hard data had been experienced by childcare coordinators, most of whom had to make a case to their local PCTs and trusts for the continued support of the childcare strategy in their area.

'To be honest I don't know how the strategy has improved working lives. We only have anecdotal evidence. The size of the impact is hard to measure particularly when you are working with a large number of organisations. And when you are putting your business case forward and you don't have the hard data, it's a problem' (childcare coordinator).

5.2 THE IMPACT ON RECRUITMENT, RETENTION AND RETURN

Notwithstanding the data collection difficulties mentioned above, this study attempted to identify and in some ways measure the impact of the childcare strategy on the working lives of NHS parents in the case studies. The main method used was to ask parents directly about the impact on them both in the questionnaire survey and subsequently, in more depth during the focus groups. Caution has to be exercised because the numbers interviewed were very small. Nevertheless some general themes emerged from this evaluation that we believe are likely to have a wider applicability.

The parents in the survey were asked to identify the ways, if any, that the childcare strategy had improved their working lives. The results are shown in Table 10.

TABLE 10 - PARENTS' VIEW ON THE IMPACT OF THE NHS CHILDCARE STRATEGY ON THEIR WORKING LIVES

Impact on working lives	No. of parents	%
Enabled to remain working within the NHS	11	31%
Enabled return from maternity leave	11	31%
Reduced the amount of absences or leave taken	11	31%
Increased job satisfaction/morale	9	26%
Other improvement	5	14%
Enabled move to another job within NHS	3	9%
Enabled recruitment to the NHS	2	6%
Enabled vocational training to be undertaken	1	3%
Enabled return to NHS after career break	0	0%
Has not improved working life	10	29%
Total parents	35	100%

Over 70 per cent of those questioned revealed that, in addition to helping to meet their childcare needs, the support provided under the strategy also had made a tangible impact on their working life. It is interesting to note that almost all of those who said that the strategy had made no impact came from one case study area. Most of these staff had been unable to access childcare support other than general advice from the coordinator. This was probably because in this area initiatives funded under the strategy were in their infancy.

'I sorted out the childcare myself. When I was recruited, I moved from Bedfordshire and would have welcomed some help' (parent).

Where the childcare strategy had made a positive impact on parents' working lives it was generally agreed that two of the biggest areas of impact had been around retaining existing staff and enabling existing staff members to return after maternity leave.

'Staff members say they have stayed working for the trust due to the childcare support they receive here. Without it they would have left' (childcare coordinator).

'If the nursery was not available I would not like to think about it' (parent).

'Getting a nursery place will enable me to return from maternity leave. I definitely would not come back if it wasn't there due to the cost' (parent).

'Maternity leavers have returned to work due to the childcare advice they received before they left and during their leave' (childcare coordinator).

The point was also made that if you could get staff members' children into the childcare system as babies and then continue to provide for them as they grew older, you could secure the long term retention of these staff, as parents were often reluctant to change settled childcare arrangements.

'Staff members know that the facilities are here for them from their child's birth until they reach the age of 11' (HR manager).

The number of parents in the study that said that the childcare strategy had helped them to be recruited to the NHS was much smaller. Over 60 per cent of childcare coordinators in the study said that the strategy had assisted recruitment. Nevertheless, there was a general perception that the NHS childcare strategy had made a bigger impact on the retention of staff than on their initial recruitment. This was partly because it was much easier for childcare coordinators to publicise and promote childcare to parents once they were in the service. Also, a number of coordinators had not yet managed to get childcare information sent out to job applicants as a matter of routine. Nonetheless, there was clear evidence that for some parents in the study, the provision of childcare support had been a decisive factor in facilitating their recruitment to the health service.

'I went to the childcare coordinator to help me with childcare and she did, and therefore I could take the job' (parent).

