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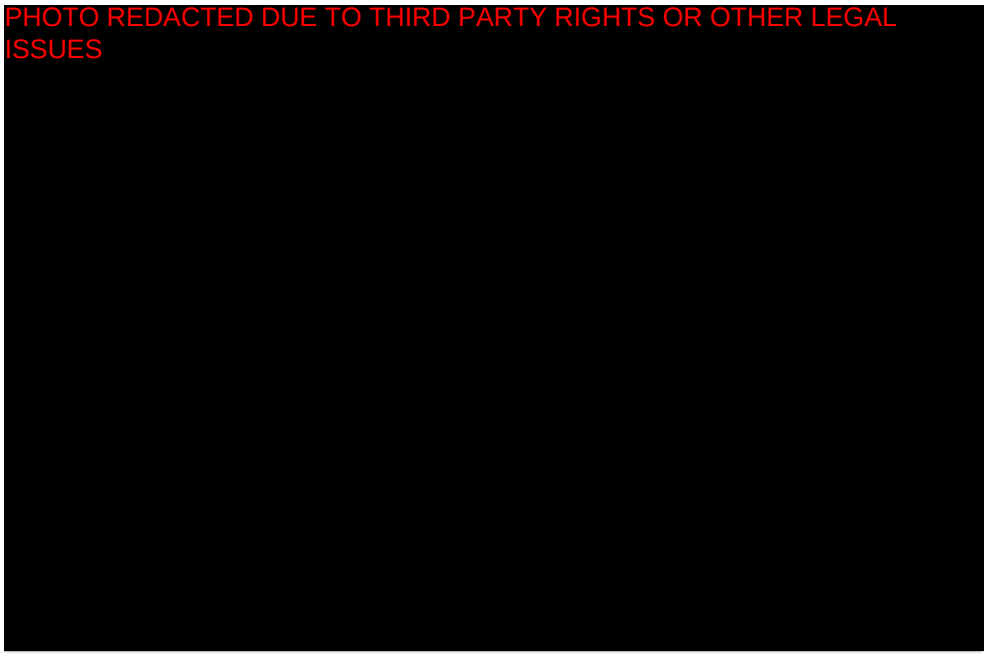
Evaluation of Flying Start

Findings from the baseline survey of families - mapping needs and measuring early influence among families with babies aged seven to 20 months

Main Report



Evaluation of Flying Start

Baseline survey of families

Mapping needs and measuring early influence among families with babies aged seven to 20 months

Ipsos MORI, Social Research Institute

Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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CONTENTS

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The evaluation has been commissioned by the Welsh Government. If you would like more information about the Evaluation, please contact us directly:

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This report was prepared by Emma Wallace, Sarah Knibbs, David Jeans, Sarah Pope, Anastasia Knox, Patten Smith, Jamie Burnett and Ivonne Nava-Ledezma of Ipsos MORI, with input from Lisa McCrindle, Marian Morris and Geoff White of SQW, and Karl Ashworth. It builds on the work of the consortium delivering the national evaluation of Flying Start comprising: SQW, Karl Ashworth, University of the West of England, Bristol and CRG Consulting. We would like to extend particular thanks to Joanne Starkey of the Welsh Government, and the Flying Start Partnerships in all 22 local authorities in Wales, who supported the survey and provided valuable information on the delivery of the programme. We would also like to thank Linda Bloomfield at the University of Hertfordshire for permitting use of the TOPSE tool, and finally, we would like to give special thanks to the 3,591 families who gave up their time to participate in the survey.

Peer review

Peer review is an important process contributing to the maintenance of high standards for research publications. This report has been subject to anonymous peer review, being evaluated for the adequacy and merit of its research by an independent, anonymous peer review who has the appropriate expertise in the academic fields covered by the Evaluation of Flying Start.

Glossary

- **Deprived areas** – These are areas which can be described as 'deprived' according to the Index of Multiple Deprivation (IMD).
- **Flying Start families** – This term has generally been used to refer to the cohort of families sampled for this study (families with a child aged seven to 20 months living in Flying Start areas).
- **Health visitor contact** – This refers to contact with a health visitor or other members of the health visiting team including a health visitor assistant, a nursery nurse, a play specialist or a family support worker.
- **High number of in-home visits from health visitor** – Over 11 in-home contacts with the health visitor.
- **High risk group** – Parents who have had post-natal depression and say that they have felt depressed for more than two weeks since the birth of their child, or who consume alcohol to excess (more than 35 units per week for women or 50 units per week for men) or have experienced domestic violence in their relationship.
- **Language and Play (LAP)** – These are courses designed to help parents and children learn together through play and fun activities. Courses are delivered in a range of community sessions within Flying Start areas.
- **Medium number of in-home visits from health visitor** – Between six and 10 in-home contacts with the health visitor.
- **Multiple socio-economic disadvantage** – Parents or families who live in workless households (no parent currently in paid employment) *and* have low (no higher than GCSE/O-level) or no qualifications (defined as none of the qualifications asked about including academic or vocational qualifications) *and* who have a gross household income of under £10,000 per year.

- **None/low number of in-home visits from health visitor** – Between none and five in-home contacts with the health visitor.[1]

- **Parent(s)** – This term has generally been used to refer to the respondent interviewed which is the main carer of the relevant child in the household (rather than all parents which would include both parents in households with two parents).

- **Parenting groups and initiatives** – Other parenting support groups and initiatives designed to provide other types of additional support for parents.

- **Parenting programmes or parenting courses** – Structured parenting courses approved by Welsh Government as eligible to be funded as part of the parenting support entitlement, for example, the Incredible Years, Family Links Parent Nurturing Programme etc.

- **Potential higher needs groups** – Parents or families with at least one of the following characteristics: workless household; no qualifications; low household income (under £10,000 gross per annum); being a young parent (aged 16 – 19); experience of post-natal depression (has felt depressed for more than two weeks since the birth of their child); heavy drinking (more than 35 units per week for women or 50 units per week for men); lone-parenthood; experience of domestic violence.

- **Potential lower-needs group** – Parents or families who do not meet any of the characteristics of the potential higher needs groups above.

- **Young parents** – Aged 16 – 19 years unless stated otherwise.

[1] The categorisation of high, medium and low number of health visitor visits has been defined by Ipsos MORI on the basis of the distribution of responses. This may not match the definition used by the Flying Start partnerships.

1. Introduction

1.1. This report presents the findings from the first wave of a longitudinal survey of families with children aged less than two years in Flying Start delivery areas and matched comparison areas. The survey was conducted as part of the evaluation of Flying Start for the Welsh Government.

1.2. This chapter outlines the key features of the programme and the evaluation, and the role and methodology of the survey. The remainder of the document sets out the key findings from the survey.

The Flying Start programme

1.3. The Flying Start programme was launched by the Welsh Assembly Government (now the Welsh Government) in 2006/07 and aimed 'to make a decisive difference to the life chances of children aged under four in the areas in which it runs'. It is administered as a grant to local authorities to provide intensive assistance to children and their families within specific catchment areas. It is targeted in the catchment areas of schools in some of the most deprived areas.[2]

1.4. The programme originally invested a minimum of £2,000 per child per annum (rising to £2,100 from 2009/10) in the delivery of the following entitlements:

- health visiting: provision of an enhanced health visiting service, with specific guidance on caseloads – one health visitor full time equivalent per 110 children aged under four in the target areas;[3]
- parenting programmes: provision of parenting programmes which have been judged to generate positive outcomes for children;

[2] Flying Start is on the whole delivered in the most deprived primary school catchment areas although in some cases it may be targeted in other ways where the school catchment has an imperfect fit with the local geographies of deprivation.

[3] This is generally agreed to be a significant reduction compared with average caseloads experienced by traditional health visitors. A factsheet produced by the Unite/Community Practitioners' and Health Visitors' Association (CPHVA) Union in 2007, based on a survey of health visitors and Trusts in England, Scotland and Wales, found that the majority (54 per cent) of full-time health visitors are holding caseloads of 200-300 families, with 26 per cent being responsible for over 400 families. See <http://www.unitetheunion.com/docs/RD674%20Fact%20Sheet%20-%20Determining%20optimum%20caseload%20sizes.doc>.

- basic skills: every family having access to Learning and Play programmes;
- childcare: an offer of 2.5 hours, five days per week of free quality part-time provision for two year olds (or younger where a need is identified);
- information sharing and referral: between all practitioners in Flying Start, to support early identification of need and action to provide higher levels of support where there is evidence of a higher need or risk. Health visitors are expected to play a key role in this process.

1.5. Although these services would be available to some extent in non-Flying Start areas across Wales, Flying Start provides a much more intense level of service and support and is much more active in promoting these entitlements to parents.

1.6. Although Flying Start is universally available within the targeted areas to families with children aged nought to three, the programme does aim to provide tailored support depending on an individual family's needs. Specifically, whilst all families receive health visiting support, some will receive more than others. Likewise parenting programmes, basic skills support and referral to other types of support will be targeted among higher need groups and it is not intended that they are necessarily utilised by all families.

1.7. A central component of delivering Flying Start entitlements is that they are not provided in isolation from one another, but instead delivered as a partnership of services based on the specific needs of each individual family. By the very nature of their work with families from the birth of the child, health visitors serve as the primary source of information on the range of support and services available through Flying Start.

1.8. The elements of Flying Start most relevant to families with babies aged between seven and 20 months surveyed this wave are health visiting, parenting support and LAP support (but not the childcare element). Further information about these elements is provided in the appendices

The programme's theory of change

1.9. The rationale underpinning the Flying Start programme is that providing these entitlements for families in disadvantaged areas will support the development of children; this will help to reduce the need for later remedial action, increase their educational attainment and ultimately reduce the proportion of people with very low skills in adulthood. This rationale is based on a growing body of evidence that supports the positive role of interventions in early years in improving the development of children and young people and their prospects in adulthood.[4]

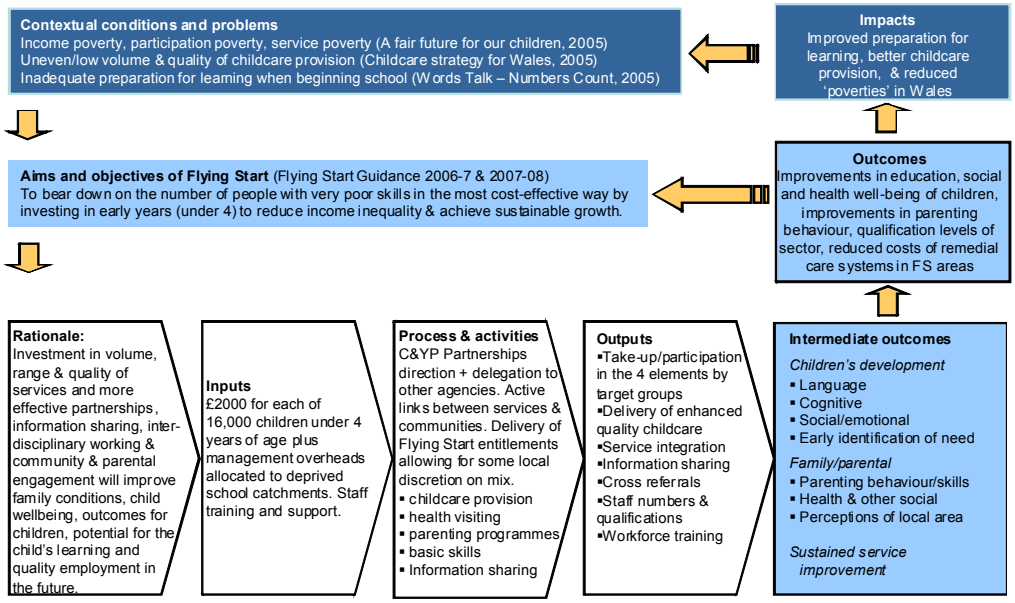
1.10. In the long term, the programme aims to reduce the proportion of people with poor skills and develop a more highly skilled economy. Whether Flying Start has achieved this will not become apparent for many years, when the children of families living in Flying Start areas have reached adulthood.

1.11. The Flying Start programme is seeking to test whether investment in early years contributes to these aims. The more specific shorter term objectives are to identify and respond to children's needs early on, and achieve tangible outcomes for the child in relation to their development, specifically language, cognitive, social, emotional and physical development.

1.12. Figure 1 shows the resulting logic framework of the programme. It is worth highlighting that, at this early stage of programme delivery and the evaluation, the survey findings reported in this document are focused on examining intermediary aspects of (i) programme outputs (e.g., engagement with and take-up of services) and (ii) intermediate outcomes (e.g. parenting behaviour). These aspects are located towards the bottom right quadrant of the diagram.

[4] A review of the rationale for the programme and a review of the available evidence on the effectiveness of early years' interventions can be found in the interim evaluation report which can be found via the following link: http://wales.gov.uk/topics/educationandskills/publications/researchandevaluation/evaluation/intereimevaluation/;jsessionid=CJQ2NSlGnPVGhky6Q1TvJlZDWhng8CQHwVm6vnVm1JfxVNznCvnj!-67787307?lang=en.

Figure 1: Flying Start evaluation logic framework



The national evaluation and the survey of Flying Start families

1.13. SQW Consulting (SQW), Ipsos MORI (with Karl Ashworth), University of the West of England (UWE), Bristol and CRG Consulting were commissioned to evaluate the Flying Start Programme. The evaluation is taking place from 2007 to 2013 and addresses a wide range of questions relating to the implementation of the programme and its early impacts among families and young children. Findings are being used to inform ongoing development and delivery of policy, services and initiatives.

1.14. The survey of Flying Start families reported here forms just one part of the wider evaluation which comprised of a range of other elements, including data and policy reviews, service provision surveys, annual area case studies, thematic case studies and in-depth qualitative work with families.

1.15. The survey of Flying Start families was undertaken by Ipsos MORI with support from SQW. The role of the survey is to provide a key source of quantitative evidence for the evaluation, regarding process and early impacts based on feedback collected directly from a sample of families.

1.16. The survey was conducted at a relatively early stage in the delivery of the programme and among families with very young children (under two years of age). This means that the range of Flying Start services families will have received at the time of Wave 1 fieldwork would have been relatively limited. In particular, free childcare places which are mainly available to children aged over two years of age would have rarely been received[5]. This report is not therefore based on the complete performance of Flying Start but the survey is first opportunity to collect quantitative data from families living in Flying Start areas and to be able to identify early influences of the programme as far as possible.

The design and objectives of the survey of Flying Start families

1.17. A key challenge for all programme evaluations is attributing any outcomes observed among the intended population to the programme itself (rather than to any other influences, such as other service activity, or social and economic influences). The evaluation was commissioned after the roll-out of the Flying Start programme had begun.[6] This means that a true pre-Flying Start baseline survey was not possible. In addition, the Flying Start programme was rolled out in some of the most deprived areas in Wales and therefore a randomised control trial (RCT) that would enable full attribution of the observed differences to Flying Start was not possible.

1.18. A quasi-experimental survey design was therefore adopted as the best approach available to the evaluation team in the context of the limitations described above. It comprised an in-home survey of families in Flying Start delivery areas and a similar survey of families in comparison areas where Flying Start was not operating, from which a matched comparison group has been identified via statistical matching for each outcome indicated measured.

[5] The Flying Start childcare entitlement is available for children aged two to three years, and a small proportion of younger children with high levels of need.

[6] Furthermore, delays (outside the control of the evaluation team and Welsh Government) in accessing Child Benefit Records which was used as the sampling frame for the study caused further delays to the survey.

1.19. The comparison group provides context against which each outcome among families in Flying Start areas can be judged. Specifically, the comparison sample has been used to help estimate, via statistical modelling, the 'counterfactual' (that is, what the outcome would have been had the Flying Start programme not been implemented), thus providing a quantitative indication of the early influence of the Flying Start programme on each outcome. Often this is referred to as the 'average treatment effect on the treated' (ATET). In essence this is simply the difference in the outcome measure between those families living in the Flying Start areas and those families living in the 'matched' comparison group. This provides evidence from which informed judgements can be made about the likely emerging early influences of Flying Start, based on knowledge of the service delivery context and programme theory of change. However, it needs to be borne in mind that features inherent to the study design mean that the impact estimates generated are not completely unbiased estimates of impact. However, for interpretative purposes it can be hypothesised that the analysis approach is more likely to underestimate the 'true' impact of Flying Start than to overestimate it.

1.20. In order to look at impacts as they emerge over time across the first few years of the programme, a longitudinal design has been used comprising two waves of surveys with families in Flying Start and comparison areas.

1.21. Wave 1: Fieldwork took place between 8 March and 11 August 2010 among a sample of families with children under two years of age (ranging from seven to 20 months)[7]. The Wave 1 survey focused on parents' early experiences of their baby's life and parenthood, as well as the Flying Start services relevant to families in the first months of the baby's life (mainly health visiting, plus potentially some additional support such as parenting initiatives or programmes).

[7] The survey also included a small number of babies (28 in total) aged 21 – 26 months. Although, ideally, we would target a narrower age band (e.g., just nine months) the relatively small number of children in the target areas is a limiting factor so we have needed to include a wider age range to secure sufficient sample sizes.

1.22. Wave 2: The second wave of the survey will involve returning to as many families as possible in 2012 when the children are approximately 31 – 44 months old and when families have had the opportunity to receive a fuller range of Flying Start services (i.e. many of the parenting, language and childcare elements of Flying Start are more relevant to older age groups). Analysis and reporting at this second stage will utilise the full range of longitudinal data collected at both Wave 1 and 2 of the survey, to provide a picture of service experience and impacts among this cohort of families as far as can be observed over the relevant time period.

1.23. Families for the survey were sampled from Child Benefit Records[8] and interviews were conducted face to face in home via a mix of interviewer administration and self-completion (for sensitive items). Once ineligible addresses were taken into account, a high adjusted response rate of 81 per cent was achieved.

1.24. The key research objectives being addressed through each wave of the survey and its analysis are summarised in Table 1 below:

Table 1: Key research objectives

Topic	Wave 1	Wave 2
Characteristics of families (Chapter 2)	Building a detailed picture of the characteristics of families with children aged about seven to 20 months in Flying Start areas. Measuring the prevalence of population groups most at risk from having higher levels of need (i.e. low income families, first time mothers and others).	Measuring population mobility outwards and within Flying Start areas among families of this age cohort. Measuring patterns of change in family context among this age cohort over time, for example relationships with partners and employment status.
Impact of Flying Start on service reach and user experience.	Measuring use and experience of Flying Start services received by the time of the survey.	Measuring use and experience of Flying Start between W1 and W2 of the survey.

[8] Child Benefit Records (CBRs) were used as the sampling frame for the survey of families. Nationally around 95 per cent of families claim Child Benefit. Given the levels of disadvantage in Flying Start areas we would expect take-up to be much closer to 100 per cent. CBRs therefore provided a robust sampling frame for the survey.

Comparing levels of awareness, usage and satisfaction with services among Flying Start parents with those among the matched comparison group. (Chapter 3)	The main focus is on health visiting, although the survey is also investigating early awareness and reach of parenting support and LAP.	There will be a greater focus at this stage on parenting courses, LAP, and childcare/early education.
Early identification and targeting of higher need groups. Quantifying the key mechanisms involved in communication and referral. (Chapters 3 and 4)	Measuring prevalence of awareness, referral and use among key groups. Understanding the role of health visitors in identification of need and cross-referral.	Measuring prevalence of awareness, referral and use among key groups. The range of key players involved will be wider by this stage.
Impact on parenting and child outcomes. Comparing outcomes among families in Flying Start areas with those among the matched comparison group (Chapter 6). Measuring the prevalence of other needs. (Chapter 7)	Examining early impacts on some parenting behaviours relevant to young babies/toddlers. Quantifying the prevalence of a wider range of parenting attitudes and behaviours and family and child wellbeing features. This provides a baseline picture of families' wider needs that will be useful looking forwards.	Examining impact on a wider range of parenting attitudes and behaviours and early impacts on child development. The survey may also measure prevalence of other needs that may require ongoing action for the future.
Parent self report of benefits from the FS services (Chapter 5).	Service users' reports of benefits from health visiting, parenting and LAP.	Service users' reports of benefits received from all FS entitlements.

Key indicators for impact assessment in the Wave 1 survey

1.25. The key indicators that have been used for the early assessment of impact at Wave 1 of the survey are outlined below. These are based on a consideration of the logic model underpinning the programme and summarise the areas where intermediate outcomes might be anticipated.

Process outcomes

Service access and experience

- Higher average number of contacts with health visitor, per family
- Higher average number of in-home contacts with health visitor, per family

- Higher awareness, referral[9] and take-up of additional parent support groups and initiatives, including those offered as part of the health visitor offer

- More positive ratings in the support offered by health visitors and ability to contact the health visitor

- Higher proportion of parents being aware of and being encouraged to attend additional parenting courses and LAP support, including increases arising due to contact from health visitors

- Higher levels of awareness, referral and service use among groups at risk of having higher levels of need compared with others. Note that referral to, and take-up of parenting courses, and especially LAP, are expected to be relatively limited at this stage and not necessarily large enough to be observable at the whole population level. This is because they will not be relevant to all parents in the sample. These services will be most relevant to higher need groups (a sub-set of the sample), and are also more relevant to children who are older than those in the sample (the full range of potential needs are not necessarily yet apparent among this age cohort)

Sufficiency of support

- Higher ratings of local services overall, and perceived sufficiency of support with baby care and parenting

- Higher proportions of parents who report receiving sufficient advice and support from health visitors

Impact outcomes

Parenting behaviour

- Higher rates of breastfeeding (proportions of mothers who have ever tried to breastfeed and succeeded in breastfeeding)

[9] Throughout the report 'referral to other services' means parents being asked to attend related services – parents would then decide whether or not to take-up the service.

- Higher rates of immunisation take-up
- Higher proportions of children being weaned at the correct age (around 6 months)
- Parents/carers sharing books and singing songs/rhymes.

1.26. It should be noted that community familiarity, propensity, knowledge and understanding have been found to play a significant role in influencing parenting behaviours such as breastfeeding (for example, some young mothers may be reluctant to breastfeed if their own close female relatives, friends and neighbours do not participate or like the idea of breastfeeding).[10] This means that one-to-one intervention from a health visitor cannot always be expected to result in immediate change. The time frames involved in achieving family and community level change in parenting behaviours can, therefore, often be relatively long and certainly longer than the time period up to the Wave 1 survey. For this reason, the range and level of behavioural change that it is realistic to expect at this stage as a result of the programme is relatively limited.

Impact assessment methodology – survey design and analysis

1.27. The target population for the survey was all households with children of target age living in Wales in the areas where the Flying Start programme is operating. For analysis purposes this population is referred to as the 'intention to treat' group. This allows the survey to gauge the level of reach of the Flying Start programme, as well as emerging indications of impact.

1.28. Households with children of the target age living in Wales but outside of the areas operating the Flying Start programme were also included in a comparison sample. The areas within which these households reside were identified at the sampling stage, based on their similarity to the Flying Start

[10] E.g. Earle (2002), http://heapro.oxfordjournals.org/content/17/3/205; Swanson et el (2005) https://dspace.stir.ac.uk/bitstream/1893/753/1/PHN00900297.pdf and Welsh Government (2001) http://cymru.gov.uk/dphhp/publication/professionals/nursing/breastfeeding/strategy/investinge.pdf;jsessionid=48CPTk1FWkCVQsKGrML2B91TJD0M0QrKw1VhSP5TnkL2jxjpdjTt!1324320823?lang=en.

areas on a number of key factors thought to have an influence on the survey outcomes, namely deprivation and numbers of households with young children. Interviews were conducted with a random sample of households in these matched areas. When interviewing parents about their child(ren), some of the questionnaire was dedicated to asking about aspects of the family that could impact on Flying Start outcomes but were not directly related to the FS programme (for example number of children in the household, birth weight, smoking prior to pregnancy). This information will later be referred to as the matching variables; at the analysis stage, these variables were used to further improve the match between the Flying Start households and households selected from the comparison area samples to be in the comparison group used for impact analysis.

1.29. Early indications of impact are being measured in two different ways:

- **Approach 1**: The main approach to measuring early indications of impact at Wave 1 of the survey, has been a two stage process involving (i) applying statistical matching and post-matching modelling to the survey data among Flying Start and comparison samples to calculate an estimate of the 'average treatment effect on the treated' for each outcome and (ii) with reference to what the evaluation team have hypothesised about the programme theories of change and also what is known about the service delivery context, considering what can be said on the basis of the evidence about the early influence of Flying Start. As mentioned above, because there may be some unknown levels of bias inherent in the estimates, some qualifications need to be made to conclusions about the early indications of impact. However, findings are useful in giving a broad indication of the direction of travel of the programme.

- **Approach 2**: The second approach being used to assess impact is via collecting measures of self-assessed impact among parents. The survey asked service users for their views of how Flying Start services had affected their parenting and the wellbeing and development of their child. Note that self-assessments of impact are perceptual only, and there will not necessarily be a strong relationship between observed impacts and perceived benefits

(the latter can often be reflective of service experiences rather than actual impact, for example).

Further methodological details of Approach 1

Stage 1: Statistical estimation of indications of impact

1.30. The statistical element involved generating an indicative estimate of the 'average treatment effect' of Flying Start on the 'intention to treat group', through statistical modelling carried out using Flying Start and comparison sample data.

1.31. Given that the comparison sample is being used to estimate the 'counterfactual', a key methodological requirement is ensuring that the households/families in the comparison group sample are as similar as possible to those in the Flying Start sample.

1.32. In order to achieve this, as mentioned, at the sampling stage, a number of comparison areas were selected that were as similar as possible in terms of deprivation levels and the number of children aged nought to three. Since Flying Start was introduced on an area basis in some of the most deprived areas in Wales and all families are eligible for services, there was never any directly matched area-based control group, and the comparison group was therefore, by definition, less deprived. Therefore, a comparison group from the most similar Super Output Areas was drawn, based on deprivation and the number of children aged nought to three (using mid-year population estimates). The profile of Flying Start areas and comparison areas is shown in the appendices.

1.33. Following this, at the data analysis stage, two stages of statistical analysis were conducted; the first to identify a comparison group from the comparison area sample pool who are as closely matched as possible to Flying Start sample families, and the second to calculate an estimate for the 'average treatment effect on the treated' from the treated and matched sample.

1.34. For each outcome, a separate propensity score[11] was calculated. Matching was performed on the propensity score, pairing families in the comparison sample to families with similar scores in the Flying Start areas. The data variables used for matching were carefully selected on the basis that they would be applicable to the Flying Start population pre-Flying Start delivery; given that the survey was conducted after Flying Start delivery had impacted, the focus was on variables that could not have been influenced by Flying Start (e.g. child age, birth weight of baby, parents work status and marital status at the time of pregnancy, etc.). This data also included local area statistics. From the set of variables identified, a sub-set of variables was used for matching for any individual indicator. Regression-based analysis was carried out to identify which variables would be most important to use for the matching.[12] The 'matching' variables used in the propensity score were those found to have a significant relationship with the outcome.

1.35. Following this, a regression-based analysis approach has been applied for each indicator to further reduce differences[13] and provide the final 'best estimate' of the average Flying Start 'treatment effect' on the intention to treat group, compared with an estimated counterfactual baseline.

Stage 2: Forming judgements about early indications of impact

1.36. The data modelling described above provides the best possible data from which judgements about the early indications of impact can be made. However, they cannot be read on their own as unbiased and confirmed measures of Flying Start impact. A number of issues need to be borne in mind in this regard and are discussed below. Whilst the statistical analysis approach has controlled for differences in the profile of the Flying Start and

[11] A Propensity Score allows for multiple variables to be used concurrently when matching cases. Essentially the difference between the two samples is modelled (using in this instance logistic regression modelling, with all the significant matching variable characteristics as predictors) and the modelled probability (or propensity) of being in the Flying Start group is estimated for each respondent. Individuals in the comparison sample pool are then matched to individuals in the Flying Start group in such a way that the two matched samples have similar propensity score distributions.

[12] Please see appendices for a more detailed description of the analysis approach.

[13] Propensity score matching involves using a finite set of 'control' variables. Additional application of regression analysis techniques makes it possible to control for any remaining differences on the basis of all other variables available about the two populations in the survey data set.

matched comparison samples in terms of socio-demographic factors at an individual and area level, it was not possible to statistically control for unknown systematic differences in service delivery context. Use of the data requires consideration of this context in forming judgements about impacts. If there are other context factors that are affecting Flying Start and comparison groups in a systematically different way, it is possible that they may be contributing to the estimated treatment effects (in addition to or instead of Flying Start).

Potential bias in impact estimates and their appropriate interpretation

1.37. A number of factors mean that impact estimates may be subject to bias. It is not possible to be sure about the extent to which potential higher outcome scores observed in Flying Start areas are attributable to Flying Start, or simply reflect different starting points and/or limitations in the efficacy of statistical matching arising from the inherent differences between the Flying Start and comparison areas. However, given the more deprived nature of Flying Start areas, it can be hypothesised that estimates are more likely to underestimate than overestimate the influence of the programme. There are three key issues relevant to this and these are discussed further below.

1.38. **Lack of baseline data about the starting point of Flying Start families relevant to comparison group families.** As mentioned, a baseline survey was not possible because the evaluation was commissioned after the start of the Flying Start programme, and this means that there is no data on the starting points against which the relative progress of the two samples can be understood. There is currently only pre-Flying Start outcome data available from administrative sources on breastfeeding and immunisations.

1.39. **Lack of availability of evidence on the service delivery context for both samples and the impossibility of controlling for differences in this in the matching analysis.** There is limited specific information on what services were available in comparison areas, and to some extent Flying Start areas both prior to the introduction of Flying Start and during survey fieldwork. Welsh Government monitoring data shows that the relevant Flying Start

entitlements were available in all Flying Start areas during fieldwork, although there was some variability in the reach, levels of intensity and quality of these entitlements at that time. No such data is collected routinely in comparison sample areas, although similar services may have been available. The difference is that in Flying Start areas, they would have been available at a much higher level of intensity, and promoted significantly more by Flying Start staff than other services in comparison areas. Formal parenting programmes and LAP were especially likely to receive greater promotion in Flying Start areas because additional resources are being used to encourage parents to attend.

1.40. **Limitations in the ability to match the two samples due to inherent differences in the profile of the two groups.** As with all quasi-experimental designs it was not possible to identify a 100 per cent equivalent comparison group. Firstly, as previously mentioned comparison areas were slightly less deprived on average than Flying Start areas (the programme was intended to be targeted at the most deprived areas), matching the samples based on the Welsh Index of Deprivation has minimised the bias and been successful in reducing socio-economic differences between the sample, but has not eliminated them completely. Secondly, the individual/household variables that are available for matching are fairly limited, and largely restricted to socio-demographic factors, such as number of children in household, parental work status etc. Ideally the Flying Start and comparison samples would also have been matched on pre-Flying Start attitudes and behaviours. This data was not, however, available as a baseline survey was not possible. Given the higher levels of deprivation in Flying Start areas it is plausible that families in Flying Start areas started with poorer attitudes and behaviours for many of the outcomes measured relative to their comparison group counterparts (although this cannot be quantified). If the matching on socio-economic factors does not account for this (which cannot be checked), then even after matching, Flying Start families who were at a particular baseline position in terms of attitudes and behaviours will be compared with a matched comparison group that potentially started somewhat further ahead. This means that Flying Start may be having a positive impact on outcomes which is not evident in the survey

analysis. Based on administrative data (which is not available for most of the other outcomes) it is identified that this is true for breastfeeding, for example[14]. For outcomes where **matching does not fully control for the potentially lower starting points in Flying Start areas, it is reasonable to hypothesise that the impact figures are more likely to underestimate than overestimate the early influence of the Flying Start programme.** However, the direction of any bias in service usage impact estimates cannot be judged as the relationship between service take up and deprivation is more complex. For example more disadvantaged groups may have higher levels of service take up *or* be harder to reach and therefore have lower levels of take up.

1.41. Note that future analysis incorporating Wave 2 survey data will be able to provide greater certainty about the extent to which early estimates of Flying Start influence are supported, given that Flying Start impacts should be increasing over time. Further technical details about survey and analysis methods and their implementation are provided in the appendices.

The survey assesses the early influence of a partial Flying Start programme

1.42. The timing of the survey fieldwork relative to programme delivery, and the age of the children in the sampled families may mean that the survey is measuring the impact of a partial rather than full Flying Start offer.[15] Therefore it may slightly under-represent the impact of the full and fully functioning programme. These issues are discussed further below.

1.43. First, the survey was conducted among families with very young children (under two years of age). This means that the range of Flying Start services families will have received at the time of Wave 1 fieldwork would have been

[14] In 2006, before the roll-out of the Flying Start programme, 43 per cent of biological mothers in Flying Start areas breastfed their child compared with 50 per cent in comparison areas and 55 per cent across Wales. This is based on data from Health Solutions Wales and is taken from the National Community Child Health Database. This data was collected by SQW from Flying Start LSOAs and selected comparison LSOAs. Please note, the comparison LSOAs are not exactly the same as those used in the survey but still provide useful comparison data. This is discussed further in the baseline report 'Final Flying Start Baseline 10.11.08' which can be found here http://www.cymorthandflyingstartevaluation.co.uk/publications.

[15] The free childcare entitlement is intended for children aged two - three years old, and younger children with high levels of need (e.g. disabled children).

relatively limited. In particular very few families would have received the free childcare element – a key part of the overall Flying Start programme important for achieving improved child outcomes. This is why impact was anticipated on a small range of indicators at this stage.

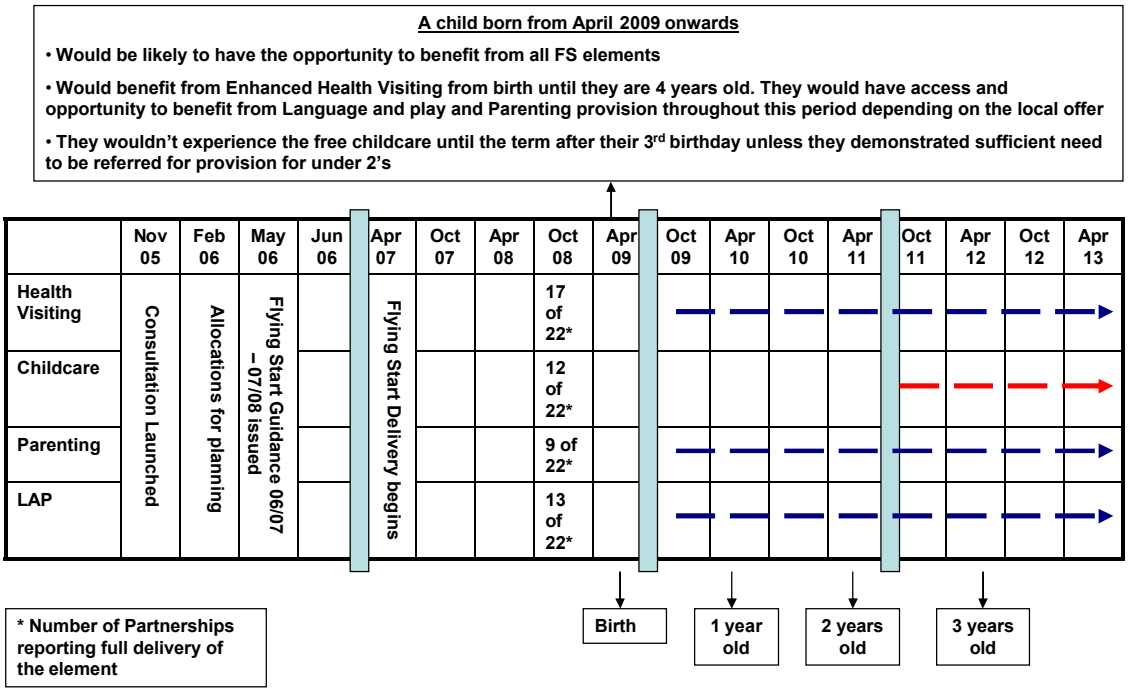
1.44. Secondly, at the time of the survey fieldwork, whilst the delivery of the Flying Start entitlements was deemed to be progressing in the right direction to make a difference to children and families in Flying Start areas, it was also deemed to be variable (as reported in the interim evaluation of Flying Start report).[16] The Welsh Government has been applying the lessons from the interim evaluation, but any developments to the programme would not have had time to take effect before the Wave 1 survey fieldwork.

1.45. At the time of the Wave 1 fieldwork, the Flying Start programme had been operational for three years and entitlements relevant to the survey cohort age group were broadly being offered by most local authorities. However, based on earlier evaluation work, it has been estimated that it was not until April 2009 that all local authorities had rolled out all elements of the programme, inevitably resulting in variation in the extent to which the entitlements were fully operational before this date.

1.46. Figure 2 shows the level of Flying Start delivery as measured by the October 2008 service census and the ages of children in the sample across fieldwork and service delivery timelines. As the Figure shows, the majority of areas were delivering the full health visiting offer by this time, and almost half were offering parenting programmes and LAP. Based on conversations with local partnerships, it has been estimated that full delivery in all areas is likely to have been completed by around April 2009.

[16] See http://wales.gov.uk/about/aboutresearch/social/latestresearch/3641013/?lang=en

Figure 2: Timeline of Flying Start programme delivery



1.47. There are two issues to consider concerning the programme roll out. Firstly, based on the above data an estimated 22 per cent of families interviewed would not have experienced the full Flying Start offer right from the day of the birth of their child as they were born prior to April 2009 (i.e. the full offer only started to be available some time after birth). It is estimated that 78 per cent of families will have had the opportunity to access fully developed Flying Start services relevant to the age of their child. Secondly, in reality services in some areas while operational may have still been 'bedding-in' and fine-tuning delivery approaches and mechanisms. This is common and inevitable for many complex programmes.[17] As a result, families in Flying Start areas where services were still being developed will potentially not have experienced services of the quality or scope that other families will have come into contact with. It is not possible to analyse the survey results by families who will have

[17] For example, the National Evaluation of the Sure Start programme in England concluded that it took at least three years before the local Sure Start programmes were in an operational 'steady state' and they did not have to meet the challenges set for the Flying Start Partnerships (e.g. with regard to health visiting caseloads).

had the opportunity to access fully developed Flying Start services relevant to the age of their child as comprehensive information about precisely what is on offer in each local authority at the time of survey fieldwork is not available.

Presentation of impact analysis data

1.48. For each section of the report, data from the statistical element of the impact analysis is presented as follows in example table 2.

Table 2: Indicative impact analysis - example table

	A		B	C	D
			Weighted results for impact analysis		
	Families in Flying Start areas (mean n)		Families in Flying Start areas (mean n)	Estimate of the counterfactual from the matched comparison group (mean n)	Indication of impact (mean n)
Number of visits from a health visitor in-home	8.5		8.6	7.1	1.5
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,734*	*1,573*	-
Number of visits from a health visitor in-home and in-clinic (combined)	17.7		17.7	16.6	1.1
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,693*	*1,518*	-

1.49. Figures in Column 'A' show findings from the Flying Start area sample which are the ones that should be quoted when using this report to evidence the characteristics and outcome measures of Flying Start families of children aged around seven to 20 months.

1.50. Figures in Columns ‘B-D’ show findings from the statistical impact analysis.

1.51. Column ‘B’ shows findings among the group of Flying Start families used for the impact analysis. In some cases this is slightly smaller than the full number of Flying Start families surveyed. This is because there were some families that could not be matched with the comparison group sample and have, therefore, been excluded for the purposes of the impact analysis. The numbers excluded are small in most/all cases and have little impact on the ability to generalise from the findings to the full Flying Start population. Any issues of interpretation are highlighted as they arise within the main report.

1.52. Column ‘C’ shows the estimate of the counterfactual that has been generated using data from the matched comparison group based on the two stage analysis approach outlined above. The base sample size varies for different indicators because the selection of the matched comparison group for each was selected separately in a tailored way.

1.53. Column ‘D’ shows the estimate of the ‘average treatment effect on the treated’. This is the difference between the weighted findings among Flying Start families and the estimate of the counterfactual. This provides an *indication* of the effect the Flying Start programme has had on each outcome which is used as the starting point for making judgements about Flying Start impact. In order to help make the table accessible to the reader, this column is headed ‘indication of impact’ rather than use the technical term ‘average treatment effect on the treated’.

Presentation of data in the report in general

1.54. Note that a number of conventions have been adopted in the presentation of analysis in the report. Therefore the following should be borne in mind when interpreting the results:

- Due to rounding, percentage figures may not add to exactly 100 per cent.
- Throughout the report, whenever the text comments on the difference between sub-groups of the sample or between Flying Start and comparison

areas, these differences have been tested for significance and have been found to be statistically significant at the 95 per cent confidence level or above, unless otherwise stated.

- Caution should be exercised especially when interpreting findings from sub-groups of fewer than 100 respondents.

- In the figures and tables, results that are less than half of one per cent of the population are labelled by an asterisk (*), results which are unavailable are labelled NA and nought (0) indicates zero per cent among the sample.

2. Key characteristics of Flying Start families

Summary

- On average, families with a child aged between seven and 20 months in Flying Start areas are significantly more disadvantaged than the wider Welsh population who have a child under four years old.
- In Flying Start areas, 46 per cent of families are 'workless households', 28 per cent live on a gross household income of under £10,000 per year, and 23 per cent of parents have no qualifications when they leave school.
- Almost two in five are lone-parent households (39 per cent); almost three times the rate among families with children aged under four year olds across Wales.
- A high proportion of parents in the Flying Start areas have suffered from post-natal depression or smoke.
- Almost three-quarters of families (74 per cent) have at least one of the following 'risk factors' which mean they could benefit from above average support: no qualifications; low income; young parenthood; post-natal depression; heavy drinking; lone-parenthood and experience of domestic violence. This highlights the importance of Flying Start services in these areas.
- A high proportion of people in Flying Start areas have risk factors for higher than average support needs, demonstrating that Flying Start has successfully targeted areas with strong concentrations of higher need populations. The findings also highlight the challenging levels of disadvantage that service providers are working to address.

Introduction

2.1. As outlined above, whilst Flying Start is universally available in the areas in which it operates, a key feature of the programme is that different types of support are tailored depending on an individual family's needs.

2.2. Bearing this in mind, the purpose of this chapter is to examine the profile of families in Flying Start delivery areas. It focuses in particular on a number of groups who are especially likely to have greater support needs, for example low incomes, or other 'risk factors' associated with a greater risk of poor child outcomes.

2.3. This chapter sets the context for examining the reach and impact of Flying Start later on in the report. It also provides up to date profile data about families with young children, helpful for informing the ongoing development and delivery of Flying Start and other services in the programme areas.

2.4. Where relevant, the reporting of the prevalence of groups has been placed in context by comparing the profile of parents in Flying Start areas with the wider Welsh population.[18]

Family make-up

First time parents

2.5. As table 3 shows, nearly four in 10 (38 per cent) of parents in Flying Start areas are first time parents.

[18] Given that the survey population is aged c. seven to 20 months, there is no equivalent national comparison group. Where possible, though, data from the 2010 Quarter 2 Labour Force Survey (LFS) for households in Wales with children age nought to four has been used to provide an indicative comparison with the wider Welsh population.

Table 3: Number of children in household

	Families in Flying Start areas[19] (%)
1 child in household (first time parent)	38
2 children in household	33
3 or more children in household	29
Base: All families	*1,776*

2.6. First time parents are a key group of interest because they have, by definition, less parenting experience than those with more than one child and may therefore need more support. Targeting first time parents will enable the programme to have a greater impact, as patterns of behaviour tend to become fixed, and therefore harder to change, as parents have other children. Finally, by encouraging good parenting behaviours in first time parents, the programme will also help any future children they may have.

2.7. When examining findings among this group it is helpful to bear in mind that they are more likely to be young parents (59 per cent are aged under 25 years, compared with 25 per cent of parents with multiple children). As might be expected, they seem to come from similar backgrounds as others (e.g., the prevalence of workless households among this group is similar to that among Flying Start families as a whole). However, reflecting their young age, a lower proportion have no qualifications (17 per cent compared with 27 per cent), but a higher proportion live on low household incomes of under £10,000 gross per annum (35 per cent compared with 24 per cent). First time parents are also more likely to be working (41 per cent compared with 29 per cent).

Number of children in household

2.8. Table 3 also shows three in 10 (29 per cent) parents have three or more children. Having multiple children may be an indicator of need because large family sizes are associated with high levels of disadvantage and increased

[19] No comparative national data for Wales is available for this.

child poverty.20 Parents of multiple children may also be able to give less individual attention to each child than those with just one child.