One of the other main benefits mentioned by parents was that having better childcare support

meant that they had to take less time off work. To a lesser degree the strategy had also enabled people to take up opportunities for promotion or training. However, for a significant number of parents, the childcare help received had not meant the difference between working or not working, as many would have fallen back on informal childcare or changed their working hours. Rather the main benefits of the strategy for this group of parents were around feeling less stressed, more valued or just happier in the knowledge that their children were being well cared for while they were at work.

'The vouchers have helped me to remain in my job, but if I wasn't there I would still need to work. But I have a bit more income now and I feel a bit more appreciated' (parent).

'Peace of mind is important, knowing your children are being well looked after' (parent).

So, the evidence from the case study areas was that there were many ways in which the NHS childcare strategy had improved parents' working lives and benefited the health service. At one end of the spectrum benefits to the service were indirect through having a less stressed and more valued workforce providing care to patients. At the other end of the spectrum the childcare strategy has helped the NHS to recruit and retain staff. The difficulty is in quantifying the extent of these gains in recruitment and retention. An analysis of the responses to the case study questionnaires reveals that the childcare strategy had enabled up to 18 (51 per cent) of the 35 parents surveyed to be recruited, retained or to return from maternity leave who could otherwise have been lost to the health service.

The figure of 51 per cent is used because, as the focus group discussions revealed, people's decisions around work and childcare are in reality often rather complex. If childcare support had not been available some of these parents might have taken up their job offers or continued in their current posts anyway. Some may have found employment with another trust that did provide childcare, so their services would still have been available to the NHS.

The overall influence of childcare on recruitment, retention and return was discussed with HR managers in all of the case study areas. Some cautioned that is was important not to overstate the impact of childcare in recruitment and retention. They pointed out that in their trusts many staff, most probably a majority, did not have children.

Some HR managers made the important point that there could be wide disparities between different occupational groups within the health service in terms of their childcare needs. Local childcare strategies had to take account of the stages that different staff groups were likely to be at in both their personal and career development. For example, it was argued that community nurses and health visitors would often work as nurses in acute trusts first then undertake further training. It was often when they became employees of PCTs that they would start a family and at this point childcare would become important to them. It is also interesting to note that over two-thirds of parents interviewed in the case study areas were aged between 30 and 40.

It was also argued that for certain occupational groups, recruitment and retention problems were caused by national shortages of trained staff. In these cases there were simply not enough trained staff to go round and childcare incentives would mainly attract staff from one trust to another rather than making any significant difference to the overall numbers of staff in the health service.

Nevertheless, most HR managers believed that, while it was 'only part of the equation', childcare provision had an important role to play in recruiting and retaining staff.

'Childcare forms part of a whole package of measures that help to retain people. It is not the only thing in the package, but we can't have the package without it' (HR director).

'It can help us compete for hard to recruit groups. We need to be better than other local hospitals' (HR manager).

'My gut feeling is that childcare is very important' (HR manager).

5.3 THE ROLE OF CHILDCARE IN RECRUITMENT AND RETENTION STRATEGIES

As demonstrated by the case study findings, childcare provision can make an impact on recruitment and retention in the NHS. To what extent therefore is childcare provision for staff currently featuring in recruitment and retention strategies at a local level? The table below gives examples of the priority groups for retention in the case study areas as identified by HR managers.

Childcare coordinators were also asked to identify the priority groups in their particular areas, but many if not most were unable to do so. In many cases the Recruitment and Retention Groups, Workforce Development Groups, Workforce Information Managers or individual Heads of Service were not passing

TABLE 11 - EXAMPLES OF PRIORITY GROUPS FOR RECRUITMENT AND RETENTION

Acute trusts	PCTs
Nurses generally	Health visitors
Theatre nurses	District nurses
Nurses for the elderly	Podiatrists
Radiographers	Physiotherapists
Pharmacists	Speech and language therapists
Some consultant posts	GPs
Ancillary staff (e.g. porters, cleaners)	Dentists

'The Recruitment and Retention Group within the trust doesn't link the childcare coordinator or me into their decisions' *(HR advisor).*

on this information to childcare coordinators.