Age of children

2.9. The age of the children in Flying Start areas at point of interview ranged from seven to 23 months as outlined in Table 4. Around a quarter (27 per cent) are aged under one year old, just under three in five (58 per cent) are aged from a year to 17 months, while 15 per cent are aged over 18 months.

[20] For example, see http://www.jrf.org.uk/publications/child-poverty-large-families.

Table 4: Age of children

	Age of children in Flying Start areas at interview (%)
7 months	1.2
8 months	3.2
9 months	5.9
10 months	7.4
11 months	9.3
12 months	10.8
13 months	9.2
14 months	10.5
15 months	10.8
16 months	9.8
17 months	7.1
18 months	10.0
19 months	2.7
20 months	1.2
21 months	0.4
22 months	0.2
23 months	0.1
24 months or older	0
Base: All families	*1,776*

Lone-parenthood

2.10. As shown by table 5, around two in five (39 per cent) parents are lone-parents, compared with around one in 10 (12 per cent) in Wales as a whole.

Table 5: Household type

	Families in Flying Start areas (%)	*Families with a child 0-4 years old across Wales[21] (%)
Lone-parent household	39	12
Two-parent household	61	88
Base: All families	*1,776*	*265,896*

*Source: 2010 Quarter 2 Labour Force Survey

2.11. Lone-parent families could benefit more from Flying Start services; they are more likely to be economically deprived than those from two-parent households.[22] Single parents may have less support at home than those with a partner and many need more external support.

Parent age

2.12. As Table 6 shows, seven per cent of parents in Flying Start areas are under the age of 20.

Table 6: Parent age

	Parents in Flying Start areas (%)
16 – 19	7
20 – 24	31
25 – 29	30
30 – 34	19
35+	14
Base: All parents	*1,776*

[21] Figure based on households in Wales with children age nought to four. Results for lone and two-parent households from the LFS are derived from questions based on household composition, household relationships and gender.

[22] Research by the Joseph Rowntree Foundation found that two-thirds of children from single-parent households are poor, compared with a quarter of children with two parents. See Gregg, Paul et al, 1999. Child poverty and its consequences, *Joseph Rowntree Foundation,* [online]. Available at: <http://www.jrf.org.uk/publications/child-poverty-and-its-consequences> [Accessed 29th August 2011].

2.13. Being a young parent is associated with lower educational attainment, reduced income and an increased likelihood of the child being brought up in with high levels of disadvantage.[23] Parents aged 16 – 19 are even more likely than Flying Start parents as a whole to live in workless households (88 per cent compared with 46 per cent) and live in households with a gross household income of under £10,000 per annum (46 per cent compared with 28 per cent). Parents aged 20 – 24 are also somewhat more likely than others to face these issues (58 per cent live in workless households, and 43 per cent have this low level of household income).

Parent ethnicity

2.14. As shown in Table 7, nine in 10 (93 per cent) of Flying Start area respondents are white. The next most prevalent ethnic group is Asian or Asian British (3 per cent).

Table 7: Respondent ethnicity

	Parents in Flying Start areas (%)
White or white British	93
Asian or Asian British	3
Chinese or other ethnic group	2
Black or black British	1
Mixed	1
Base: All parents	*1,776*

Socio-economically disadvantaged groups

2.15. A variety of characteristics can contribute to an individual or family being socio-economically disadvantaged, including low income, unemployment and low qualifications. Families with these characteristics could benefit most from

[23] For example, see: http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/l_1119_What_works_in_supporting_teenage_parents.pdf.

Flying Start as, once again, children born into families with these characteristics have a greater risk of poorer outcomes than others.[24]

Work status

2.16. Being in paid work is an important way of avoiding poverty.[25] As Table 8 shows, below, six in 10 (62 per cent) parents in Flying Start areas are economically inactive. Whilst this is not necessarily surprising, given the age of the children covered by the survey, it does have implications for household finances.

Table 8: Work status of Flying Start parents (main carer)

	Parents with a child <2 years old in Flying Start areas (%)
In paid work	33
At home/not seeking work	58
Local or government training scheme involving paid work	*
Local or government training scheme not involving paid work	*
Modern apprenticeship not involving paid work	*
Registered unemployed/signing on for JSA	2
Not registered unemployed but seeking work	2
Long-term sick or disabled	2
Full-time education	2
Other	*
Economically active	37
Economically inactive	62
Base: All parents in Flying Start areas	*1,776*

2.17. When looking at the household as a whole, almost half of all households in Flying Start areas (46 per cent) are workless households, in which no parents

[24] For example, see http://www.jrf.org.uk/publications/child-poverty-and-its-consequences.

[25] According to the Poverty Site based on 2010 data from DWP "In the three years to 2008/09, the risks of low income among working-age adults were: 70% for unemployed families; 57% for economically inactive families; and 28% for those with some paid work". See The Poverty Site, 2010. *United Kingdom: Low income by work status* [online]. Available at: http://www.poverty.org.uk/39/index.shtml?2. [Accessed 29 August 2011.]

are in work. This is significantly higher than the proportion of households with a child under two who are workless across Wales as a whole (18 per cent). Workless families tend to have the lowest incomes, and often have low skill levels and other types of disadvantage, and therefore are a key group for Flying Start services.

Table 9: Household work status of Flying Start families

	Households with a child <2 years old in Flying Start areas (%)	Households with a child <2 years old across Wales[26] (%)
No parent in work	46	18
At least one parent in work	54	82
Base: All families	*1,776*	*1,020,000*

2.18. The high proportion of workless households is linked to the greater proportion of households in Flying Start areas that are lone-parent households and therefore not able to split caring and work responsibilities between two people (81 per cent of lone-parent households are workless, compared with 23 per cent of two-parent households). Of course, single parenthood is not the only factor involved and other factors are likely to play a part, such as education and skills.

Type of employment

2.19. Employed parents in Flying Start areas tend to be in jobs that, typically, require low skill levels and are poorly paid. For example, as shown in lecturers (just two per cent).

2.20. Table 10, they are much more likely to be engaged in semi-routine and routine occupations such as cleaning or telesales, compared with families with children age nought to four in Wales as a whole (57 per cent compared with 28 per cent). Correspondingly, very few parents in Flying Start areas are

[26] Data is based on families with a child aged 0-2 across Wales and is taken from the Office for National Statistics Annual Population Survey.

classed as employed in managerial or professional occupations such as office managers or university lecturers (just two per cent).

Table 10: National Statistic Socio-economic Classification (NS-SEC) (main carer)

	Parents in Flying Start areas (%)	***Parents with a child 0 – 4 years old across Wales (%)**
Higher Managerial and Professional	2	11
Lower Managerial and Professional	12	24
Intermediate Occupations	12	12
Small Employers and Own Account Workers	2	6
Lower Supervisory and Technical	7	10
Semi-routine Occupations	37	17
Routine Occupations	20	11
Never Worked, Long-term Unemployed	7	9
Base: All parents excluding those classed as 'not classified'	*1,500*	*265,896*

*Source: 2010 Quarter 2 Labour Force Survey

Household income

2.21. As has been shown above, a large proportion of parents in Flying Start areas are workless or where parents are employed, they are in occupations that are poorly paid. Furthermore, parents in Flying Start areas are more likely to be lone-parent households, meaning that they are more likely to be reliant on just one income. It is not surprising, therefore, that the total household income of parents is affected accordingly. As shown in table 11, over one quarter (28 per cent) of Flying Start households have a total income of less than £10,000; whilst one third have an income of between £10,000 and £19,999.

Table 11: Annual household income of Flying Start families before tax

	Families in Flying Start areas (%)
£9,999 or less	28
£10,000 – £19,999	32
£20,000 – £29,999	15
£30,000 or more	12
Refused	13
Base: All parents	*1,776*

2.22. Evidently, low income families have fewer resources and may benefit from the additional support offered by Flying Start. Furthermore, low household income, as discussed below and later on in this report, is also associated with other problems, for example these parents are also more likely to suffer from post-natal depression, more likely to smoke and more likely to binge drink than their better-off counterparts. As all of these factors can impact on child outcomes, this group is consequently a key group for Flying Start.

Education

2.23. Almost a quarter (23 per cent) of parents in Flying Start areas have no formal qualifications, whilst four in 10 (41 per cent) have just GSCE, O-Level or equivalent qualifications. About one quarter (23 per cent) have qualifications at A/AS level or equivalent whilst just one in 10 (nine per cent) are educated to degree level or higher.

Table 12: Levels of parental education

	Parents in Flying Start areas (%)
None	23
GCSE/O level or equivalent	41
A levels or equivalent	23
Degree or higher	9
Trade apprenticeship	1
Other	2
Don't know	*
Refused	*
Base: All parents	*1,776*

2.24. Parental education can impact on child outcomes in many ways, including by allowing parents to access higher paying jobs, and therefore reducing financial difficulties facing households and evidence shows it can also impact on child development.[27] Consequently, those parents who have low, or no, qualifications may have higher needs so may benefit from additional support from the Flying Start programme.

Parental health and health behaviours

2.25. Parental health and health behaviours can impact on child outcomes because of the direct implications that they have for children's health and safety. In addition, they can also affect the resources available to the household, as well as the home learning environment. For this reason, families where the parent or carer has poor health, or engages in health behaviours that are likely to reduce child outcomes may be more likely to benefit from Flying Start.

[27] For example, see http://www.iser.essex.ac.uk/files/iser_working_papers/2010-16.pdf.

Long-term illness or disability

2.26. In Flying Start areas, one in 10 (11 per cent) parents have a long-term illness or disability that limits their activity in some way. In contrast, just six per cent of the wider Welsh population have a long-term illness.[28] It is likely that this group would, therefore, benefit from support to maximise outcomes for their child. A further six per cent have a long-term illness or disability that does not limit their activity.

2.27. In addition to this, 12 per cent of parents in Flying Start areas say that their partner has a long-term health condition. Fifty-nine per cent of these parents say that this long-term condition limits their partner's activities in some way. This is likely to have implications for the amount of support that these families need.

Table 13: Long-term parental health

	Parents in Flying Start areas (%)	**Parents with a child 0-4 years old across Wales[29] (%)**
Parent has illness/ disability /infirmity	17	6
Parent has illness/disability /infirmity that limits their activities	11	*
Parent does not have illness/disability/infirmity	83	94
Base	*1,776*	*265,896*

2.28. Long-term parental illness and disability are linked to disadvantage. For example, 21 per cent of those who are out of work suffer from a long-term

[28] Quarter 2 Labour Force Survey (LFS) for households in Wales with children age nought to four has been used to provide an indicative comparison with the wider Welsh population. LFS question wording 'Do you have any health problems or disabilities that you expect will last for more than a year?'

[29] LFS question wording "Do you have any health problems or disabilities that you expect will last for more than a year?"

condition compared with 10 per cent of those who are in work.[30] Furthermore, some disabilities may also make certain childcare tasks and service engagement difficult, increasing parents' need for support.

Post-natal depression

2.29. A third (33 per cent) of parents in Flying Start areas say that they, or the biological mother of their child, have suffered from post-natal depression.[31] As shown in Table 14 below, the majority of those who experienced post-natal depression did so relatively soon after the birth of their child.

Table 14: Commencement of post-natal depression

	Parents in Flying Start areas (%)
A month or younger	54
Two months	15
Three months	8
Four months	5
Five months	1
Six months	5
Seven–eight months	5
Nine–10 months	2
11–12 months	2
Over 12 months	2
Don't know	1
Base: Parents who have suffered, or say that the biological mother of their child has suffered post-natal depression	*594*

[30] According to The Poverty Site, based on data from the DWP around a third of all disabled adults aged 25 to retirement are living in low-income households, twice the rate of that for non-disabled adults. The main reason for this disparity is as a result of their high levels of worklessness. See: The Poverty Site, 2010. *United Kingdom: Low income and disability.* Available at: < http://www.poverty.org.uk/40/index.shtml?2>. [Accessed 29 August 2011].

[31] This is higher than rates of post-natal depression in the UK as a whole; according to NHS statistics around one in 10 mothers suffer from post-natal depression. See NHS Direct Wales, *Post-natal depression,* Available at <http://www.nhsdirect.wales.nhs.uk/encyclopaedia/p/article/postnataldepression/>. [Accessed 29 August 2011].

2.30. While this appears to be a short-term issue for most, for a sizable minority the issue is perhaps more serious. Two in five (41 per cent) of those who have felt sad or low for two weeks since the child's birth say the feeling is ongoing, particularly those who are not first time parents.[32] In addition, around one third of mothers (31 per cent) report that it is not the first time they have felt this way since their child was born.[33]

Table 15: Duration of post-natal depression

	Parents in Flying Start areas (%)
One to 10 weeks	40
11 – 20 weeks	10
21 – 30 weeks	4
31 – 40 weeks	2
40+ weeks	1
Ongoing	41
Don't know	2
Base: Parents who have suffered, or say that the biological mother of their child has suffered post-natal depression	*594*

2.31. In addition to post-natal depression, one quarter (26 per cent) of parents in Flying Start areas who are either the biological mother, or who live with the biological mother, report they or the mother has been formally diagnosed with depression or serious anxiety. Of these, just under half (47 per cent) are currently being treated for their condition, although a greater proportion may have been treated in the past.

2.32. More parents with a long-term condition that limits their activities have suffered from post-natal depression than any other group (61 per cent).

[32] Over two in five (46 per cent) of those who are not first time parents say that the feeling of being low or sad is ongoing compared with a third (32 per cent) of first time parents.

[33] When this group were asked on how many separate occasions they have felt this way, 14 per cent say that there had been one such occasion, one quarter (22 per cent) say there had been two occasions, 15 per cent on three to four occasions and 19 per cent say that there had been five or more.

2.33. There is a link between disadvantage and parental health. This is particularly acute for those on low incomes, with 16 per cent of biological mothers (or those who live with the biological mother) in a household with an annual income of £9,999 or less saying that they suffer from post-natal depression on an ongoing basis. This is a significantly higher proportion than the six per cent of those with an annual income of £30,000 or more who said they feel this way. Those with higher incomes are also less likely to have been diagnosed with depression or severe anxiety (19 per cent of those with a household income of £30,000 or more compared with 29 per cent of those with a household income of £9,999 or less).

2.34. In addition, parents who are not working are significantly more likely than those who work to say that there have been multiple occasions when they also felt low or sad (35 per cent and 19 per cent, respectively).

2.35. Research has shown that maternal post-natal depression can lead to poorer quality care-giving, which may in turn affect child language development, particularly in economically disadvantaged households.[34] In addition to this, post-natal depression has also been linked to increased rates of child psychopathology.[35]

Domestic violence

2.36. Four per cent of parents in Flying Start areas say that they have experienced abuse within their relationship.[36] Where domestic violence occurs between adults, children may also suffer. Children in such households are likely to witness abusive behaviour, more likely to be abused themselves, and are less

[34] See Alan Stein et al. 2011. *The influence of maternal depression, care giving and socioeconomic status in the postnatal year on children's language development.* Available at < http://www.familieschildrenchildcare.org/images/24story_pdf.pdf>. [Accessed 29th August 2011].
[35] Susan Pawlby et al, 2008. Postnatal depression and child outcome at 11 years: The importance of accurate diagnosis. *Journal for Affective Disorders* [online]. Available at http://www.cf.ac.uk/psych/home2/papers/hay/Dale%20Hay-Postnatal%20Depression%20article.pdf. [Accessed 29th August 2011].
[36] Parents were asked the question about abuse in the self-completion section of the questionnaire along with other more sensitive questions. That said, it is likely that this is still an under-estimation of the true figure.

likely to achieve positive child outcomes.[37] Consequently, parents who are in abusive relationships may need additional Flying Start support.

Potential high need groups

2.37. Whilst the indicators set out above are not the only indicators of need, parents with any one of these characteristics may benefit from additional support. In total, nearly three quarters (72 per cent) of parents display at least one of the following characteristics:

- no qualifications;
- low household income (under £10,000 gross per annum);
- workless household;
- being a young parent (aged 16-19);
- experience of post-natal depression (has felt depressed for more than two weeks since the birth of their child);
- heavy drinking (more than 35 units per week for women or 50 units per week for men);
- lone-parenthood;
- experience of domestic violence.

2.38. Throughout the report these parents will be described as belonging to 'potential higher needs groups'.

2.39. Eighteen per cent of parents living in Flying Start areas fit into a category that can be defined as 'high need' for socio-economic reasons. These are parents who live in workless households, have low (no higher than GCSE/O-level) or no qualifications and who have a household income of under £10,000 per year. Throughout the report this group will be referred to as parents 'with multiple socio-economic disadvantages'.

2.40. In addition to this group, a quarter of parents (24 per cent) may be categorised as 'high need' because of their health and personal relationships,

[37] See Domestic Violence London, 2011. *What is domestic violence/impact upon children*. <http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/8-impact-upon-children.html>. [Accessed 29 August 2011].

and the negative impact that these can have on child outcomes. These are parents who say that they have felt depressed for more than two weeks since the birth of their child, experienced domestic violence in their relationship or have a long-term condition that limits their activities in some way. A very small proportion have also been included who consume alcohol to excess (more than 35 units per week for women or 50 units per week for men. Throughout the report this group will be referred to as 'high risk' parents. When examining findings among this group it is helpful to bear in mind that this group have a similar socio-demographic profile to parents in general (for example, in terms of age, work status and household income etc). This group are therefore no more likely to fall into the 'high socio-economic need' group mentioned above than those who are not in this group.

2.41. As Flying Start resources are intended to support high need individuals, these terms will be used throughout this report to identify key groups who would potentially benefit from additional support, enabling the delivery of Flying Start services.

2.42. First time and young parents are also examined throughout the report as these are groups of particular interest. In addition to this, other groups are also commented on where relevant.

3. Programme reach

Summary

Health visiting

- Flying Start families have 17.7 contacts with the health visitor, on average. The analysis indicates that families in Flying Start areas are receiving an average of 1.1 additional visits, compared with families in the matched comparison group. There also appears to have been a shift towards in-home visits away from in-clinic visits

- Health visitors in Flying Start areas are proactive in encouraging parents to take-up wider support. A higher proportion of families in Flying Start areas say they have been asked to attend a parenting group or received free baby related goods (an extra 28.4 per cent of parents, compared with families in the matched comparison group), a parenting course (an extra 10.5 per cent of parents) and LAP (an extra 12.9 per cent of parents) by health visitors. A high level of health visitor contact is also correlated with a higher likelihood of attending parenting courses.

Parenting groups and initiatives

- Overall, the vast majority of parents are aware of at least one parenting group or initiative (86 per cent). These are designed to provide additional types of support for parents but are not necessarily funded by Flying Start. 64 per cent have taken up at least one.

- In Flying Start areas an extra 19.2 per cent of parents are aware of these groups and initiatives than among the matched comparison group, and an extra 25.4 per cent of parents are now participating in these activities.

Parenting programmes and courses

- Altogether, three in 10 parents (30 per cent) are aware of Flying Start-approved programmes and courses, and nine per cent of parents have

attended.

- An extra 11.5 per cent of parents in Flying Start areas are aware of these parenting programmes, compared with parents in the matched comparison group, and an extra four per cent now attend one of these programmes.

LAP

- Altogether, over a third of parents (37 per cent) are aware of LAP and one in eight (12 per cent) of parents have attended.
- An additional 22.8 per cent of parents in Flying Start areas are aware of LAP programmes, compared with parents in the matched comparison group.

Potential higher need groups

- The picture is mixed regarding levels of reach to the most disadvantaged groups.
- Flying Start has been successful in providing enhanced support to parents with health-related needs, such as a limiting long-term condition or post-natal depression. These groups tend to receive a higher number of visits from their health visitor, and are also more likely to be attending a parenting course. They are also just as likely as others to be attending parenting groups and LAP.
- Young parents under 25 years also seem to receive slightly more support from the health visitor and their team than older parents, although the difference is not significant among the very youngest. Furthermore, this group is no more likely than others to be attending parenting groups or parenting courses, and less likely than others to be attending LAP.
- First time parents receive more support than more experienced parents from health visitors, but are no more likely to be using parenting groups, initiatives or courses. It will be helpful to consider the extent to which this group is being sufficiently targeted for additional support. They are also less likely to be using

LAP.

- Flying Start is having least success in reaching socio-economically disadvantaged families and this may be an area that warrants further attention. Whilst workless families receive slightly more health visiting contact than others, those with multiple disadvantages (workless, and low income and low qualifications) do not (levels of contact are actually lower, although differences are not statistically significant). Families from black and minority ethnic groups also have fewer contacts on average (fewer in home visits and fewer clinic visits). Socio-economically disadvantaged groups also tend to be less likely than others to be attending parenting groups, and LAP, and no more likely than others to be attending parenting courses.

- At this stage, usage of LAP tends to be more common among the most advantaged and educated groups, with lowest take-up among parents with no qualifications, those on low incomes, and first time parents. It may be that less focus has been given to encourage uptake of LAP among more disadvantaged groups among the cohort surveyed given the relatively young age of children concerned, but it will be helpful to reflect on whether the level of focus given to this is appropriate, or if it needs to be reviewed.

Health visiting

Introduction

3.1. Health visiting is one of the four main entitlements offered as part of the Flying Start programme, and is the first service that most families will come into contact. Under the enhanced Flying Start offer the caseload for each health visitor is capped at a ratio of 1:110. The reduced caseload enables health visitors to have more frequent contacts with families, as well as to spend more time with them, where needed. It is expected that the families in Flying Start areas would report higher numbers of health visitor visits, and in particular higher numbers of in-home visits as a result of the Flying Start programme. Through their contact with families, health visitors promote the range of Flying Start support to families, make assessment of need and, if required, refer the families for additional support outside of Flying Start.[38]

3.2. Given that Flying Start is the primary means through which health visiting is delivered, it has been judged that any impact on views and levels of health visiting support identified by the impact analysis findings can be attributed to Flying Start with confidence.

Health visitor support contacts received among total population

3.3. The findings from the impact analysis show that families in Flying Start areas receive a higher number of health visitor contacts than families in the comparison group. Families in Flying Start areas have had an average of 17.7 contacts with health visitors, which is an average of 1.1 more visits than among families in the comparison group. Looking just at in-home visits, families have received on average 1.5 more visits than families in the comparison group.