As a consequence there was very little evidence of childcare initiatives in the case study areas taking much account of strategic priorities for recruitment and retention. The only exception to this was in the criteria for allocating nursery places in certain areas which did favour hard to recruit groups. In one area nursery places were allocated according to a list of nine priority groups. However, similar allocation criteria were not applied to other childcare initiatives in that area.

Some childcare coordinators expressed a reluctance to give priority on recruitment and retention grounds, believing that access to childcare support should be open to all staff members on an equal basis. Some coordinators had a particular difficulty with the idea of giving preference to higher paid occupational groups, even where these were the priority groups for recruitment and retention.

'If we targeted subsidies on the higher paid members of staff, people would call us and complain' (childcare coordinator).

'I support GPs, but the money should go to the lower paid people. I limit my services to GPs to advice only' (childcare coordinator).

Other coordinators said that they would be willing to target their policies on hard to recruit groups, however well paid, if this was ultimately in the best interests of the health service and of most benefit to patients.

'We should try to be equitable, but we have to remember that it's a recruitment tool' (childcare coordinator).

Nearly all childcare coordinators complained that the nature of their work was not fully appreciated by trust boards and senior managers. They argued that managers often failed to see how childcare provision could assist recruitment and retention and, therefore, help the trust meet its service delivery objectives.

'The board wants reduced waiting lists and trolley waits but they don't see the importance of what we do' (childcare coordinator).

'We are conscious that there is a big gap between HR and childcare on the one hand and service priorities on the other' (HR advisor).

'The childcare strategy is only seen as something nice for staff' (childcare coordinator).

Many childcare coordinators reported that they were struggling to get integrated into strategic decision-making. Many felt they had difficulty getting access to the appropriate decision making bodies or senior mangers.

'The problem is where we are within the organisational structure. We are not high enough up within our own organisations' (childcare coordinator).

Childcare coordinators were having particular difficulty in making a business case to persuade the management of PCTs and trusts to continue to support and fund the strategy after the devolution of funding to PCTs from April 2004. This was in part because many coordinators lacked the experience to know how to make an effective business case.

'Coordinators tend to be people with a good knowledge about childcare but not about NHS structures and how they work. They are not good at making a business case, and they don't know where to channel that business case' (WDC childcare lead).

'This is a whole new learning experience for all of us, putting forward a credible picture of what we are doing and its impact' (childcare coordinator).

Childcare coordinators had received initial training from Daycare Trust on general childcare issues, but it was now felt by many that they needed a 'masterclass' on how to develop and present a strategic business case and to develop a better understanding of matters such as PCT bidding processes and timings.

5.4 FUTURE PROSPECTS FOR THE CHILDCARE STRATEGY

With less than six months to go before PCTs assume funding responsibilities for the childcare strategy at a local level, childcare coordinators were very concerned that so much remained unresolved. In a number of the case study areas it had not been decided which 'lead' PCTs would hold the budget or how the funds would be distributed to the other PCTs and trusts. In some cases childcare coordinators were unclear as to the processes by which these important decisions would be made between now and April.

While the new method of funding could help to make NHS childcare provision more reflective of local needs and priorities, there was a concern, voiced by childcare coordinators and others in the study, that the new funding arrangement could also lead to parochialism. When funds for the childcare strategy were distributed by the WDC it was often on the basis of a strategic overview of the needs of the whole area. There was a fear that under the new arrangements each ortganisation would want its own slice of the money.

'The PCTs want to focus on their own employees rather than the local health economy as a whole' (HR manager).

Another area of concern was the fact that funding for the NHS childcare strategy was no longer ring-fenced. Many felt that it was inevitable that in coming years PCTs would divert monies away from childcare to service areas that they regarded as higher priority.