[38] Although the survey measured the number of visits and outcomes that may be expected from the health visiting support (e.g., immunisations, breastfeeding etc) a detailed analysis on the amount of visits parents received relative to the improvements in outcomes is beyond the scope of the Wave 1 evaluation. However, this is an important area policy makers may want to focus on in the future.

Table 16: Indication of impact of Flying Start on number of health visitor visits

			Weighted results for impact analysis (mean)		
	Families in Flying Start areas (mean n)		**Families in Flying Start areas (mean n)**	**Estimate of the counterfactual from the matched comparison group (mean n)**	**Indication of impact (mean n)**
Number of visits from a health visitor in-home	8.5		8.6	7.1	1.5
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,734*	*1,573*	-
Number of visits from a health visitor in-home and in-clinic (combined)	17.7		17.7	16.6	1.1
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,693*	*1,518*	-

3.4. The mean number of in-clinic contacts is slightly higher in comparison areas than Flying Start areas (9.53, compared with 9.16). This suggests that Flying Start may have led to a shift away from clinic visits towards in-home visits, as well as leading to higher overall levels of contact. It may be helpful to reflect on this finding, bearing in mind the advantages of in-home visits for quality engagement as well as their higher resource requirements.

3.5. Although no targets are set on the number of health visitor contacts, this additional number of contacts in Flying Start areas is lower than anticipated. There are a number of possible explanations for the limited number of additional visits. Given that levels of health visiting support are dependent on need, this number of additional visits may be a result of significantly higher numbers of visits targeted among a smaller set of Flying Start families. The generic health visiting service is also delivered on the basis of need and because the comparison areas are also relatively disadvantaged, families living in these areas may be receiving a higher than average number of health visitor visits from the generic health visiting service. It could also be the case

that Flying Start health visitors have created a displacement effect, releasing time that generic health visitors can spend with their caseloads – although this is out of scope for this element of the evaluation at this stage. Finally, the Flying Start health visiting entitlement potentially allows for more time to be spent with families in each household at each individual visit which was not measured in the survey, but may be having beneficial effects on the families living in Flying Start areas.

3.6. Almost half (44 per cent) of Flying Start families received one to five in-home visits from the health visitor, and another third (33 per cent) received six to 10. However, a small minority (five per cent) were visited over 21 times. This high number of visits was more common among parents with a limiting long-standing illness, disability or infirmity (12 per cent) and in families where the mother has suffered from post-natal depression (10 per cent).

3.7. While less than one per cent had not received any in-home visits, one in 10 (10 per cent) had not taken their child to see a health visitor in a clinic. The majority (63 per cent) had brought their child to the clinic between one and 10 times, and again, one in 12 (eight per cent) had been to the clinic more than 21 times.

Health visitor support contacts received among different sub-groups

3.8. As shown in table 17, in general, health visiting teams seem to be successful in ensuring that families in the combined potential higher need group described in the previous chapter receive more support. They had an average of 8.9 in-home contacts with health visitors compared with 7.8 contacts among those not in this group.

Table 17: Average number of health visitor contacts – sub-groups

Sub-group (Base in brackets)	No. of in-home visits since birth (mean)	No. of in-clinic visits since birth (mean)	No. of visits In-home or in-clinic (mean)
All (1,776)	8.5	9.2	17.7
Level of need			
Potential higher needs group (1,282)	8.9	9.1	18.0
Potential lower needs group (494)	7.8	9.3	17.1
Demographic groups			
Young parents (aged 16 – 19) (120)	9.0	9.1	18.1
Ethnicity – White (1,650)	8.7	9.3	18.0
Ethnicity – Black and Minority Ethnic (122)	6.9	7.0	13.9
Socio-economic groups			
At least one person in work (967)	7.8	9.5	17.3
Workless household (809)	9.5	8.8	18.3
Low household income (less than £9,999) (495)	8.8	9.4	18.2
Multiple socio-economic disadvantage (317)	9.2	8.3	17.5
Health needs			
Limiting long-term condition (193)	11.1	8.7	19.8
Any long-term condition (306)	10.2	9.2	19.4
Post-natal depression (594)	10.5	9.0	19.5
High risk (420)	10.1	9.0	19.1
Parenting needs			
First time parent (673)	8.8	10.6	19.4
Not first time parent (1,103)	8.4	8.3	16.7
Use of Flying Start support			
Attended LAP (220)	9.0	10.5	19.5
Attended a Flying Start-approved parenting programme (224)	10.5	10.7	21.2

3.9. Specifically, parents in the high risk group where extra health visitor support is likely to be necessary (those who suffer from post-natal depression, experience domestic abuse or have issues with alcohol abuse) tend to have more contact, with a mean of 19.1 interactions compared with 17.7 overall. Parents with post-natal depression or long-term conditions also receive more in-home support from health visitors (10.5 and 10.2 visits respectively), though not a significantly higher level of contact overall.

3.10. Proportionately more parents in workless households report receiving health visitor contact than those where at least one person is in work (18.3, compared with 17.3), although they are less likely to report receipt of higher levels of in-home support. However, groups with multiple socio-economic disadvantages did not report higher contact with health visitors; and this may warrant further exploration given the likelihood that some have additional support needs.

3.11. White parents are also significantly more likely to receive more health visitor support than parents from BME groups (18.0 and 13.9 interactions, respectively).

Parenting groups and initiatives

Introduction

3.12. There are a number of parenting initiatives and groups available in Flying Start areas, including initiatives to make available free baby-related goods (such as home safety and dental goods) and baby-related groups such as baby massage and breastfeeding groups. These are different to the formal parenting courses/programmes (e.g. the Incredible Years etc) which are discussed in a separate section below. These types of parenting groups and initiatives discussed in this section are also available in non-Flying Start areas. However, the Flying Start programme is distinct in that there is an expectation that health visiting teams will play a key role in referring parents to parenting initiatives/groups and other support, particularly in cases where they feel there is a specific need. At the time the survey was conducted higher levels of awareness of, referrals to and take-up of parenting groups and initiatives would be expected in Flying Start areas.

Awareness, referral and take-up of parenting groups and initiatives

3.13. Most (86 per cent) parents are aware of a parenting initiative or group and say that they or their partner has been invited to attend one by a health visitor (75 per cent), and almost two-thirds of parents have attended a group or received free goods from relevant initiatives (64 per cent).

3.14. Impact analysis also estimates an additional 19.2 per cent of parents in Flying Start areas are aware of these groups or initiatives, compared with parents in the matched comparison group. An additional 28.4 per cent of parents for whom they or their partner have been invited to one of these groups or initiatives and an additional 25.4 per cent of parents have taken them up. An additional 28 per cent of young parents in Flying Start areas are taking up these initiatives, compared with young parents in a matched comparison group.

Table 18: Indication of impact of Flying Start on knowledge of, referral to, and take-up of parenting groups and initiatives

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Knowledge of parenting groups/ initiatives among main parent	86		86.5	67.3	19.2
Base: All parents	*1,776*				
Base: All matched parents			*1,567*	*1,372*	-
Invitation to parenting/ group initiative given to parent or their partner	75		75.8	47.4	28.4
Base: All parents	*1,776*				
Base: All matched parents			*1,473*	*1,295*	-
Attendance at a parenting group/initiative by main parent	64		65.4	39.9	25.4
Base: All parents	*1,776*				
Base: All matched parents			*1,769*	*1,502*	-

3.15. When prompted with a list of parenting groups and initiatives available in their area,[39] but not necessarily funded by Flying Start nearly all parents in Flying Start areas (86 per cent) report awareness of at least one of the listed initiatives (see table 19 below). The initiatives that are most commonly recognised as being available are baby massage (54 per cent), free toothpaste/tooth brushes (43 per cent) and free smoke alarms (37 per cent).

Table 19: Parenting initiatives or groups (awareness, referral, take-up)

Group (all above 3% awareness)	Aware of group/initiative (%)	Invited to group/initiative (%)	Attended group/initiative (%)
Any	86	75	64
Baby massage	54	40	20
Free toothpaste/toothbrushes from your dentists/health visitor/other health professional/Dental pack	43	37	39
Free smoke alarms from the fire service or loans of safety equipment such as baby-gates/fireguard	37	26	22
Breastfeeding support group	34	17	5
Free safety check and pack – birth pack and toddler pack (from your local authority)	29	22	21
Ones/Baby club (Beginning With Baby)	23	18	11
Weaning/nutrition group/party	21	13	5
Safety party	7	4	2
Baby rhymes	3	2	1
Base: All (1,776)			

3.16. As shown in Table 19, three quarters of parents in Flying Start areas had been asked to attend at least one group or initiative (75 per cent). The most common activity that parents have been asked to attend is baby massage (40 per cent of parents). A high proportion have also been asked if they want to

[39] Given the area-specific nature of the services, parents were shown a list of groups and initiatives that were on offer in their own area at the time of the interview.

receive free toothpaste and brushes, free smoke alarms and a free safety check and pack (37 per cent, 26 per cent and 22 per cent, respectively).

3.17. The initiatives with the highest take-up are those that provided free baby-related goods. A far smaller proportion of parents in Flying Start areas attend the parenting groups on offer. For example, baby massage is attended by one in five and one in 10 attended baby club or 'Ones'.

3.18. Weaning and nutrition groups and safety parties tend to be attended just once by most parents (44 per cent and 51 per cent, respectively). For other courses and groups, attendance tends to involve multiple sessions. Attendees of baby massage attended 4.69 sessions on average. Those who attend a baby club go 15.2 times on average, and attendees of breastfeeding club go 7.55 times.

Take-up of parenting groups and initiatives among different sub-groups

3.19. Looking at early indications of impact, the findings suggest that higher proportions of first time parents, lone-parents, young parents and parents experiencing multiple levels of disadvantage are taking up these groups and initiatives than their counterparts in comparison areas.[40]

3.20. However, there are some differences in levels of take-up between sub-groups within Flying Start areas. These initiatives are reaching first time parents (67 per cent take-up at least one group or initiative). The majority of parents (64 per cent) across all the total potential higher need group also take-up at least one initiative or group.

3.21. However, there are differences between potential higher need groups. They are reaching those with limiting long-term conditions and post-natal depression effectively (see table 20). However, parents in workless households are less likely than those in households where at least one person is in work to have taken-up at least one initiative (63 per cent and 65 per cent, respectively). Similarly, those on low incomes (£9,999) are less likely than those on incomes in excess of £30,000 to have taken up one of these

[40] The results from this sub-group impact analysis are provided in tables in the appendices.

initiatives (63 per cent and 70 per cent, respectively). This suggests that there is work to be done to further encourage socio-economically disadvantaged parents to take-up these initiatives.

3.22. While the difference is not significant, parents who have had a medium or high level of contact with a health visitor are more likely to have taken up at least one initiative or group. This lends support to the picture that Flying Start health visitors are active in contributing to the referral and take-up of these services.

Table 20: Take-up of parenting initiatives or groups by sub-groups

Sub-group (Base in brackets)	Attended at least one parenting initiative or group (%)
All (1,776)	64
Level of need	
Potential higher needs group (1,282)	64
Potential lower needs group (494)	65
Demographic groups	
Young parents (aged 16-19) (120)	62
Ethnicity – White (1,650)	65
Ethnicity – BME (122)	58
Socio-economic groups	
At least one person in work (967)	65
Workless household (809)	63
Low household income (less than £9,999) (495)	63
Multiple socio-economic disadvantage (317)	59
Health needs	
Limiting long-term condition (193)	67
Any long-term condition (306)	67
Post-natal depression (594)	67
Parenting needs	
First time parent (673)	67
Not first time parent (1,103)	63
Use of Flying Start support	
None/low number of in-home visits from health visitor (784)	58
Medium number of in-home visits from health visitor (586)	68
High number of in-home visits from health visitor (373)	72
Attended LAP (220)	81
Attended a Flying Start-approved parenting programme (224)	75

Parenting programmes

Introduction

3.23. Another key aspect of the Flying Start programme is the funding and wide availability of approved, evidence-based, high-quality parenting programmes and courses. These are more formal parenting courses that are approved by the Welsh Government because there is evidence that they improve parenting. They are different from the more informal parenting groups and initiatives discussed above. The Flying Start health visiting offer also requires that health visitors refer parents to these programmes or courses, particularly in cases where they feel there is a specific support need. At the stage at which the survey was conducted higher levels of awareness of these parenting programmes or courses would be expected in Flying Start areas. However, given the ages of many of the children at the time of the survey, not much impact was expected on referral or usage as many of the courses are designed for families aged two and over.

Awareness, referral and take-up of parenting programmes or courses

3.24. The findings show higher levels of awareness of, referral to and take-up of parenting programmes or courses among families in Flying Start areas, compared with parents in the matched comparison group. Almost a third (30 per cent) of parents are aware of a parenting programme, almost one in five (18 per cent) have been invited to attend and nine per cent) have attended. The analysis indicates that an additional 11.5 per cent of parents in Flying Start areas are aware of these programmes or courses, an additional 10.5 per cent of parents have been invited to attend and four per cent of parents have attended them, compared with parents in the matched comparison group.

Table 21: Indicative impact of Flying Start on knowledge of, referral to, and take-up of parenting programmes

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Main parent's knowledge of parenting programmes	30		30.1	18.6	11.5
Base: All parents	*1,776*				
Base: All matched parents			*1,757*	*1,555*	-
Main parent's knowledge of parenting programmes from a health visitor or member of health visiting team	14		15.0	8.0	7.0
Base: All parents	*1'776*				
Base: All matched parents			*1,776*	*1,661*	-
Whether main parent or their partner was asked to attend a parenting programme	18		18.4	7.9	10.5
Base: All parents	*1,776*				
Base: All matched parents			*1,562*	*1,309*	
Attendance at a parenting programme by main parent	9		9.4	5.4	4.0
Base: All parents	*1,776*				
Base: All matched parents			*1,638*	*1,343*	-

3.25. Three in 10 parents are aware of at least one of the Flying Start approved parenting programmes when prompted with a list, while around three in five (61 per cent) are not aware of any. Just over one in 10 parents (13 per cent)

are aware of Stepping Stones – the most commonly mentioned programme. The Incredible Years was mentioned by a further seven per cent, while a similar proportion (six per cent) is aware of The Family Links Nurturing Programme.

Table 22: Parenting programmes or courses (awareness, referral, take-up)[41]

Group (all aware above 3%)	Aware of programme (%)	Asked to attend programme (%)	Attended programme (%)
Any	30	18	9
Stepping Stones	13	3	*
The Incredible Years	7	5	2
The Family Links Nurturing Programme, Nurture Group, Nurturing Programme	6	4	2
Handling Children's Behaviour	5	2	1
Coping With Young Children	4	1	1
The Healthy Child	3	2	1
Fun and Families	3	1	1
Parenting Positively or Parenting Plus	3	1	*
Base: All (1,776)			

3.26. Health visitors are currently the main source of information for hearing about parenting programmes, with two in five parents who are aware of one of the programmes (41 per cent) having heard about parenting programmes in this way. A small proportion of parents say that they became aware specifically

[41] Respondents could provide multiple answers to these questions.

through Flying Start (seven per cent). One in five (18 per cent) say they heard about the parenting programmes through word of mouth or from other parents, while less than one in 10 mentioned other routes of communication such as GPs' surgeries (seven per cent), advertising leaflets (seven per cent), and schools (five per cent).

3.27. Overall, nine per cent of parents in Flying Start areas had attended one of the approved parenting programmes. Of these, the most widely used were The Incredible Years and The Family Links Nurturing Programme (or Nurture Group), which may, of course, reflect the greater availability of these programmes in Flying Start areas. Two per cent of parents in Flying Start areas attended these courses during the last two years (i.e. during the time that Flying Start had been in operation). One per cent had attended Handling Children's Behaviour and Coping with Young Children and Fun and Families. Many of the other courses were attended by less than one per cent of parents in Flying Start areas[42], while some were not attended by anyone, possibly reflecting levels of availability.[43]

Take-up of parenting programmes or courses among different sub-groups

3.28. Findings from the additional impact analysis conducted among sub-groups show that higher proportions of first time parents, lone-parents, young parents and parents experiencing multiple disadvantage are taking up parenting programmes than would be the case if Flying Start was not operating. Indeed, findings are particularly positive for disadvantaged groups with an additional nine per cent attending a parenting programme – which is double the average of four per cent among parents as a whole.

3.29. Looking at differences among sub-groups within Flying Start areas it appears that the courses are being taken up by the parents with highest needs. The proportion taking up these programmes in the potential high need groups as a whole (10 per cent) is higher than those who are not within higher need

[42] 'Triple P', 'High Scope' 'Steps to Excellence', 'Webster Stratton', 'Taming Your Toddler', 'Bumps to Babies', 'Parents Together', 'Parenting Can Be Fun', 'You Make the Difference', 'Fun and Play in Welsh Club' and 'The Neonatal Behavioural Assessment Scale'.
[43] 'Families Learning', 'Early Bird', 'Exploring Senses', 'Falling in Love With Your Baby', 'PIPPIN' and

groups (eight per cent); however, this difference is not statistically significant and thus indicative only.

Table 23: Take-up of parenting programmes or courses by sub-group

Sub-group (Base in brackets)	Attended at least one parenting programme or course (%)
All (1,776)	9
Level of need	
Potential higher needs group (1,321)	10
Potential lower needs group (455)	8
Demographic groups	
Young parents (aged 16-19) (120)	11
Ethnicity – White (1,650)	9
Ethnicity – BME (122)	7
Socio-economic groups	
At least one person in work (967)	8
Workless household (809)	10
Low income (less than £9,999) (495)	11
Multiple socio-economic disadvantage (297)	10
Health needs	
Limiting long-term condition (193)	16
Any long-term condition (306)	13
Post-natal depression (594)	10
Parenting needs	
First time parent (673)	9
Not first time parent (1,103)	9
Use of Flying Start support	
None/low number of in-home visits from health visitor (784)	7
Medium number of in-home visits from health visitor (586)	10
High number of in-home visits from health visitor (373)	12
Attended LAP (220)	24

3.30. Those with a limiting long-term health condition are more likely (16 per cent) than average to have attended an approved programme. Ten per cent of parents with post-natal depression also report attending.

3.31. Unlike the parenting initiatives or groups, there are no significant differences by socio-economic group, suggesting that health visitors are succeeding in encouraging parents from different backgrounds to take-up these programmes.

3.32. Parents who have had a high number of in-home visits from health visitors are significantly more likely to have taken up these programmes than those who have had a low number or no in-home visits (12 per cent and seven per cent, respectively). This lends support to the picture that Flying Start health visitors are active in contributing to the referral and take-up of these services.

3.33. Twenty-seven per cent of those who have attended LAP have also attended a parenting programme or course, suggesting that many parents are invited to attend both and take-up the offer.

LAP

Introduction

3.34. LAP is an interactive course which shows parents how they can help to improve their child's language through play, stories, songs and rhymes. These courses are widely available in Flying Start areas and health visitors are instructed to refer parents to these courses where there is a specific need. At this stage in the programme, higher levels of awareness of LAP, and possibly higher levels of referral or take-up are expected. Whilst the report provides figures for the levels of use of LAP reported among Flying Start families, impact analysis has not been conducted to look at the impact of Flying Start on LAP usage. This is because the relatively low levels of use expected of LAP by this stage in the programme and also given the young age of children in the Wave 1 survey mean that effects on this were not deemed likely to be detectable.

Awareness, referral and take-up of LAP courses among total population

3.35. Just over one third (37 per cent) of parents in Flying Start areas are aware of this programme, just over one in five (20 per cent) have been asked to attend it and one in eight (12 per cent) have attended.

3.36. An additional 22.8 per cent more parents in Flying Start areas are aware of LAP, than parents in the matched comparison group. Furthermore just over one in 10 families in Flying Start areas (11.9 per cent) have been made aware of LAP by the health visitor and an additional 12.9 per cent of parents have been invited to take-up this course.

Table 24: Indicative impact of Flying Start on knowledge of, and referral to LAP

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Main parent's awareness of LAP	37		36.8	14.0	22.8
Base: All parents	*1,776*				
Base: All matched parents			*1,714*	*1,408*	-
Main parent's knowledge of LAP from a health visitor or member of health visiting team	16		16.4	4.5	11.9
Base: All parents	*1,776*				
Base: All matched parents			*1,706*	*1,380*	-
Whether main parent or their partner was asked to attend LAP	20		20.7	7.8	12.9
Base: All parents	*1,776*				
Base: All matched parents			*1,770*	*1,471*	-

3.37. Parents said they had heard about LAP in a similar way to the approved parenting programmes. The majority who are aware of the programme had heard about it through Flying Start, with over two in five (43 per cent) made

aware by a health visitor, and 12 per cent specifically through Flying Start. Another one in eight first heard about it through a nursery group (12 per cent).

Take-up of LAP among different sub-groups

3.38. Parents in high need groups are not taking up LAP courses in the same proportions as those not in these groups (16 per cent and 11 per cent, respectively).

Table 25: Take-up of LAP by sub-group

Sub-group	Attended LAP (%)
All (1,776)	12
Level of need	
Potential higher needs group (1,282)	11
Potential lower needs group (494)	16
Demographic groups	
Young parents (aged 16-19) (120)	8
Ethnicity – White (1,650)	12
Ethnicity – BME (122)	12
Socio-economic groups	
At least one person in work (967)	13
Workless household (809)	11
Low income (less than £9,999) (495)	13
Multiple socio-economic disadvantage (317)	9
Health needs	
Limiting long-term condition (193)	15
Any long-term condition (306)	15
Post-natal depression (594)	13
Parenting needs	
First time parent (673)	10
Not first time parent (1103)	14
Use of Flying Start support	
None/low number of in-home visits from health visitor (784)	12
Medium number of in-home visits from health visitor (586)	12
High number of in-home visits from health visitor (373)	14
Attended a Flying Start-approved parenting programme (224)	27

3.39. In particular, take-up of LAP is lower among young parents aged 16 – 19 (eight per cent) and first time parents (10 per cent, compared with 14 per cent of parents who are not first time parents). The lower take-up among young parents may be because they are more likely to have younger children (see section 2).

3.40. However, a higher proportion of those with health conditions, including post-natal depression and long-term conditions, reported attending LAP courses, although the difference is not significant (13 per cent and 15 per cent, respectively, compared with 12 per cent overall).

3.41. Those who have had a high number of in-home visits from the health visitor appeared marginally more likely to have attended LAP than all others (14 per cent and 12 per cent, respectively) but this difference is not significant. Although Flying Start is leading to a large number of invitations to parents to attend LAP, extra work may be needed to make these courses more 'attractive' to those who are referred, especially to the potential high need population.

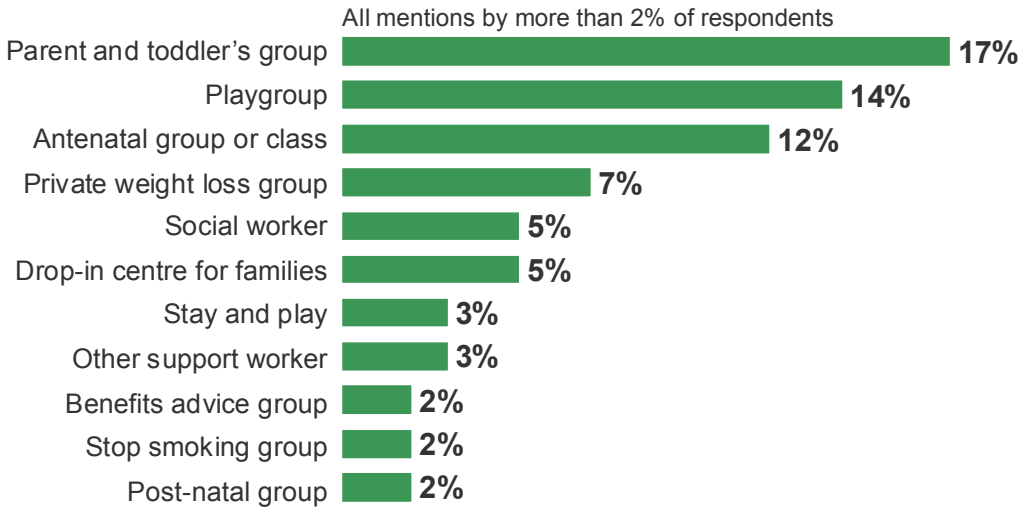
Other support

Take-up of other support among total population

3.42. Almost half of the parents in Flying Start areas (47 per cent) have received help and support from professionals and groups that are not a part of Flying Start. The figure below outlines the most common sources of support, which tend to be general child or parent groups rather than more topic-specific courses or classes.

Figure 3: Other help and support

Q. Have you or your partner received help or support from any professionals or groups other than those we have already talked about?



Base: 1,776 respondents in Flying Start areas. Fieldwork: 8 March – 11 August. Source: Ipsos MORI

Take-up of other support among different sub-groups

3.43. Table 26 shows differences by sub-group within Flying Start areas for receipt of the extra support outlined above. Flying Start support is associated with greater likelihood of using other support. Those parents who receive a high number of in-home visits from the heath visitor and those who have attended a parenting group or LAP are all more likely than average to attend a parent and toddler's groups (21 per cent, 35 per cent and 32 per cent, respectively). Those who have attended a parenting group or LAP are also more likely than average to attend a playgroup (21 per cent and 35 per cent, respectively, compared with 14 per cent overall).

Table 26: Take-up of extra support by sub-group

Sub-group (Base in brackets)	Attended parent and toddler's group (%)	Attended play group (%)	Attended antenatal group or class (%)	Used drop-in centre for families (%)
All (1,776)	17	14	12	5
Level of need				
Potential higher needs group (1,282)	16	13	11	5
Potential lower needs group (494)	19	14	16	3
Demographic groups				
Young parents (aged 16 – 19) (120)	16	14	12	10
Ethnicity – White (1,650)	17	14	12	5
Ethnicity – BME (122)	11	7	11	2
Socio-economic groups				
At least one person in work (967)	18	14	16	4
Workless household (809)	15	13	8	6
Low household income (less than £9,999) (495)	15	14	10	5
Multiple socio-economic disadvantage (317)	14	14	8	5
Health needs				
Limiting long-term condition (193)	18	12	8	5
Post-natal depression (594)	18	13	13	6
Parenting needs				
First time parent (673)	18	13	17	6
Not first time parent (1,103)	16	14	9	4
Use of Flying Start support				
None/low number of in-home visits from health visitor (784)	15	13	12	3
Medium number of in-home visits from health visitor (586)	17	13	13	5
High number of in-home visits from health visitor (373)	21	15	12	6
Attended LAP (220)	32	25	15	8
Attended a Flying Start-approved parenting programme (224)	35	21	11	12

3.44. Those in potential higher need groups are less likely than others in Flying Start areas to have attended an antenatal group or class (16 per cent and 11 per cent, respectively). Similarly, those in workless households are also less likely to have attended these than parents in households where at least one parent is in work (16 and eight per cent, respectively).

3.45. Parents from white backgrounds are more likely than parents from BME backgrounds to have attended a play group (14 per cent compared with seven per cent), which fits with the wider pattern of a greater prevalence of child-related service use among white parents.

3.46. Finally, young parents (aged 16 - 19) are more likely than average to have used a drop-in centre for children and families (10 per cent, compared with five per cent).

Barriers to using services

Introduction

3.47. To help inform the future delivery of the Flying Start programme, this section explores the reasons why parents are not accessing services that are available to them.

Parenting groups or initiatives: referral by health visitor or health visiting team

3.48. Around three in five (62 per cent) parents who have been invited to attend a parenting group by their health visitor (or another health professional) chose not to attend. As these parents have been identified as having a specific need that would benefit from additional support, it is important to understand the reasons why they are choosing not to take-up these services.

Table 27: Reasons for not attending a parenting group or initiative

Reason for not attending	(%)
Too busy/don't have time	16
I don't need it/not relevant too me/I am confident in being a parent	15
Not interested	9
The course runs at an unsuitable time	6
Too shy/unconfident	5
Not thought about it	6
Don't know much about it	3
I wouldn't know anybody else there	3
Base: All who were asked to attend a parenting group but did not (1,095)	

3.49. The most commonly cited reasons for non-attendance are practical. One in six parents (16 per cent) could not take-up an initiative as they did not have the time. Similarly, a small proportion of parents had not attended a parenting group as it ran at times that were not suitable for them (six per cent).

3.50. Other barriers are attitudinal; 15 per cent said they had not attended as they did not feel they needed to attend or that the course was irrelevant to them, while a further nine per cent were not interested. Five per cent were too shy or lacking in confidence. This suggests that there may be a need for health visitors to emphasise the benefits of attending the various parenting initiatives, by focusing on aspects that are relevant to each individual family's needs. Qualitative work on this aspect of the programme found that, for some, there is a stigma attached to being asked to learn more about parenting, but if parents were advised of the parenting courses in ways that made them seem like a welcoming, non-judgemental arena for picking up useful advice and tips, fewer would see them as 'irrelevant' or intimidating and more might be interested.

3.51. Findings highlight the importance of tailored approaches to encouraging parents to participate in these groups or initiatives. Young parents under 20 are much less likely than those in other age groups to say that they do not

need these courses, with only one per cent citing this as a reason. In contrast, one in six (15 per cent) have not attended because they are 'too shy/unconfident', while just over one in 10 (13 per cent) did not go because they 'wouldn't know anyone else there'. This suggests that there is a demand for these groups/initiatives amongst young parents, but that attitudinal (rather than practical) barriers to attendance exist. As such, there may be scope for increasing attendance by this group through supporting attendance and boosting confidence to attend, perhaps by making efforts to assign parents to groups of people of a similar age.

Parenting programmes or courses: reasons for not attending

3.52. Almost one in seven (68 per cent) of those who have heard of one of the Flying Start approved parenting programmes or courses have not attended them. Here, the most commonly cited reason for parents in this group to have not attended a course is a lack of information. Just under three in 10 (28 per cent) say they do not attend the course because they do not know much about it. Another one in five (19 per cent) have not thought about it. This suggests that health visitors or the wider Flying Start team could play more of a role in fully explaining the benefits and relevance of these programmes to parents. Again, busyness is a reason for a large proportion of parents (18 per cent), though not the primary reason for non-attendance. As in the case of parenting groups, a small proportion of parents have not attended a parenting course as it runs at an unsuitable time.

Table 28: Reason for not attending a parenting course or programme

Reason for not attending (all mentions above 3%)	**(%)**
Don't know much about it	28
Not thought about it	19
Too busy/don't have time	18
I don't need it/not relevant too me/I am confident in being a parent	15
Not interested	9
The course runs at an unsuitable time	6
Too shy/unconfident	3
No places available	3
Base: All who had heard of a Flying Start approved parenting programme or course but did not attend (360)	

3.53. Parents who have more than one child are more likely than parents who are first time parents to say they are too busy to attend a parenting programme they have heard of (22 per cent and 10 per cent, respectively). Parents in households where someone works were also more likely to say this than those in workless households (24 per cent compared with 10 per cent). This may be because of the additional demands that multiple children and work place on these parents' time and could indicate a need to arrange classes that are designed specifically to fit around the schedules of busier parents, for example, on weekend mornings, or childcare to be offered to further support ease of attendance.

3.54. For first time parents, not knowing much about the programme was a particular barrier to them attending the course. A third (34 per cent) of first time parents say that they did not attend because they did not know much about it compared to just one quarter of those with more than one child (24 per cent). It may be helpful to target first time parents with greater provision of information about these courses.

LAP courses: referral by health visitor or health visiting team

3.55. Around two in five (38 per cent) parents who have been invited to attend a LAP course by their health visitor (or another health professional) choose not to attend. As these parents have been identified as having a specific need that would benefit from additional support, it is important to understand the reasons why they are choosing not to take-up these services.

Table 29: Reason for not attending LAP

Reason for not attending (All mentions above 3%)	**(%)**
Too busy/don't have time	31
The course runs at an unsuitable time	15
I don't need it/not relevant too me/I am confident in being a parent	15
Don't know much about it	9
Not thought about it	9
Too shy/unconfident	7
Not interested	4
Too far away/transport problems	4
I don't like the other parents who go	4
I will go/be attending/hasn't started yet	4
Base: All who had heard of a LAP but did not attend (137)	

3.56. Barriers here were more likely to be practical than attitudinal. Almost a third (31 per cent) of those who have not taken up the course say it was because they were too busy. Fifteen per cent say it is because the course was not available at a suitable time (32 per cent of working parents said this).

3.57. As base sizes are extremely low, it is not possible to work out any differences between sub-groups.

Awareness of Flying Start

3.58. Over eight in 10 (85 per cent) of parents have heard of Flying Start. Awareness of Flying Start is higher than awareness of Sure Start (67 per cent).

3.59. There is no difference in awareness of Flying Start amongst those whom the programme is targeted at; parents in the potential higher needs groups, those facing multiple socio-economic disadvantages and those facing health and safety risks are no more or less likely to be aware of Flying Start than other groups.

3.60. When considering demographic groups, young parents are significantly less likely to be aware of Flying Start than average (78 per cent compared with 85 per cent). Furthermore, this group is also less likely to be aware of the programme than those in the 20 – 24, 25 – 29 and 30 – 34 age groups (85 per cent, 87 per cent and 89 per cent respectively).

3.61. In line with this, first time parents are also less likely to have heard of Flying Start than non-first time parents (77 per cent compared with 89 per cent). Whilst this is not surprising, given the frequent overlap between young and first time parents, this finding does suggest that more could be done to publicise Flying Start to these two crucial groups.

Table 30: Awareness of Flying Start by sub-group

Sub-group (Base in brackets)	Awareness of Flying Start (%)
All (1,776)	85
Level of need	
Potential higher needs group (1,282)	84
Potential lower-needs group (494)	86
High risk group (420)	87
Socio-economic groups	
Multiple socio-economic disadvantage (317)	87
Demographic groups	
Young parents (aged 16 – 19) (120)	78
Parenting needs	
First time parent (673)	77
Not first time parent (1,103)	89

3.62. Of those who have heard of Flying Start, six in 10 (58 per cent) say that they know a great deal or a fair amount about it, whilst four in 10 (42 per cent) say that they know not much or nothing about it.

3.63. There are no significant differences in the amount that parents feel they know about Flying Start by potential higher need group, multiple socio-economic disadvantage or by parents facing health and safety risks

3.64. Similarly, there are no significant differences by age of parent. However, first time parents are significantly less likely than non-first time parents to say that they know a great deal or a fair amount about Flying Start (47 per cent compared with 64 per cent).

Table 31: Knowledge of Flying Start by sub-group

Sub-group (Base in brackets)	Know a great deal/a fair amount about Flying Start (%)	Know not very much/nothing about Flying Start (%)
All who have heard of Flying Start (1,503)	58	42
Level of need		
Potential higher needs group (1,078)	58	42
Potential lower-needs group (425)	60	40
Socio-economic groups		
Multiple socio-economic disadvantage (277)	58	42
At risk groups		
Parents facing health and safety risks (366)	55	45
Demographic groups		
Young parents (aged 16 –19) (93)	54	46
Parenting needs		
First time parent (516)	47	53
Not first time parent (987)	64	36

4. Experience and perceived sufficiency of services

Summary – health visiting services

- The majority of Flying Start parents say they can contact their health visitor easily most of the time (73 per cent) and that they receive enough support from the health visiting team (79 per cent). Furthermore impact analysis indicates an additional 11 per cent of parents in Flying Start areas can make contact easily, and an additional four per cent who say they receive sufficient support, compared with parents in the matched comparison group.

- Potentially higher need groups are as likely as other parents to rate support from health visitors positively. Parents in the high risk group[44] (who receive higher than average levels of support from health visitors as shown in Chapter 3) are also just as likely as others to say they receive sufficient support. However, parents within many other potentially higher need groups are more likely than parents on average to say they need *more* support from their health visitors. This includes first time parents (25 per cent, compared with 21 per cent among parents on average), young parents (25 per cent) and parents in workless households (23 per cent).

- Parents facing multiple socio-economic disadvantages are less likely than parents on average to say they want more support from health visitors despite the fact that they have received lower numbers of health visitor contacts than average, and are potentially more likely to have additional support needs. It may be worth investigation to understand why this is, and to check for example, whether there are engagement issues between parents in these circumstances and health visitors.

Summary – views of parenting support services in general

- Around two-thirds (64 per cent) of Flying Start parents are positive about

[44] As mentioned at the start of the report these are parents who have experienced post-natal depression, drink to excess or have experienced domestic violence in their current relationship.

the parenting support for young children available locally.

- Furthermore, the impact analysis indicates there is an additional six per cent of parents in Flying Start areas who rate the facilities to help bring up children as very/fairly good, and 11 per cent who rate the advice and support they receive from local services as very/fairly good, compared with parents in the matched comparison group. Parents who are using multiple Flying Start parenting support services are especially positive about services.

- However, a minority of parents rate services as poor and want more support. In particular, around one in five parents want more support with having a good relationship with their child and keeping their child happy and healthy (19 per cent and 21 per cent, respectively) and a quarter (26 per cent) want more advice and support on how to help their child reach their full potential.

- 'High risk' parents tend to be happy with the quality and sufficiency of the support they receive.

- However, other higher need groups tend to rate parenting services as a whole more negatively than average and to say they need more support. For example, among the potentially higher need group as a whole, 22 per cent want more help with how to care for their child to keep them happy and healthy, compared with 15 per cent among parents with potentially lower needs; and the same pattern emerges for other types of help. Young parents, first time parents and those with socio-economic disadvantages are especially likely to say they want more support from parenting support services.

- Another key group emerging as requiring extra help is parents who do not have a high degree of informal support from friends and family. It will be helpful for service providers to be alert to parents in this situation and the potential extra support they may require.

Health visiting services

Introduction

4.1. Given the crucial role health visitors play in supporting parents, identifying need and making referrals to other services, it is extremely important that families have positive perceptions towards the advice and support they offer. This is especially the case for families with younger children within the Flying Start population.[45] Negative perceptions are likely to lead to a straining of the relationship between families and their health visitor, and in such cases a breakdown of the Flying Start offer is potentially a risk.

4.2. Given the universal nature of the health visiting offer and the slightly greater extent that these services are being used in Flying Start areas, as seen in Chapter 3, (and the expectation that due to the reduced case load visits contact time with families in Flying Start areas may also be longer) it is reasonable to expect that there be some impact on parents' perceptions of the service as a result of the Flying Start programme even at this early stage.

4.3. It must be remembered that due to the age of the children at the time of the interview, and the time frames of the rollout of the service delivery across the Flying Start areas, most parents will not have received the *full* Flying Start health visitor offer which continues to be received through children's early years. This means that findings presented here relate to part of the health visiting entitlement, rather than all of it for many parents. The impact of the health visiting offer as a whole may prove to be greater than can be quantified at this stage.

Views of health visiting among the target population

4.4. The majority of parents, across all groups, report good levels of access to their health visitor and/or the health visiting team when they need them. Just under nine in 10 (88 per cent) say they are able to contact their health visitor and/or team when they want to with just under three-quarters (73 per cent) saying that they are able to do so most of the time. Encouragingly, it also

[45] That is the populations sampled for Wave 1 of the survey.

appears that when parents make contact with their health visitor and/or the team these encounters are seen as worthwhile and meet the needs of parents. Nine in 10 (90 per cent) parents report that the advice and support they receive from their health visitor and/or the team to care for and help bring up their child is helpful, while the majority (79 per cent) also say that they are receiving enough support from their health visitor and/or the team.

Table 32: Ability to contact their health visitor and/or team when want to

	Ability to contact health visitor and/or team when want to (%)
Yes, most of the time	73
Yes, some of the time	15
Not very often	7
No never	3
Don't know	2
Yes – at least some of the time[46]	*88*
No[47]	*3*
Base: all parents (1,776)	

[46] This figure is the combination of those who said 'Yes most of the time' or 'Yes some of the time'.
[47] This figure is the combination of those who said 'Not very often' or 'No never'.

Table 33: Ratings of amount of support from the health visitor and/or team

	Ratings of support (%)
You had enough support	79
You would have liked a little more support	15
You would have liked a lot more support	6
Don't know	*
Enough support	*79*
Would like more support[48]	*21*
Net enough support[49]	*58*
Base: all parents (1,776)	

4.5. The findings from the impact analysis indicate that parents in Flying Start areas are positive about health visitor services, with an additional 10 per cent of families in Flying Start areas saying they can usually contact their health visitor easily, compared with parents in the matched comparison group. In addition, an extra six per cent of families rate the support they receive from their health visitor as very helpful, and seven per cent report that they have received enough advice and/or support, compared with parents in the matched comparison group.

[48] This figure is the combination of those who said they would have 'like a little more support' or 'a lot more support'.
[49] This figure is the difference between those who said they have 'enough support' and those who said they 'would like more support'.

Table 34: Indicative impact of Flying Start on parents' perceptions of contact with their health visitor and/or team

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Ease of contacting health visitor easily most of the time	73		74.6	64.9	9.7
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,559*	*1,323*	
Rating of helpfulness of advice and support from health visitor as very helpful	61		61.5	55.3	6.2
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,768*	*1,741*	
Parents received enough support from their health visitor	79		79.2	72.6	6.6
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,770*	*1,740*	

4.6. While these are positive overall results, it is still the case that for some respondents the system is still not fully meeting their needs as discussed in detail later in the section. One in five (21 per cent) parents say they would like more support from health visitors. The main reason given is that they do not feel that health visiting services have, thus far, been responsive to their needs (picked out by 39 per cent of those who say they would like more support, which equates to eight per cent of all parents). Given the focus of the Flying Start programme is to target and address the needs of parents (within it's operational boundaries), particularly those of vulnerable groups, this finding is a concern. Other commonly cited issues by parents who would like more support relate to difficulty of being able to contact the health visitor and/or health visiting team easily (24 per cent, equivalent to five per cent of all parents), the health visitor not being very helpful (18 per cent, equivalent to just under four per cent of all parents) or that the clinic opening hours are inconvenient (eight per cent, equivalent to just under two per cent of all parents). In addition to these common issues parents who would like more support also mention a range of other factors including lack of continuity of care, transport problems, lack of adequate staff, poor communication and a lack of information.[50]

Views of health visiting among different service user groups

4.7. Whilst ratings of health visitors tend to be high across all groups, parents who have received the highest number of visits in-home from a health visitor are more likely to be positive about the health visiting service than others (97 per cent rate the advice and support as helpful compared with 86 per cent, respectively).

Views of health visiting among different socio-demographic groups

4.8. Given that an aim of Flying Start is to tailor support towards specific groups where need is greatest (within its operational boundaries), it is important to

[50] All mentioned by fewer than four per cent of these parents.

consider how higher need groups view health visiting services, and whether they feel they receive sufficient support from them.

4.9. Impact analysis was conducted among 'high need' sub-groups to detect whether Flying Start is having an impact on their experience of the health visiting service. The findings indicate that a higher proportion of all groups in Flying Start areas included in the analysis (lone-parents, first time parents, young parents and parents experiencing multiple disadvantage) say they have received enough advice and support from their health visitor, compared with parents with the same characteristics in matched comparison groups. Similarly a higher proportion of all parents apart from those experiencing multiple disadvantage report receiving helpful advice and support from their health visitor.

4.10. Lone-parents and those experiencing multiple disadvantages in Flying Start areas are also more likely than their counterparts in matched comparison groups to find the health visitor accessible. However, by contrast, first time parents and young parents in Flying Start areas are *not* more likely than their counterparts in matched comparison groups to find the health visitor accessible. The findings therefore suggest that it may be beneficial to focus on these groups of parents to ensure they are receiving the support they require.

4.11. As well as looking at impact on the sub-groups discussed above, it is also important to look at differences between sub-groups within Flying Start areas to see how perceptions vary across the different groups. While it is encouraging that some high need groups appear to be getting all the support they require from health visiting services, this is not the case for all.

4.12. Parents from **potentially higher need groups** as a whole, are just as likely as other parents to have reported being able to access their health visitor easily when they need to, and to have rated the support they have received from the health visitor and/or team to help bring up their child as positive. However, these parents are more likely than others to say they would like *more* support from their health visitor and the health visiting team (22 per cent

parents from potentially high need groups say this, compared with 17 per cent of parents from lower need groups). This finding indicates that despite the additional number of visits that this group of parents received (see Chapter 3), they would welcome even greater levels of support. Thus while Flying Start services are doing well in providing access to health visiting services for the key groups, perhaps more can be done to ensure that service provision *fully* meets the needs of these parents.