All of this had left many childcare coordinators anxious about their jobs. In some of the case study areas as many as half of the childcare coordinators were on fixed term contracts. However, many coordinators believed that their jobs would continue to be funded, at least in the short term. Some coordinators believed that the need for all PCTs and trusts to meet the IWL standards would help in this respect, although they suspected that they would not necessarily always be retained for the right reasons. This view was borne out by the comments of an HR manager in one of the case study areas on the subject of childcare provision.

'It will be a good thing for the organisation to have, like a kitemark' (HR manager).

Childcare coordinators were not so sure about the continuing funded by the childcare strategy was due to open in the next few months commitment to fund actual childcare initiatives. In one area a new nursery with attached revenue funding for a £30 per week discount per place. It had been decided not to take account of the discount in calculating the nursery's budget, because the uncertain funding situation after April 2004 meant that the discount might not be sustainable.

To sum up, the whole atmosphere among childcare coordinators was very much one of anxiety and uncertainty. There were real fears expressed that the changeover in funding arrangements could lead to the NHS childcare strategy running out of steam.

'If the funding is just for my post and nothing else then we're back to basics and we'll be able to develop nothing. Then it will just be another one of those 'initiatives" (childcare coordinator).

Conclusions

The evidence from the study is that the NHS childcare strategy has been successful in helping parents working in the NHS to meet their childcare needs. Over 80 per cent of parents in the case study sample had found the strategy helpful in meeting their needs.

The NHS childcare strategy has also made a significant impact on parents' working lives. The exact extent of the impact on recruitment, retention and return is difficult to measure. However, the evidence from the case studies is that the biggest impacts have been in helping to retain staff within the NHS, enabling parents to return from maternity leave, reducing sickness and absence levels and in improving the job satisfaction and morale of staff members with children.

Nevertheless, the study also found that insufficient attention had been paid as to how the childcare strategy could be used to attain recruitment and retention goals at a local level. Another important finding is that many of the initiatives undertaken under the childcare strategy are still in their infancy and have not yet had sufficient time to make their full impact on meeting parents' childcare needs or improving their working lives.

In terms of what specific measures work best, the study found that this was dependent on local circumstances and the specific needs of parents. NHS on-site nurseries were very popular in terms of providing parents with more affordable, higher quality childcare at more appropriate hours than was often available elsewhere. However, it was not always viable for PCTs and trusts to develop their own nursery provision.

Many parents in the study, particularly those with school age children found other initiatives such as holiday playschemes more helpful to them. This finding endorses the government's earlier decision to expand the childcare strategy beyond the provision of NHS nurseries.

The study also identified areas where there were still significant gaps in provision, most notably in relation to the provision of emergency childcare, holiday playschemes for children aged 11 and over and before and after-school care.

The value of the advice and support to parents that is available from childcare coordinators was underlined by the study. However, many coordinators highlighted the difficulty of maintaining a high level of personal contact with parents and

at the same time meeting the strategic requirements of the job.

The study highlighted the value of childcare coordinators expanding their role to provide assistance to staff members with other care issues. While this would help make the work of childcare coordinators relevant to a wider group of staff it also places more demands on coordinators' time and requires them to take on a role that they are not necessarily qualified to perform.

The evidence from the case studies also suggests that childcare coordinators are experiencing difficulties in communicating with staff. Particular difficulties were reported in reaching certain sections of the workforce, notably GPs and GP practice staff, staff working in the community and those without access to email. Childcare coordinators' communication difficulties are greatly exacerbated by the fact that HR information systems do not record whether staff members have children, thereby making it very difficult to target those members of the workforce who potentially need childcare support.

Difficulty in affording the cost of childcare was identified as the single most important childcare issue facing parents working in the NHS. The study raised a number of issues about how the childcare strategy could best help parents to meet the costs of their childcare. Many felt that the cost savings to parents from vouchers were often not big enough or tangible enough to make them popular with parents. Subsidy schemes, whereby parents could claim part of the cost of their childcare back from the NHS, appeared to have a better take up. However, the schemes were proving time consuming to administer and the discounts were liable to both tax and national insurance.

It also appears that the childcare element of Working Tax Credit is proving helpful to NHS parents in contributing towards their childcare costs. Over half of the parents in the study were in receipt of the childcare element of Working Tax Credit. However, the claims process was criticised for being too long and complicated and its effectiveness was thought to be limited by the fact that many NHS parents on middle incomes were not eligible to receive it.

The study highlighted the importance of flexible working arrangements in supporting the childcare strategy. Many of the parents interviewed had benefited from flexible working arrangements and most had found their managers agreeable to requests to work flexibly. However, there were reports of some managers within the health service being obstructive and unsympathetic to staff members with childcare issues.

The study revealed the value of PCTs and trusts working in partnership with one another and with other organisations such as EYDCPs. In many cases it was more viable to pool resources or to help parents to access external provision rather than to develop schemes in house. However, the study also uncovered instances where different organisations were failing to co-operate, for example where one NHS trust did not allow parents employed by other trusts to access its workplace nursery.

Another key issue that emerges from the study is the difficulty that many childcare coordinators are experiencing with integrating into the organisational structures of PCTs and trusts. In the case studies many coordinators were receiving their main support and direction from their WDCs and childcare coordinator networks rather than the organisations they were serving.

The study calls into question the strength of support for the childcare strategy within many PCTs and trusts. There is a widely held perception among childcare coordinators that senior management often regard childcare provision as a perk for staff rather than as a tool that can help them to meet their strategic objectives around service delivery and patient care. The attempts of childcare coordinators to convince management about the importance of the childcare strategy appear to have been hampered by the lack of experience of most coordinators in making a business case for childcare.

Finally, it is apparent from the study that the change in funding arrangements from April 2004, whereby childcare will be funded out of PCT budgets, is creating a great deal of uncertainty about the level of future support for the childcare strategy. There is a real danger that with the switch to the new funding regime the NHS childcare strategy will lose much of its momentum.

Many felt that it was inevitable that in coming years PCTs would divert monies away from childcare to service areas that they regarded as higher priority.

Recommendations

RECOMMENDATIONS TO CHILDCARE COORDINATORS,WDC CHILDCARE LEADS, PCTs AND TRUSTS

- That much greater importance is placed on using the childcare strategy to further PCTs' and trusts' strategic objectives on recruitment and retention.
- That childcare coordinators and those responsible for recruitment within NHS organisations place greater emphasis on using the strategy to recruit new staff to the NHS.
- That childcare coordinators and Workforce Development Confederation childcare leads give high priority to making a business case to management in PCTs and trusts for continued funding of the childcare strategy, and that a key element of this business case is a demonstration of the benefits of childcare for the development and sustainability of an effective workforce providing high quality care for patient.
- That childcare coordinators improve their monitoring of childcare enquiries and the take up of various childcare initiatives in their area, and that this information is recorded on a computer database.
- That the childcare lead in Workforce Development Confederations work with PCTs, childcare coordinators and other stakeholders on how to manage the transition to the new funding arrangements in April 2004.
- That, despite the devolution of funding responsibilities to PCTs from April 2004, childcare coordinators continue to maintain strong links with one another. These are currently being fostered by childcare leads in WDCs and we encourage the continuation of this arrangement.
- That childcare coordinators give greater emphasis is given to working in partnership with other NHS trusts and with EYDCPs, both in terms of the joint funding of childcare initiatives and of allowing mutual access to one another's schemes.
- That any newly formed childcare coordinator territories are designated on a rational basis in consultation with surrounding trusts, and also that they are of a manageable size so as to allow childcare coordinators to have personal contact with staff.
- That childcare leads review the coverage of existing childcare coordinator territories in their area to establish whether the distribution of territories could be done on a more equitable and rational basis.
- That childcare coordinators develop new childcare initiatives according to an analysis of local needs and, in particular, local recruitment and retention priorities, but that special consideration is given to providing more holiday care for children aged 11 and over, more emergency care and more before and after school care.
- That childcare coordinators give special priority is given to developing initiatives that help parents to afford the cost of childcare and that careful consideration is given to the most effective methods of achieving this.
- That consideration is given to the merits of the childcare coordinator's role being expanded to cover other caring issues but, where this occurs, that childcare coordinators are given the training needed to enable them to take on their new responsibilities.