4.13. However, levels of unmet need vary between high need groups. For example, those 'high risk' **parents** who are using health visiting services to a greater extent than other parents, are no more likely than parents in general to say they want more support from health visitors.

4.14. However, other key target groups do feel they need more support. A quarter (25 per cent) of **first time parents** say they would like more support compared to one in five (18 per cent) of those who are not first time parents. As seen in Chapter 3, this group are already receiving more support from health visitors than parents on average, but this finding indicates they may welcome *even more* support.

4.15. **Young parents** are also more likely than others to want more support (25 per cent, compared to 15 per cent among parents aged 35+ years). As shown in Chapter 3 they seem to receive only a slightly greater number of visits from health visitors than other groups; therefore this current level of support may be insufficient.

4.16. Those on **low incomes** (24 per cent) and those in **workless households** (23 per cent) are more likely than those with higher incomes (16 per cent)[51], and those in households where someone works (19 per cent) to feel that they would like more support from their health visitor and/or the health visiting team. Workless households are currently receiving slightly more support from health visitors than average, but this may not be sufficient given their potentially higher levels of need.

[51] Those families with an annual household income in excess of £30,000.

4.17. Interestingly, **parents in households facing multiple socio-economic disadvantage** are no more likely than average to say they want more support from health visitors (21 per cent), despite the fact that they receive less health visitor support than parents on average (see Chapter 3). Given that they are likely to have greater support needs, it may be beneficial to investigate this issue further. For example, it may point to potential lack of positive engagement between parents in this group and health visitors, which may be limiting the potential for this group to fully benefit from the health visiting entitlement.

Overall support for parents

Introduction

4.18. This section looks at parents' perceptions of the extent to which parenting support services in general are adequate to meet families' needs.

Views of overall support for parents among target population

4.19. As shown in Table 35, the majority of parents in Flying Start areas are positive about the standard of their local parenting services. Around two-thirds rate both the facilities, services and support available for families, and the advice and support that is available locally about how to care for their child, as very/fairly good (64 per cent and 68 per cent, respectively).

Table 35: Ratings of local parenting facilities

	Rating of the facilities, services and support available for families with children aged 0 to 3 (%)	Rating of advice and support from services that is available to you locally on how to care for and bring up your child (%)
Very good	24	27
Fairly good	39	41
Neither good nor poor	15	14
Fairly poor	13	10
Very poor	6	5
Don't know	3	3
Good[52]	*64*	*68*
Poor[53]	*19*	*15*
Net good	45	53
Base: all parents (1,776)		

4.20. As shown in table 36, the findings from the impact analysis indicate that an additional six per cent of parents in Flying Start areas rate the facilities to help bring up children as very/fairly good and an additional 11 per cent rate the advice and support they receive from local services on how to bring up their baby as very/fairly good, compared with parents in the matched comparison group.

[52] These figures are the combination of those who said 'Very good' or 'Fairly good'.
[53] These figures are the combination of those who said 'Fairly poor' or 'Very poor'.

Table 36: Indicative impact of Flying Start on parents' rating of facilities for children and overall rating of advice and support from local services

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Rating of the facilities, services and support available for families as very/fairly good	64		66.1	60.4	5.7
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,637*	*1,461*	
Rating of advice and support from services available locally on how to bring up baby as very/fairly good	68		70.8	59.4	11.4
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,624*	*1,346*	

Views of sufficiency of parental support for specific aspects of wellbeing

4.21. Reflecting the positive ratings given to parenting support overall, it is also encouraging to see that the majority of Flying Start parents feel that they receive enough advice and support from local services to care for their child to keep their child happy and healthy, have a good relationship and help their child to meet their full potential (80 per cent, 80 per cent and 73 per cent, respectively).

Table 37: Ratings of level of support from local parenting services

	How to care for your child to keep them happy and healthy (%)	How to have a good relationship with your child (%)	How to help your child learn and meet their full potential (%)
Enough	80	80	73
Need a little more	15	14	20
Need a lot more	5	4	6
Don't know	1	1	1
Base: All parents (1,776)			

4.22. The impact analysis indicates that an additional three per cent of parents in Flying Start areas say they receive enough support and advice to help keep their child happy and healthy, five per cent to help with the parent child relationship, and eight per cent for helping their child to reach their full potential, compared with parents in the matched comparison group.

Table 38: Indicative impact of Flying Start on whether respondent had enough advice and support in three key parenting aspects

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Proportion saying they received enough advice and support on how to look after Baby to keep to keep them happy and healthy	80		80.2	77.6	2.6
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,760*	*1,478*	
Proportion saying they received enough advice and support to help develop parent/child relationship	80		81.3	76.4	4.9
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,743*	*1,706*	
Proportion saying they received enough advice and support to help their child reach full potential	73		74.6	67.1	7.5
Base: All parents	*1,776*				-
Base: All matched parents excluding those who responded don't know or refused			*1,497*	*1,287*	

4.23. Despite the overall positive ratings there remains a significant minority of parents who have a negative view of local parenting services, and this will warrant attention from policy makers and practitioners. As Table 35 shows, one in five parents (19 per cent) rate the facilities and support available for

families with nought to three year olds as poor, while one in seven (15 per cent) rate the advice and support they receive on how to care for their baby as poor. Reflecting this, it is no surprise that a minority of parents also say they would like more advice and support to help with their child. As shown in Table 37 above, one quarter (26 per cent) of parents would like at least a little more advice and support on how to help their child reach their full potential, while around one in five would like more advice and support about how to have a good relationship with their child and how to keep their child happy and healthy (19 per cent and 20 per cent, respectively).

Views of support for parents among different service user groups

4.24. Parents who are receiving more than average levels of support from Flying Start tend to be more positive about *parenting support services in general*. This includes those who have had at least six in-home visits from a health visitor since the birth of their child, and those who have attended a parenting group or course. These parents are not only more positive than others about parenting facilities, services and advice available locally, but also are more likely to feel well supported on key measures to help bring up their child. Furthermore, parents who have received *multiple* Flying Start services are also more positive than others about these aspects[54]. It is not possible to be sure if this means that Flying Start service use is a contributing factor to more positive ratings, and/or whether it is those who have had more positive experiences of parent support services in general who have been able to receive the most Flying Start service support, for example. However, this could be an area for further investigation.

[54] For example, those who have had at least six contact/visits with their health visitor since their child was born and who have attended a parenting group/course validated for Flying Start funding, are more likely than parents in general to rate both the facilities and support, and the advice and support available locally to help bring up children as good (75 per cent compared with 64 per cent, and 78 per cent compared with 68 per cent, respectively). The same is true for parents who have made similar use of their health visitor and attended any parenting group, or parenting group and course. These groups are also more likely to say they receive enough support.

Views of support for parents among different socio-demographic groups

4.25. The findings show that at this stage in programme delivery, many high need groups are less likely to be positive about parenting services than other parents.

4.26. When looking at the potentially higher need groups as a whole, one in five (21 per cent) rate the facilities, services and support in the local area as very or fairly poor, compared with just over one in 10 (13 per cent) of those in potentially lower need groups; the same relationship is also true when looking at ratings of the advice and support available locally on how to care for and bring up their child.[55] As Table 40 below shows, parents in the potentially higher need group as a whole are also more likely than others to say that they would like a little more support in how to care for their child to keep them happy and healthy (22 per cent compared to 15 per cent, respectively), have a good relationship with their child (21 per cent compared with 13 per cent, respectively) and how to help their child reach their full potential (27 per cent compared with 22 per cent, respectively).

4.27. However, the picture does vary between different need groups.

4.28. **'High risk' parents** are as likely as other parents in Flying Start areas to rate local parenting support positively (62 per cent and 64 per cent respectively) and to say the support they receive is sufficient,[56] despite their greater level of needs. It is notable that this group are also receiving more Flying Start support than the average across parents as a whole (see Chapter 3). Whilst the analysis does not allow causal links between these two features to be drawn, nevertheless it is clear that despite their higher level needs, they are no more likely to feel they need more support than others, and this indicates that Flying Start services may already be doing enough to target them sufficiently for extra support.

[55] Seventeen per cent of parents from potentially higher need groups rate this as very or fairly poor compared with eight per cent of parents from potentially lower need groups.
[56] For example around four in five of parents overall and those in the 'high risk' group say they have received enough support from local parenting services about how to have a good relationship with their child (80 per cent and 78 per cent respectively).

4.29. However, **young parents**, and also **parents from socio-economically disadvantaged groups** such as those from workless households and low income households, are less likely than average to rate the facilities and services, or advice and support on offer locally as *very or fairly* good. As shown in Table 40 below, they are also slightly more likely than their older, working and more affluent counterparts to say that they would like more advice and support with how to bring up their child. As shown in Chapter 3, many of these parents, despite their potential needs, were not receiving more support from Flying Start services than parents in general. Their relatively low rating of local parenting services, and the greater extent to which they express a desire for more support would suggest that greater targeting of support among these groups may be helpful. As discussed in sections 4.8 to 4.17 above, many of these groups do rate health visiting services as positively as parents on average, meaning that it may be wider parenting support services that they regard less positively. This may be an area for policy makers and practitioners to focus on further (see Chapter 3).

4.30. **First time parents** are as likely to rate parenting services positively as parents in general. As seen in Chapter 3, this group receives more support from health visitors than parents on average. However, first time parents are more likely than parents with other children to say that they would like *more advice and support* in how to care for and look after their child (23 per cent compared with 17 per cent, respectively) and how to help their child reach their full potential (33 per cent compared with 22 per cent, respectively). This indicates that even greater levels of support would be welcomed by them in helping them to address their needs. It is notable that their greater levels of health visitor support are not also translating into greater levels of support from parenting support groups and courses (they are no more likely to receive these than parents in general). As well as reflecting on whether levels of health visiting support are sufficient for this group, it will be important to ensure that health visitors are doing what they can to ensure parents access these services where required and for the any barriers to access for these groups to be addressed (see Chapter 3).

Table 39: Ratings of enough advice and support on how to care for their child – sub-groups

Sub-group *(Base in brackets)*	Need a little/a lot more support		
	How to care for your child to keep them happy and healthy (%)	How to have a good relationship with your child (%)	How to help your child learn and meet their full potential (%)
All (*1,776)*	20	19	26
Potential higher needs group *(1,282)*	22	21	27
Potential lower-needs group (*494)*	15	13	22
Demographic groups			
Young parents (aged 16 – 19) (*120)*	22	19	31
Black or minority ethnic group (BME) *(122)*	20	12	23
Socio-economic groups			
At least one person in work (*967)*	16	16	25
Workless household *(809)*	24	22	27
Low income (less than £9,999) *(495)*	23	23	28
Multiple socio-economic disadvantage *(317)*	22	20	26
Parenting needs			
First time parent *(673)*	23	22	33
Not first time parent *(1,103)*	17	17	22

4.31. The level of parenting support in general locally is also not seen as sufficient for **those who lack their own adequate informal support networks**. These parents are also less positive about local parenting services, and the support available to them than other parents. More than one in five parents who only have one or two friends/family that they are able to turn to for support rate both the facilities and services, and the advice and support available for families locally as poor; a significantly greater proportion than parents in general (24 per cent and 22 per cent, respectively compared with 19 per cent and 15 per cent). A similar pattern is also evident when taking account of the level of support received from friends and family, with those parents who would like more support from their informal network of friends/family also

more likely to rate facilities and services, and advice and support on offer locally as poor (24 per cent and 21 per cent, respectively).

4.32. Using the findings presented in this chapter to help isolate for which groups the quality, quantity and/or accessibility of parent support is unsatisfactory will prove useful for ensuring that future Flying Start service provision meets expectations for a greater number of parents. Therefore, it would be interesting to undertake further research to identify the optimum mix and make-up of service use that appears to meet the needs of different types of parents most effectively.

5. Parent self-report of impact

Summary

Health visiting and parenting groups and initiatives associated with the health visiting entitlement

- Among the two-thirds (64 per cent) of parents who have received support from parenting groups and initiatives as well as health visitors, the majority are positive about the overall helpfulness of the advice and support they have received from the health visiting-related Flying Start services: eight in 10 say they have increased their confidence as a parent (79 per cent) and three-quarters say they have been helped with decision making about how to look after their baby (75 per cent), and that are happy with the amount of support that they have received. For many parents the contact they have had has been helpful across a number of areas, especially giving parents an understanding of their child's general development, enabling them to meet other families or parents with young children, and informing them about other services and support available locally (76 per cent, 72 per cent and 71 per cent, respectively).

- However, there is demand for more support from these services in a number of aspects, especially, for even more provision of information about services and support available locally (43 per cent), help for parents to address problems with their baby's sleeping (23 per cent) and help for parents to meet other families with young children (22 per cent).

- Notably, whilst there are significant proportions of parents who are interested in more help with breastfeeding (17 per cent) this is relatively low compared with the proportion who have not attempted to breastfeed (around half – see Chapter 6). This highlights the challenges that health visitors face in communicating the benefits of breastfeeding and encouraging take-up of it.

Parenting courses

- Parents are overwhelmingly positive about the programmes' impact and the vast majority believe the courses help their confidence as a parent, their ability to understand their child and their relationship with their child (83 per cent, 80 per

cent and 79 per cent say a great deal or a fair amount respectively).

- As a result of attendance at parenting courses many parents (around two in five) say they are interacting with their child to a greater extent, and using the techniques they have learned on the course at home.

LAP

- LAP sessions are helping users to interact with their child in an educational way, with many parents who have attended the sessions reporting talking to, sharing stores, singing songs and rhymes and counting things more as a result (52 per cent, 45 per cent, 60 per cent and 49 per cent more respectively).

- Parents also largely acknowledge the positive impact that LAP sessions are having on their child. For example, around half say that as a result of attending LAP, their baby shows more interest in books or stories (55 per cent) or counting things (48 per cent) and that they know more songs and rhymes than they did previously (57 per cent).

Potential higher need groups

- Promisingly, some of the higher need groups have been more positive than other users about the benefits of some of the services. First time parents are especially positive about the impact of health visiting and parenting groups on certain aspects of caring for their baby, and also about the impact of LAP, but are also especially likely to want more help with other aspects from health visiting and parenting groups. Young parents are especially positive about how health visiting and parenting groups have helped them with weaning, and parents living with multiple socio-economic disadvantages are especially positive about the impact of LAP.

- However, many higher need groups are more likely than average to want health visitors and parenting groups and initiatives to provide them with more information about other sources of advice and support, especially first time parents and young parents.

- Similarly, 'high risk' parents are more likely than others to want additional help from health visiting teams with their own health and wellbeing, and also with their baby's sleeping habits, and in some cases with getting them into a routine with

their baby.

5.1. The survey also provided an opportunity to explore parents' perceptions of the usefulness and impact of Flying Start services on their relationship with their child, their child's behaviour, access to support services and the type and level of interactions they have with their child. The findings constitute a subjective assessment of the programme from the point of view of users themselves. These may not necessarily correlate with objective measures from the impact analysis as, for example, they can be influenced by service experience rather than service changes. Furthermore, it is very difficult for beneficiaries with complex needs to attribute change in their lives to individual initiatives. However, despite this, they remain a useful insight into what extent parents themselves believe Flying Start is having an impact on their lives.

Health visiting and parenting groups

Introduction

5.2. Parents in Flying Start areas who had attended a parenting initiative or group, which amounts to 64 per cent of all parents, were asked to consider how helpful these groups, their health visitor and the health visiting team, referred to throughout as 'health-visiting related Flying Start support', had been to them.

5.3. Note that parenting support groups and initiatives can be regarded as very much linked with the Flying Start health visitor offer (e.g. some health visitor support is specifically delivered in these group formats). It was for this reason that parents' views of impact of these were sought together.

5.4. Parents were asked their views of the impact of these services in relation to three general aspects of parenting:

- keeping their child healthy and happy
- increasing their confidence as a parent or carer

- making decisions on how to look after their child (for example, about childcare, health matters etc.).

5.5. Encouragingly, users of some of the key parenting groups and initiatives are positive about the overall helpfulness of the advice and support they have received from health-visiting related Flying Start support across the above three aspects. This is most strongly felt in teaching parents how to keep their child happy and healthy, with over four in five parents (84 per cent) saying these services have helped them at least a fair amount. Slightly fewer, but still the majority, also reported that health-visiting related Flying Start support they accessed helped to increase their confidence as a parent or carer and helped them to make decisions about how to look after their child.

Table 40: Users' of specific groups self-reported impact of health visitor, health visiting team and other parenting initiatives

	Keeping Baby healthy and happy (%)	Increasing your confidence as a parent/carer (%)	Making decisions about how to look after Baby (%)
A great deal	36	35	30
A fair amount	48	44	45
Not very much	12	16	18
Not at all	4	5	6
A great deal/a fair amount[57]	*84*	*79*	*75*
Not very much/not at all[58]	*16*	*21*	*25*
Net helpful	67	58	50
Don't know	*	*	1
Base: 558 parents in Flying Start areas who have attended one or more of baby massage, weaning/nutrition group, safety party, one baby club, breastfeeding support group or Aquatots			

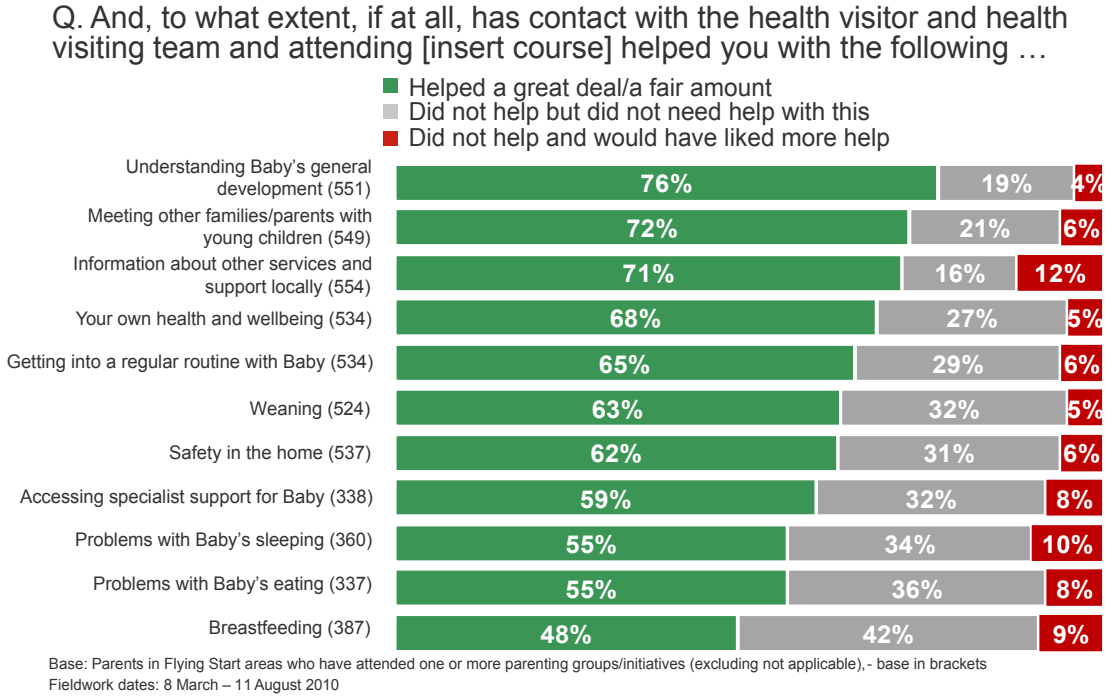
5.6. Users were asked to consider how helpful health-visiting related Flying Start support had been in helping them with practical advice to help support them

[57] These figures are the combination of those who said 'A great deal' or 'A fair amount'.
[58] These figures are the combination of those who said 'Not very much' or 'Not at all'.

as their child develops, information about services (parenting or other) and help for some specific problems that their child may have.

5.7. As Figure 4 shows, for many parents the contact they have had has been helpful, particularly in giving parents an understanding of their child's general development, enabling them to meet other families or parents with young children, and informing them about other services and support available locally (76 per cent, 72 per cent and 71 per cent, respectively said the health-visiting related Flying Start support helped at least a fair amount in these respects). Around two-thirds of parents also reported the contact they have had was helpful with regard to their own health and wellbeing (68 per cent), getting into a regular routine with their child (65 per cent), weaning (63 per cent) and safety in the home (62 per cent).

Figure 4: Users' self-report of the helpfulness of health visitor, health visiting team and other parenting initiatives in 11 key areas



Base: Parents in Flying Start areas who have attended one or more parenting groups/initiatives (excluding not applicable), - base in brackets
Fieldwork dates: 8 March – 11 August 2010

5.8. There is a small minority of parents who did not find the support they received helpful and would have liked more help. Aspects with which parents are most likely to say they need more help are information on other local services and

support (this is the case for 12 per cent of parents overall), problems with their baby's sleeping (mentioned by 10 per cent of parents) and breastfeeding (mentioned by nine per cent). As these are some of the most difficult issues for parents, it may be helpful to focus improvements on these aspects.

5.9. However, some of the discrepancy between the proportions who did not regard support as helpful, and proportions who want more support may reflect a lack of awareness of the benefits of the help being offered, lack of successful engagement between health visitors and client groups, and/or resistance to health visitor input on some of these aspects. For example, in relation to breastfeeding in particular, it is notable that whilst 17 per cent would like more help with this, around half have not tried to breastfeed (see Chapter 6 for more details). Furthermore, the fact that around half of service users said breastfeeding advice from the health visitor and parent groups was not very/at all helpful indicates that, as yet, health visitors have not been successful in engaging a sizeable proportion of parents on this issue effectively. It is notable that there does not seem to be any clear patterns in the data with regards to levels of interest in additional support with breastfeeding across different socio-demographic groups. However sub-group sample sizes are too small to draw definitive conclusions in this regard.

5.10. Nevertheless, there is positive demand for more support and information from some parents. As shown in Figure 4, one in ten parents say they would like more help with regard to information about services and support available locally, problems with their child's sleeping and breastfeeding (12 per cent, 10 per cent and nine per cent respectively). For these specific areas in particular it would appear that the current advice and support offered by health-visiting related Flying Start support is not meeting the needs of all parents. There are also a small proportion of parents who are also actively keen on receiving more support in relation to each of the other aspects measured.