RECOMMENDATIONS TO THE DEPARTMENT OF HEALTH

- That the Department of Health makes further efforts to promote the benefits of the national childcare strategy to NHS organisations.
- That the Department of Health makes further efforts to promote the childcare strategy to local NHS organisations and, in particular, to demonstrate how improved childcare provision can help them to attain their strategic objectives.
- That the Department of Health provides advice to childcare coordinators on the merits of the various means available for helping parents to afford the cost of childcare. the advice should consider the implications of the changes in the tax and national insurance treatment of employer supported childcare that will take effect from April 2005, whereby employer contracted childcare and childcare vouchers will be exempt from tax and national insurance up to an amount or £50 per week.
- That the Department of Health considers the merits and cost effectiveness of centrally funding the development of a childcare coordinator's database that can then be distributed to all coordinators for recording and monitoring enquiries, services provided and their impact.
- That consideration is given to recording basic information on childcare as part of the Electronic Staff Record, most crucially the numbers of children each staff member has and their dates of birth.
- That the Department of Health commissions a further impact assessment of the childcare strategy in around 18 months time. By this time most childcare coordinator posts will be well established and it will be possible to assess the impact of the devolved funding arrangements.
- That the Department of Health continues to work with the government departments and national agencies to promote the childcare strategy and to secure its effective implementation.

APPENDIX 1
Making a business case for childcare

The table below suggests various ways in which childcare coordinators may be able to use 'hard data' to make a business case for childcare provision to the NHS organisations they work with. The table concentrates on data that are likely to be currently available to childcare coordinators or that they can collect relatively easily by means of sample surveys.

TABLE 12 - SUGGESTED WAYS TO MAKE A BUSINESS CASE FOR CHILDCARE

MEASURE	DATA SOURCE	USES
Estimate of number and percentage of staff with children	Sample survey of all staff	Helps demonstrate potentially how big an issue childcare is for the organisation
Percentage of staff wanting/needing different forms of childcare	Sample survey of staff with childcare needs	Can help demonstrate the need/demand for different forms of childcare
Numbers of staff on waiting lists for nursery, playscheme places etc.	Administrative data from projects	Can demonstrate level of demand/unmet need for specific types of childcare
Numbers using various childcare initiatives or number and percent of places taken up	Administrative data from projects	Can help to justify initiatives and make a case for their continuation or expansion
Numbers of women going on maternity leave per annum and percentage of these returning within one year	HR data	Time series data will allow judgement to be made as to how successful childcare initiatives are in encouraging maternity leavers to return to work
Number of staff requesting childcare assistance per annum and number of requests for different types of assistance	Childcare Coordinator's database	Can help to demonstrate the need for the childcare coordinator's service as well as need for different kinds of childcare support
Percentage of staff satisfied with childcare services provided or who judge services as 'effective' in meeting their childcare needs	Sample survey of staff using NHS childcare services (sample drawn from project records and childcare coordinator's database)	Can help to measure the effectiveness of different forms of support in meeting childcare needs
Number/percent of staff using childcare services who believe childcare provision helped them to be recruited to NHS, return after maternity leave, stay within service, take fewer absences etc	Sample survey of staff using NHS childcare services (sample drawn from project records and childcare Coordinator's database)	Can help to measure the impact of childcare support on people's working lives and on recruitment, retention, return and absence