Views of health visiting and parenting groups among different service user groups

5.11. Those who have used multiple Flying Start services are more likely to rate the contact that they have had with health-visiting related Flying Start support as

helpful across most of the 11 areas, and also subsequently report a positive impact from this. This appears to be the case for making decisions about how to look after their baby, where half of parents (50 per cent) who have at least medium health visitor usage and attended a Flying Start parenting course say that the contact they have had has helped them a great deal. This is compared with three in 10 (30 per cent) of parents in general; this is also true of keeping their baby happy and healthy[59], and increasing their confidence as a parent/carer[60]. As seen throughout, service use plays a pivotal role in shaping the views of parents towards Flying Start and wider parenting services. However, whilst it is the case that use of multiple Flying Start services coincides with more positive use of the impact of health visitors it is not possible from the current analysis to conclude that there is a causal relationship. This could be an aspect where further analysis could be useful.

5.12. It would be useful to understand what the optimum service package/level of use is in order for positive benefits to be seen or felt by the parents. Undertaking further research to investigate what this package may look like, especially where impact corresponds with self-report benefits is likely to significantly enhance understanding of these topics.

Views of health visiting and parenting groups among different socio-demographic groups

5.13. There is little variation between how helpful **potentially high need groups** as a whole rate the helpfulness of their contact with health-visiting related Flying Start services, compared with parents in general, with no consistent significant differences across 10 of the 11 areas asked about. Interestingly, the exception to this is for helping with information for other services and support locally, where those from high need groups are particularly more likely to say that the contact they have had has not helped very much or at all with this (32 per cent compared with 20 per cent of parents from potentially low

[59] Nine in 10 (91 per cent) of those who have attended LAP sessions say their contact with the health visitor, the team and parenting course has been helpful with this compared with 84 per cent of parents in general.
[60] Two in five (42 per cent) parents who have had a high number of in-home health visitor visits say their contact help a *great deal* compared with one in three (30 per cent) of those who have received a low number or no in-home visits.

need groups). This finding may indicate that, while Flying Start support is perceived by parents as meeting the needs of most parents, it may not be providing adequate advice to those parents who have a diverse range of support needs – some of which may well relate to issues beyond parenting alone, and therefore the most likely groups to need additional information, advice and support.

5.14. Self-reported benefits of the contact that parents have had with health-visiting related Flying Start support is fairly consistent across the Flying Start population, including a number of the high need groups identified in Chapter 3 which is encouraging. However, there are a number of patterns by sub-group that are worthy to note and helpful for policy makers and practitioners to consider when reviewing and developing services.

5.15. First time parents are more likely than parents with other children to find health-visiting related Flying Start support helpful in getting into a regular routine with their child, with problems with their child's sleeping, their own health and wellbeing, safety in the home and understanding their child's general development. As a result of this contact this group of parents report that the support has also helped them to keep their baby happy and healthy, and increase their confidence as a parent/carer.[61] For this group, it is encouraging that the advice and support offered by Flying Start appears to be viewed as helpful in many areas, and useful in helping them develop as a parent/carer. As such it is even more important to ensure this group of parents have sufficient support from Flying Start services (see Chapters 3 and 4).

[61] Just under nine in 10 first time parents (87 per cent) say that the contact they have had has helped them to keep baby happy and healthy compared with four in five non first time parents (80 per cent). In addition 84 per cent of first time parents also report the contact they have had has helped to increase their confidence as a parent/carer compared with three-quarters (75 per cent) of non-first time parents.

Table 41: Users' self-report of the helpfulness of health visitor, health visiting team and other parenting initiatives in key areas – first time parents

	Getting into a regular routine with Baby (534)	**Problems with Baby's sleeping** (360)	**Your own health and wellbeing** (534)	**Safety in the home** (537)	**Understanding Baby's general development** (551)
All (% great deal/fair amount)	65	55	68	62	76
First time parents (% great deal/fair amount)	69	63	72	67	81
Non first time parents (% great deal/fair amount)	61	48	64	57	72
Base: provided for all parents in Flying Start areas who have attended one or more parenting groups/initiatives excluding not applicable – bases in brackets					

5.16. However, **first time parents** are also more likely than parents with other children to say that they would have liked more help across five of the 11 key areas asked about including getting into a regular routine with their baby, weaning, problems with their baby's eating, understanding their baby's general development and meeting other families with young children as shown in table 42.

Table 42: Users' self-report of wanting more support from their health visitor – first time parent's sub-group

	Getting into a regular routine with Baby (187)	Weaning (193)	Problems with Baby's eating (148)	Understanding Baby's general development (128)	Meeting other families with young children (149)
All (% want more help)	17	12	19	16	22
First time parents (% want more help)	23	19	31	26	31
Non first time parents (% want more help)	12	7	10	10	14
Base: base provided for all parents in Flying Start areas who found contact with the health visitor/visiting team and attending parenting groups/initiatives did not help them with each aspect – bases in brackets					

5.17. Looking at the 11 specific areas, there are other socio-demographic groups of parents, in addition to first time parents, who find health-visiting related Flying Start support more or less helpful in each respect. Positively, **young and Black or Minority Ethnic (BME) parents** are particularly likely to find health-visiting related Flying Start support helpful with regard to weaning, while white parents are particularly likely to find the support helpful with regard to safety in the home. In contrast, **young parents** are particularly likely to say that they did not find health-visiting related Flying Start support helpful with regard to providing information about other services and support locally.

5.18. **Biological mothers who have had post-natal depression**, despite higher than average contact with health visitor services among this group of parents, are another key group who would have liked more support from the contact they have had with health-visiting related Flying Start support for their child and themselves. This group of parents are more likely than parents in general to have said they would like more help with problems with their baby's sleeping[62], accessing specialist support for the baby[63], information on other

[62] Thirty-five per cent compared with 23 per cent want more help respectively.
[63] Thirty-four per cent compared with 19 per cent want more help respectively.

services available locally[64] and, perhaps unsurprisingly, their own health and wellbeing[65].

5.19. Consistent with this, **'high risk' parents** are also more likely than parents in general to say that they would like more support from the groups or initiatives they attended in a number of areas, as shown in Table 43 despite their greater use of these services. Whilst two of the aspects they want more help with relate to their child directly, most aspects they want more help with relate to wider needs (including their own health and wellbeing, for example), and this is likely to reflect the multiplicity of other issues parents in this group could be having to deal with.

Table 43: Users' self-report of wanting more support from their health visitor – 'high risk' sub-group

	Getting into a regular routine with Baby (187)	**Problems with Baby's sleeping** (159)	**Your own health and wellbeing** (170)	**Meeting other families with young children** (149)	**Information about other services and support locally** (159)
All (% want more help)	17	23	16	22	43
'High risk' (% want more help)	30	41	31	38	67
Base: base provided for all parents in Flying Start areas who found contact with the health visitor/visiting team and attending parenting groups/initiatives did not help them with each aspect – bases in brackets. Note that bases for each vary because per cent ages have been re-based to exclude parents where the issue was not applicable.					

5.20. As the Flying Start service offer is developed it will be important to investigate the possible reasons for why the needs of certain groups are not being met, and, where this is the case, take action to address this.

Parenting courses

5.21. The Flying Start parenting courses are intended to have an impact on parental confidence and the ways in which they relate to their children. Parents were

[64] Fifty-six per cent compared with 43 per cent want more help respectively.
[65] Thirty-one per cent compared with 16 per cent want more help respectively.

therefore asked about the impact the courses had across these factors, as well as their relationship with their child, their ability to understand their child's needs and their confidence as a parent/carer. As shown in Chapter 3, just over one in 10 (13 per cent) parents in Flying Start areas reported attending one of these parenting courses.

5.22. Encouragingly, parenting course users are overwhelmingly positive about the courses' impact on all key aspects of parenting and family life that were measured. The vast majority believe that the course(s) have helped their confidence as a parent, their ability to understand their child and their relationship with their child (83 per cent, 80 per cent and 79 per cent say a great deal or a fair amount respectively). Across all three categories, just seven per cent of parents say the courses they attended were not at all helpful in these areas.

5.23. A smaller proportion of users are positive about the impact the courses have in helping them to maintain or develop a good relationship with their partner. Just under two-thirds (63 per cent) say that the courses help at least a fair amount in this respect. However this is unsurprising given the probability that this is not the primary focus of the courses.

Table 44: Users' self-report of the impact of Flying Start parenting courses

	Your relationship with Baby (%)	Understanding Baby's needs (%)	Your confidence as a parent (%)	Maintaining or developing a good relationship with your partner (%)
A great deal	44	40	47	26
A fair amount	39	41	38	38
Not very much	13	13	10	16
Not at all	7	7	7	18
Don't know	1	1	1	2
A great deal/a fair amount[66]	*79*	*80*	*83*	*63*
Not very much/not at all[67]	*21*	*20*	*17*	*34*
Net helpful	59	60	66	29
Base[68]	*164**	*164**	*164**	*93***

** Base: parents in Flying Start areas who have attended/are attending any course in relation to Baby*

***Base: parents in Flying Start areas who have a partner and who have attended/are attending any course in relation to Baby*

5.24. Parents were also asked about the impact of the parenting courses on the regularity with which they interact with their child, such as talking, cuddling and having fun with them, as well as being able to calm them down if their child is upset or angry. Over half (54 per cent) report having fun with their child more often, over two in five say they are more likely to talk to their child and are more able to calm their child down (46 per cent and 45 per cent, respectively), while two in five (38 per cent) said they cuddle their child more.

[66] These figures are the combination of those who said 'A great deal' or 'A fair amount'.
[67] These figures are the combination of those who said 'Not very much' or 'Not at all'.
[68] Please note that this table contains multiple responses and as a result sums to greater than 100 per cent. This is the case because the results combine the ratings of these measures for each parenting course attended. If parents attended more than one parenting course then a response for each course attended is included. As only eight respondents attended more than one course the findings provide a good summary of the views of users' towards the parenting courses attended in general.

Table 45: Users' self-report of the impact of Flying Start parenting courses on parents' interaction with their child

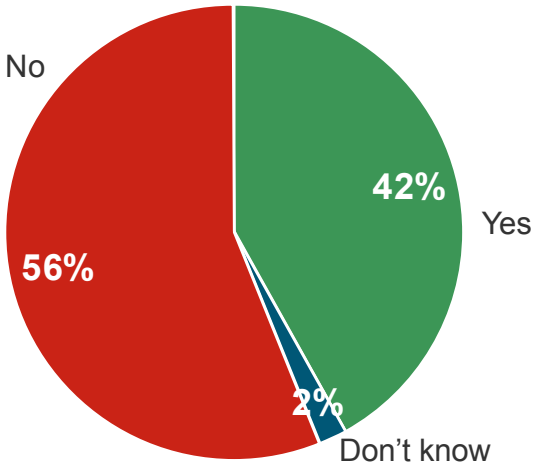
	Talking to Baby (%)	Having fun with Baby (%)	Cuddling Baby (%)	Being able to calm Baby down when Baby is upset or angry (%)
More	46	54	38	45
Less	3	3	2	5
About the same	52	44	59	52
Don't know	1	2	2	1
Base[69]: 164 parents in Flying Start areas who have attended/are attending any course in relation to Baby				

5.25. In addition to asking about impact from a parental point of view, parents were also asked whether they had noticed a change in their child. Given one of the key aims of the Flying Start programme is to have a long-lasting impact on the development of children themselves, this is certainly an important area to measure even at this early stage. Encouragingly, despite the young age of the children more than two in five parents (42 per cent) say they have seen a change in the behaviour of their child since attending the parenting course.

[69] Please note that this table contains multiple responses and as a result sums to greater than 100 per cent. This is the case because the results combine the ratings of these measures for each parenting course attended. If parents attended more than one parenting course then a response for each course attended is included. As only eight respondents attended more than one course the findings provide a good summary of the views of users' towards the parenting courses attended in general.

Figure 5: Users' self report of impact of Flying Start parenting courses on children

Q. Since attending the parenting course(s) have you noticed any change in the behaviour of Baby or not yet?



Base: 164 respondents in Flying Start areas who have/whose partner has attended/are attending a parenting course in relation to Baby
Fieldwork dates: 8 March - 11 August 2010

Source: Ipsos MORI

5.26. When asked what changes had been noticed, just over half of the parents who had noticed a change in their child's behaviour said that they were happier (54 per cent, which equates to 23 per cent of users), and one third said they showed more interest in things (33 per cent, which equates to around 14 per cent of users). Around one in five said they cry less (23 per cent, which equates to 10 per cent of users) or were better behaved (22 per cent, which equates to nine per cent of users).

LAP

5.27. Around 12 per cent of parents had used LAP services, and the prevalence of use was slightly higher among more advantaged groups, such as those with high levels of qualifications (see Chapter 3). Parents who had attended LAP sessions with their child were asked about their views of the impact of these sessions with regards to the following:

- how much they felt the sessions had helped them in their interactions with their child

- the frequency of their engagement with their child in terms of playing, singing, etc.
- their child's interest and knowledge relating to language and numbers.

5.28. When considering the helpfulness of LAP, parents were asked about three specific areas of interaction:

- enjoying playing with their child more
- playing with their child in ways that help the child learn
- understanding what the child is saying or communicating.

5.29. According to parents, LAP sessions are having a positive impact on the relationship between parents and their children. The majority of users report that LAP sessions helped them across all three of the examples outlined above; in particular, almost four in five (79 per cent) say that the sessions helped them to play with their child in ways that help their child to learn; parents said they are now enjoy playing with their child more, as shown in Table 46.

5.30. While parents are less certain about the impact of LAP sessions in helping them to understand what their child is saying or communicating (due perhaps to the young age of the children of those interviewed), the majority – over six in 10 (64 per cent) – still believe LAP sessions are helping with this, while a third (34 per cent) do not currently believe that LAP sessions help them to understand what their child is saying or communicating.

Table 46: Users' self-report of the helpfulness of LAP in facilitating interactions between parent and child

	Enjoying playing with Baby more (%)	Playing with Baby in ways that help Baby learn (%)	Understanding what Baby is saying or communicating (%)
A great deal	34	31	22
A fair amount	43	48	42
Not very much	12	12	23
Not at all	10	7	10
A great deal/a fair amount	77	79	64
Not very much/not at all	22	19	33
Net helpful	55	60	30
Don't know	1	2	2
Base: 220 parents in Flying Start areas who have attended a LAP session			

5.31. The helpfulness of LAP in enabling parents to play with their child in an educational way is reflected by the increase in frequency with which many are doing this since attending the sessions. For three of the four measures asked about – sharing stories, talking to the child and counting things together – around half of LAP users (52 per cent, 45 per cent and 49 per cent, respectively) report that they do these things more as a result. The biggest reported increase is in singing songs and rhymes, with three in five parents (60 per cent) reporting that they now do this more.

Table 47: Users' self-report of the impact of LAP on the amount of educational play activities parents undertake with children

	Share stories (%)	Talk to your child (%)	Sing songs and rhymes (%)	Count things together (%)
More	52	45	60	49
Less	1	2	*	2
About the same	45	51	38	47
Don't know	1	2	2	2
Base: 220 parents in Flying Start areas who have attended a LAP session				

5.32. Users of LAP also largely acknowledge the positive impact that their attendance and involvement in LAP sessions is having on their child. In two of the three measures – shows interest in books or stories and knows songs and rhymes – the majority report that the amount the child does this has increased since attending the sessions (55 per cent and 57 per cent, respectively). In addition, just a slightly smaller proportion of parents (48 per cent) say the same about their child showing an interest in counting things.

Table 48: Users' self-report impact of LAP on child engagement

	Shows interest in books or stories (%)	Knows songs and nursery rhymes (%)	Shows interest in counting things (%)
More	55	57	48
Less	2	2	1
About the same	40	37	46
Don't know	3	4	5
Base: 220 parents in Flying Start areas who have attended a LAP session			

Views of LAP among different service user groups

5.33. While attendance at LAP courses appears to have a relatively consistent impact on the extent to which parents report that they engage with their children across the Flying Start population, there are some differences among

specific groups. Those parents who attend LAP sessions in conjunction with other services, such as health visitors or Flying Start parenting courses, are more likely than other parents to say they interact with their child a great deal more as a result of LAP. Those who have received a high number of in-home health visitor visits are more likely to say they understand what their baby is saying or communicating a great deal more since attending the sessions (37 per cent compared with 22 per cent of parents in general). Those parents who have attended health-visiting related Flying Start parenting groups are particularly likely to report that as a result of LAP they are playing with their baby in ways that help the baby learn a great deal more than other parents (48 per cent, compared with 31 per cent).

5.34. It is difficult to know at this stage if this indicates that multiple service use is more effective than LAP alone in generating positive perceptions of impact on parents, or whether it is simply a reflection of the profile of service users. This could be a useful area for further analysis.

Views of LAP among different socio-demographic groups

5.35. There are some key Flying Start target groups who also report interacting with their child to a greater extent since attending LAP sessions. Those parents who have **multiple socio-economic disadvantages** are particularly likely to report understanding what baby is saying or communicating a great deal more since attending the sessions (33 per cent). They are also particularly likely to report that their child is doing certain things more since attending LAP sessions, with these parents saying that their child talks more since attending LAP sessions (73 per cent compared with 50 per cent overall).

5.36. **First time** parents are more likely than parents with other children to report playing with baby in ways that help baby learn at least a fair amount more than before (88 per cent compared with 75 per cent, respectively). Perhaps providing an explanation for the greater impact reported by first time parents, it would appear that they are making greater use of what they have learnt. They also report being able to do the activities they have learnt at the LAP sessions at home to a greater extent than their more experienced

counterparts (88 per cent compared with 71 per cent, respectively), and subsequently they are also more likely to report that their child knows songs and rhymes more since attending the sessions (69 per cent compared with 57 per cent overall).

5.37. LAP sessions also appear to have had a particularly positive impact on parents who do not feel that they get the support they need from their informal network of friends and family. Those who say they would like more support from their friends and family are more likely than other parents to report talking to their child more (62 per cent compared with 45 per cent, respectively) and singing songs and rhymes with their child more since attending LAP sessions (76 per cent compared with 60 per cent, respectively). These parents are also more likely than other parents to report that their child talks, shows an interest in stories and books, knows songs and rhymes and shows interest in counting things more than before attending LAP sessions.[70]

5.38. These findings indicate that LAP users believe that LAP sessions are making a real difference to the level of interactions that they are having with their children, and leading to the emergence of impact on their child's behaviour. It is particularly encouraging that some of the largest impacts are being reported among some of the key groups who have potential higher levels of need, such as first time parents, or those who do not feel that they are getting the support they need from their informal networks. This suggests that LAP is well designed in terms of helping many of those it is intended to support. However, as outlined in Chapter 3, attendance at LAP sessions is lower among parents from these key groups, which is disappointing given the apparent effectiveness of the support these sessions provide to such families. In addition, while they appear to cater well for these specific parents there are other groups of parents with potentially equal, or even higher needs, which are currently not reporting significant benefits from attending LAP sessions. As the programme progresses it will be important to ensure that LAP is

[70] Around three-quarters of those who would like more support from their friends and family report that their child talks (76 per cent), shows an interest in books and stories (74 per cent), knows songs and rhymes (76 per cent) and shows an interest in counting things (69 per cent) more since attending LAP sessions compared with around half of parents in general (50 per cent, 55 per cent, 57 per cent and 48 per cent, respectively).

accessible to all parents who may potentially benefit from the support it offers, and effective in providing support to parents with different needs.

6. Parenting behaviour outcomes

Summary

- Almost three-quarters of Flying Start parents (73 per cent) say they sing to their baby at least once a day. The impact analysis indicates an additional four per cent of parents in Flying start areas are doing this, compared with parents in the matched comparison group. Around half of parents (49 per cent) are reading to their child at least once a day.

- Young parents and those parents who are socio-economically disadvantaged in some way are less likely to regularly engage in singing or reading to their child[71] and these groups may warrant more focus within Flying Start areas. As shown in Chapter 3, parents with multiple socio-economic disadvantages are not receiving higher rates of health visitor visits than others, and are less likely to be attending some additional support programmes such as LAP.

- Rates of breastfeeding are low in Flying Start areas in comparison to England and Wales, (47 per cent of Flying Start parents have tried to breastfeed and 39 per cent succeeded in doing so). This compares with 71 per cent of mothers across Wales who have breastfed their child on at least one occasion, according to the Infant Feeding Survey 2010.

- Impact analysis highlights no impact of Flying Start on breastfeeding as yet. However, if matching analysis did not fully control for the lower start point of Flying Start families relative to the comparison group, it is possible there has been some impact that has not been picked up. However, there are 17 per cent of parents who would like more help with breastfeeding indicating there is potentially more that Flying Start health visitors and other support services could do to improve success rates.

[71] As shown in Chapter 2, young parents tend to be socio-economically more disadvantaged.

- Almost half (48 per cent) of Flying Start parents wean their child within one month of the advised timescales (i.e. between five and seven months). That said, a minority continue to wean their child earlier, or less commonly later, than is recommended.
- The vast majority of children in Flying Start areas are also up to date with their recommended vaccinations. However, young parents are less likely to say this than older parents, and could benefit from additional support.
- No impact from Flying Start is observable from the impact analysis on weaning or take-up of immunisations.
- Parents who are disadvantaged in some way, are less likely to have attempted to breastfeed their child and more likely to have started to wean them earlier; targeting resources at this group might therefore be beneficial in changing parent behaviours and improving child outcomes.

Introduction

6.1. Flying Start is intended to increase the occurrence of a variety of parenting behaviours that have been shown to have a positive impact on child outcomes. These include increasing the number of mothers breastfeeding and weaning their children at the correct time (around six months), as well as the proportion of children who have received, and are up to date with, all of the recommended vaccinations. These aims are to be achieved through the support made available through health visitors, and through referral to parenting groups and initiatives in order to support these behavioural outcomes. An additional goal is to increase the amount that parents read and sing to their children.

6.2. It is important to note that cultural norms play an important role in influencing parenting behaviours such as breastfeeding. For example, mothers may be unwilling to breastfeed if their own close female relatives, friends and neighbours do not breastfeed or openly express opposition to it. In particular,

research has shown that parental norms exert a powerful influence on breastfeeding intentions and beliefs in young mothers.[72] Furthermore, there is evidence to suggest that mothers often make decisions relating to feeding prior to birth, and that these are often taken in spite of their awareness of the benefits of breastfeeding, reducing the capacity of the health visitor to make an impact.[73] This means that a one-to-one intervention from a health visitor cannot always be expected to result in immediate behaviour change. Indeed, the time frames involved in achieving family- and community-level change can be relatively long and, importantly, longer than the time period up to the Wave 1 survey.

6.3. For the reasons outlined above, the range and level of behavioural change that it is realistic to expect in families with children aged 7 to 20 months, as a result of Flying Start is limited at this stage.

6.4. Although baseline data on the prevalence of breastfeeding prior to the introduction of Flying Start could not be collected as part of the evaluation, there is evidence that breastfeeding rates were lower among Flying Start mothers than mothers in comparison areas before Flying Start.[74] Importantly this means that if matching analysis was unsuccessful in fully controlling for this difference in starting points, there may be a Flying Start impact on breastfeeding rates not picked up in the findings. However, this is not the case for immunisations, where administrative data show take-up rates to be similar

[72] Swanson, Vivien et al, 2005. The impact of knowledge and social influences on adolescents' breastfeeding intentions and beliefs, *Public Health Nutrition* [online]. Available at https://dspace.stir.ac.uk/bitstream/1893/753/1/PHN00900297.pdf>. [Accessed 8 September 2011].

[73] Earle, Sarah, 2002. Factors affecting the initiation of breastfeeding: implications for breastfeeding promotion, *Health Promotion International* [online]. Available at < http://heapro.oxfordjournals.org/content/17/3/205.abstract?sid=96cb2057-b568-42d8-b815-a177ab31988c>. [Accessed 8 September 2011].

[74] In 2006, before the roll-out of the Flying Start programme, 43 per cent of biological mothers in Flying Start areas breastfed their child compared with 50% in comparison areas and 55 per cent across Wales. This is based on data from Health Solutions Wales and is taken from the National Community Child Health Database. This data was collected by SQW from Flying Start LSOAs and selected comparison LSOAs. Please note, the comparison LSOAs are not exactly the same as those used in the survey but still provide useful comparison data. This is discussed further in the baseline report 'Final Flying Start Baseline 10.11.08' which can be found here http://www.cymorthandflyingstartevaluation.co.uk/publications.

in Flying Start and comparison sample areas prior to be Flying Start.[75] Data on weaning rates by area type is not available.

Breastfeeding

6.5. The positive health effects of breastfeeding for mother and child are well established and range from short-term health benefits like reducing the chance of the baby having diarrhoea or vomiting, to longer-term benefits such as the baby being less likely to become obese (and therefore developing Type II Diabetes and other illnesses later in life) and the mother having a lower risk of developing breast and ovarian cancer.[76] Additional benefits also include aiding mother – child bonding and attachment.

Breastfeeding rates among the total population

6.6. The survey highlights that rates of breastfeeding within Flying Start areas are low compared with the average across England and Wales. Just under half (47 per cent) of mothers in Flying Start areas tried to breastfeed.[77] Four in five (82 per cent) mothers who tried to breastfeed were able to do so (which equates to 39 per cent of all parents). In contrast, the 2010 Infant Feeding Survey found that the incidence of breastfeeding in Wales on at least one occasion is 71 per cent.[78]

6.7. The World Health Organisation and the Department of Health recommend that, if medically possible, mothers should breastfeed their baby exclusively for around the first six months of their life.[79] However, a significant minority of mothers stopped breastfeeding earlier than is recommended. Of those

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[75] Baseline data from Health Solutions Wales shows no difference in immunisation rates between Flying Start areas and comparison areas before Flying Start.

[76] NHS Choices. Breastfeeding: Health benefits for your baby. Available at: http://www.nhs.uk/Planners/breastfeeding/Pages/breastfeeding-benefits.aspx>. [Accessed 29 August 2011].

[77] This figure includes both those parents who were themselves the biological mothers of their child and behaviour reported by those who are not themselves the biological mother.

[78] Infant Feeding Survey 2010: Early Results, June 2011. Available at < http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/infant-feeding-survey/infant-feeding-survey-2010-early-results>. Accessed 29 August 2011.

[79] See NHS Choices, 2010, *Breastfeeding: Introducing solid foods (weaning)*. Available at < http://www.nhs.uk/Planners/breastfeeding/Pages/breastfeeding-and-weaning.aspx>. [Accessed 30 August 2011].

mothers who were able to breastfeed, just over a third (35 per cent) did so for under a month and three quarters (74 per cent) did so for less than six months. A smaller proportion (15 per cent) breastfed for more than six months).

Table 49: Length of time for which mothers breastfed

Length of time for which breastfeed	Mothers who were able to breastfeed in Flying Start areas (%)
Less than one day	3
1 – 7 days	12
1 – 4 weeks	20
1 – 6 months	39
More than six months	15
Still breastfeeding	11
Base: 690 parents who were able to breastfeed, or who know whether the biological mother was able to breastfeed	

6.8. The impact analysis indicates that rates of breastfeeding in Flying Start areas are no higher than in comparison areas. However, as mentioned, it is feasible that impact may be being underestimated if the matching analysis has not fully controlled for the lower starting point of Flying Start mothers (although this cannot be said to be the case with any certainty). Lack of impact may also reflect the stage of programme delivery relating to this element at the time of the survey. It is anecdotally reported that not all health visitors will have been trained in the importance of encouraging parents to breastfeed at the time of the survey and in the past year since the survey took place there has been much more focus on this aspect by health visiting teams.

Table 50: Indicative impact of Flying Start on whether respondent has tried to breastfeed

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Attempted breastfeeding	47		47.5	49.2	-1.7*
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,454*	*1,292*	-

* Please note that this change is not statistically significant – results indicate no difference

Table 51: Whether respondent is able to breastfeed

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Ability to breastfeed	39		38.0	39.2	-1.2*
Base: All parents	*1,776*				
Base: All matched parents excluding those who responded don't know or refused			*1,688*	*1,432*	-

* Please note that this change is not statistically significant – results indicate no difference.

6.9. As mentioned above, it may be that cultural and social factors operating within Flying Start areas are discouraging women from breastfeeding; such influences take time to change and, as the programme is relatively new, it is possible that it has not yet had time to do this. The Infant Feeding Survey suggests that the rate of change at a national level is very slow. Over five years, for example, between 2005 and 2010, the breastfeeding rates in Wales

increased by only five percentage points, from 67 per cent to 71 per cent, despite the presence of a large campaign promoting breastfeeding.[80]

6.10. However, there does seem scope for further developing breastfeeding support. As shown in Chapter 5 there are 17 per cent of parents who are interested in further help with breastfeeding.

Breastfeeding rates among service user groups[81]

6.11. There are no significant differences in these behaviours according to the number of visits from health visitors received by parents. This may be a result of the cultural factors that can inhibit breastfeeding, as discussed above. This is likely to at least partly reflect the higher need profile of those who receive the most health visitor contact. Those who receive a high level of health visitor contact are more likely to be under 25 years (44 per cent compared with 38 per cent among parents as a whole) and more likely to be living in workless households (53 per cent compared with 47 per cent), and these types of groups are less likely to breastfeed (discussed further in the next section below).

Breastfeeding rates among demographic sub-groups

6.12. Those parents who are likely to be disadvantaged in some way are both less likely to have attempted to breastfeed and, if they did breastfeed, tended to do so for a shorter period of time than less disadvantaged parents. Parents with multiple socio-economic disadvantages are significantly more likely to say that they did not try to breastfeed than average (68 per cent compared with 53 per cent). As seen in Chapter 3, this group are receiving on average a similar number of health visitor visits as Flying Start families as a whole and this may be a group where further focus could be beneficial.

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[80] NHS (2010) Infant Feeding Survey. Available at http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/IFS_2010_early_results/Infant_Feeding_Survey_2010_headline_report2.pdf. [Accessed 29 August 2011].

[81] A breakdown of behaviours by demographic group and service group is available at the end of this chapter.

6.13. When looking at breastfeeding by age, it is apparent that young mothers are less likely to have tried to breastfeed, and this is likely to at least partly reflect that they are more likely to be socio-economically disadvantaged. One third (34 per cent) of parents aged 16 – 19 report having tried to breastfeed, whilst six in 10 (62 per cent) of those aged 35 or more say the same thing. Young mothers are also more likely to stop breastfeeding sooner than average. Four in 10 (41 per cent) of parents in this category say that they (or the baby's biological mother) stopped breastfeeding within a week. In contrast, older parents are more likely than average to breastfeed for longer; one in four (23 per cent) of those aged 35 or more say that they or the baby's mother breastfed for more than six months, compared with an average of 15 per cent. Whilst young parents are receiving slightly more health visiting visits on average than older women, it is clear that this group could benefit from further additional support in this regard.

6.14. When looking at breastfeeding amongst 'high risk' parents there are no notable differences in the likelihood of this group trying or being able to breastfeed, despite their higher levels of contact with health visitors.

6.15. When looking at perceptions of services, first time mothers do not say that they would like additional help with breastfeeding (see Chapter 5). This group are more likely to try breastfeeding than those who are not first time mothers (51 per cent compared with 43 per cent), perhaps reflecting the additional support that they report receiving from health visitors. However, they are also more likely to breastfeed for less than one day (five per cent, compared with two per cent), which perhaps suggests that further help would be beneficial.

6.16. Furthermore, additional analysis was conducted among young parents, lone-parents, first time parents and parents experiencing high levels of disadvantage to see if Flying Start is having an impact on breastfeeding rates among these specific groups. The findings show that at this stage, there is no significant difference between breastfeeding rates among parents in Flying Start areas than in the matched comparison areas. However, as discussed, influencing parents' propensity to breastfeed requires deep cultural change which may make take many years to become apparent. Furthermore these

groups maybe starting from a much lower baseline of need so Flying Start may well have had an impact on breastfeeding rates but the impact analysis is not able to detect this (see section 6.8 for further discussion of this). This may also reflect the nature of the Flying Start programme at the time of Wave 1 fieldwork as breastfeeding support was variable in delivery across Flying Start areas and it is reported that over the past year significant improvements have been made.

Weaning

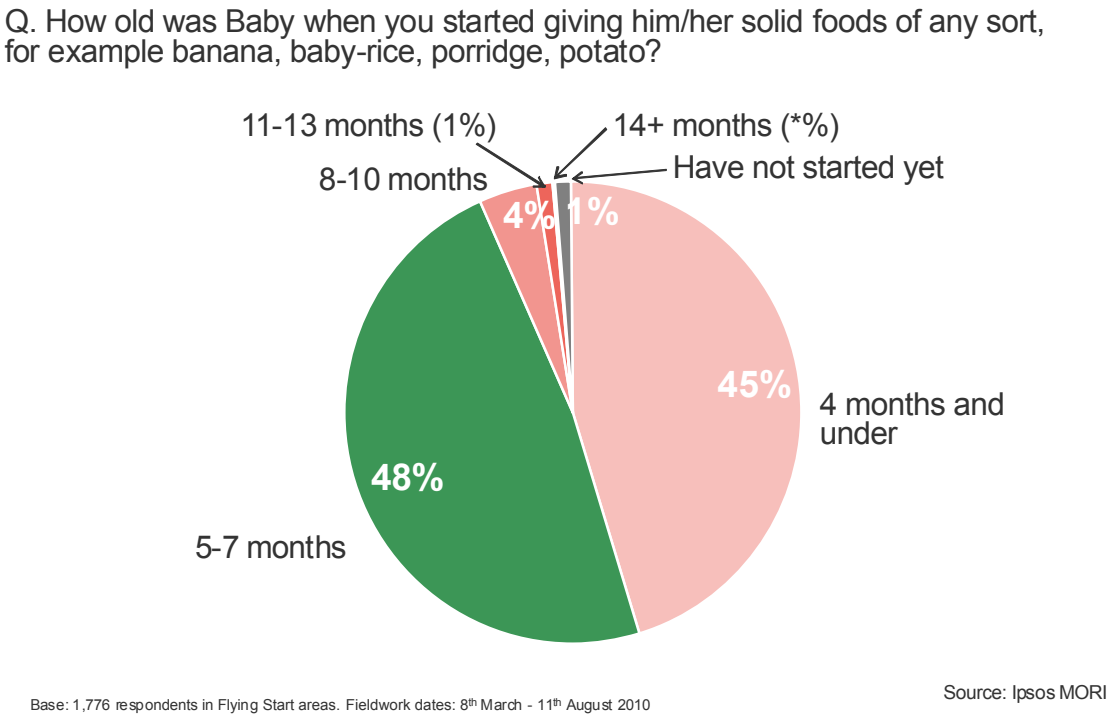
6.17. The Department of Health recommends that parents begin to give their children solid foods at six months.[82] Weaning babies too early may increase the risk of allergies and infections, whilst late weaning has been associated with iron deficiency anaemia.[83] Flying Start aims to encourage parents to wean their children at the appropriate age.

Weaning in the total population

6.18. Just under half of parents (48 per cent) weaned their child within one month of advised timescales. This increases to 80 per cent of parents within two months of advised timescales. One per cent of parents had not started to wean their child at the time of their interview, although whether or not this is an issue would depend on the age of the child at the time, which varied between families.

[82] See NHS Choices, 2009. *Babies, weaning,* Available at <http://www.nhs.uk/Conditions/Babies-weaning/Pages/Introduction%20old.aspx>. [Accessed 30 August 2011].
[83] See Sultan Ali N. Zuberi, *Late weaning: The most significant risk factor in the development of iron deficiency anaemia at 1-2 years of age*. Available at <http://ayubmed.edu.pk/JAMC/PAST/15-2/Niloufer%20Weaning.htm>. [Accessed 30 August 2011].

Figure 6: How old was Baby when you started giving him/her solid foods of any sort?



6.19. The impact analysis suggests there is no difference in the weaning age among families in Flying Start areas and those in comparison areas.

Table 52: Indicative impact of Flying Start on weaning age of infants

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Weaning age of infants between 5 and 7 months[84]	48		47.3	48.0	-0.8*
Base: All parents	*1,776*				
Base: All matched parents			*1,755*	*1,632*	-

* Please note that this change is not statistically significant – results indicate no difference.

[84] Department of Health guidance is that parents begin weaning their child at six months. In the analysis we looked at parents who weaned their child within one month of the advised guidelines i.e. between five and seven months.

6.20. If weaning rates had a lower starting point in Flying Start areas than in comparison areas that was not controlled for in the matching it is possible that Flying Start may have had an impact which was not detected in the analysis. However, this cannot be judged from the available evidence. Additionally, given that weaning age can be a controversial issue and the cultural influences that determine beliefs in relation to weaning, securing behaviour change in this area may be comparatively difficult and, therefore, it may be too early in the programme to expect change. Nevertheless, it may also be the case that changes to the Flying Start programme itself, or more effective targeting (see below), may be beneficial; currently 37 per cent of parents say that health visiting support in relation to weaning was not helpful.

Weaning age among service use sub-groups

6.21. It might be expected that those parents who had received additional support from Flying Start services would be more likely than those who had received no such support to wean their child at the recommended age. This is particularly the case given that this group are especially likely to say that Flying Start has had an impact in this area (36 per cent of those who have received a high number of in-home health visits say that these helped a great deal with weaning, compared with an average of 23 per cent). However, as for breastfeeding, there are no notable trends in the age at which parents start to wean their child according to their Flying Start service use. Although parents who have received a medium number of in-home health visitor visits are more likely than those who have received a low number of, or no, visits to start weaning at five to seven months (53 per cent compared with 46 per cent), they are also more likely to start weaning at this age compared with those who have received a high number of visits (46 per cent). It should be noted that this discrepancy may be a result of the profile of parents who receive this level of visits, that is, they may have been more inclined towards this kind of behaviour to start with. Without further analysis it is not possible to have a definitive solution to this. There are no significant differences by attendance of parenting groups or courses.

Weaning age among demographic sub-groups

6.22. The findings from the impact analysis conducted among lone-parents, young parents, first time parents and parents facing multiple disadvantage show that there are no differences in weaning age among these groups.

6.23. However, looking at the differences between different groups within Flying Start areas parents in the potential higher need group as a whole are significantly more likely than those who are not in these groups to start weaning earlier than recommended (48 per cent started weaning at four months or less, compared with 39 per cent). This group may, therefore, benefit from additional support in this area.

6.24. There are no significant differences in weaning age amongst 'high risk' parents despite their greater levels of contact with health visitors (see Chapter 3). There are also no notable differences in weaning age amongst young parents compared with other groups, and again this is a group who are slightly more likely to receive the highest levels of parenting support.

Immunisation

6.25. As part of Flying Start's aims of improving child health, the programme encourages parents to vaccinate their children against a number of preventable diseases and illnesses including measles, polio and diphtheria, among others. As a measure of this, parents were asked about the vaccinations that their child has received, and whether they are up-to-date with their immunisation plan.

Immunisation in the total population

6.26. Table 53 shows the vaccinations that parents say that their children have received.

Table 53: Vaccinations received by children

	All children who have received vaccination (%)	Children aged 14 months or over who have received vaccination (%)
Diphtheria, tetanus and whooping cough combined	97	97
Polio	95	96
Haemophilias influenza B (HIB)	92	94
Meningitis C	82	91
Pneumococcal conjugate vaccine (PCV)	79	87
Measles, mumps and rubella (MMR)	60	80
Base: 1,776 parents; 753 parents with children aged 14 months or over		

6.27. Given the age of the children in the sample (all seven months or more, all children in the sample would have been due to have received all of the vaccinations above (or at least the first instalment), all except the measles, mumps and rubella (MMR), which is due around 12 – 13 months.[85]

6.28. The table shows that the majority of children are receiving their vaccinations, but only nine in 10 are receiving Meningitis C and PCV (91 per cent and 87 per cent respectively), and an even lower proportion have received the MMR vaccine by 14 months or older (80 per cent).

6.29. Amongst parents who report that their child has received the combined diphtheria, tetanus and whooping cough vaccinations, the polio vaccination and the haemophilias influenza B vaccination, nine in 10 (89 per cent) say that their child received all three of these vaccinations, five per cent say that they have received two of them and two per cent say that they received just one. This is slightly lower than the available figure for Wales which shows that

[85] For a schedule of recommended vaccination ages see Patient.co.uk, 2011. *Immunisation schedule (UK)*. Available at http://www.patient.co.uk/doctor/Immunisation-Schedule-(UK).htm>, [Accessed 30 August 2011].

95.8 per cent of children at one year old had received these immunisations.[86] However it is important to bear in mind that data from the survey is based on parents' recall which may underestimate take-up and not reflect actual uptake which the comparative Wales data is based on.

6.30. Of parents who say that their child has received all of these three vaccinations, nearly all (97 per cent) say that the immunisations are up-to-date and that their child has received three doses of each immunisation.

6.31. Looking at parents with a child aged 14 months and over, almost three-quarters say their child has received all three of the MMR, meningitis C and pneumococcal conjugate vaccines and they are up to date. Eight per cent of parents say that their child has not received any of these vaccines.

6.32. Although rates of immunisation are relatively high for most vaccines, the impact analysis indicates that immunisation take-up is no different in Flying Start than in comparison areas.

[86] This figure is taken from the 'National immunisation uptake data' for Wales in the financial year 2010-11 which is the closest match to the fieldwork period. This data is based on uptake at one year of age so is not strictly comparable with the age of children in the sample (c. seven to 20 months). However, it does provide useful context for judging immunisation take-up in Flying Start areas.

Table 54: Impact of Flying Start on whether Baby had immunisations[87]

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Babies in receipt of three doses of the combined diphtheria, tetanus and whooping cough vaccinations, the polio vaccination and the haemophilias influenza B vaccination[88]	89		89.1	89.6	-0.5*
Base: All parents	*1,776*				
Base: All matched parents with a child aged 14 months or over excluding those who responded don't know or refused			1,755	1,632	-
Babies up to date with pneumococcal conjugate vaccine (PCV), meningitis C, measles, mumps and rubella immunisations [89]	73.0		73.5	73.0	0.5*
Base: All parents with a child aged 14 months or over	*919*				
Base: All matched parents with a child aged 14 months or over excluding those who responded don't know or refused			*913*	*818*	-

* Please note that this change is not statistically significant – results indicate no difference.

6.33. Administrative data sources show that immunisation take-up rates prior to Flying Start delivery were similar in Flying Start and comparison sample areas[90], so the lack of higher ratings in Flying Start areas now are indicative of

[87] Please note that the findings in this table are based on whether the immunisations of the index child are 'up to date', i.e. that they have received all does that they should have given their age.
[88] All babies in the sample should have received all of these immunisations.
[89] Please note babies will receive the MMR vaccine between 12-13 months, so we have only included parents with a child aged 14 months or over in the impact analysis for this group of vaccines.
[90] Baseline data from Health Solutions Wales shows no difference in immunisation rates between Flying Start areas and comparison areas before Flying Start. This is discussed further in the baseline

a lack of progress in improving these. However, it should be noted that slightly higher levels of population mobility in Flying Start areas, relative to comparison areas may mean it is relatively more challenging to ensure parents stay up to date with their immunisations.[91]

Immunisation among demographic sub-groups

6.34. The findings from the impact analysis indicate that immunisation take-up is no different in Flying Start areas than in comparison areas among lone-parents, first time parents, young parents and those experiencing multiple disadvantage.

6.35. Looking at the difference between sub-groups within Flying Start areas there are no notable patterns amongst the potential higher need groups in relation to their children's immunisation status. Although nearly all of this group say that their child has received the diphtheria, tetanus and whooping cough vaccine, there are no further differences. It would seem, therefore, that Flying Start is currently working for this group in this regard.

6.36. There is just one key group where differences in rates from the average are notable. Young parents are less likely than older parents to have had their child vaccinated. These parents are less likely than average to say that their child has received all three of the combined diphtheria, tetanus and whooping cough, polio and haemophilias influenza B vaccinations (83 per cent compared with 91 per cent). Similarly, this group is also less likely than those aged 35 or more to say that all three of these vaccines are up to date (98 per cent compared with 94 per cent). It seems this is a group where further attention might be useful to increase immunisation rates.

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report 'Final Flying Start Baseline 10.11.08' which can be found here http://www.cymorthandflyingstartevaluation.co.uk/publications.

[91] Whilst it is difficult to paint an exact picture, it does seem as though Flying Start parents are more likely to be transient than those living in comparison areas. Sixty-three per cent of the Flying Start population moved to their current address since 2006. This compares with 60 per cent of the comparison group population. This impression is supported by the data compiled on 'movers' by the project team during the course of fieldwork. Where respondents were no longer at the address provided by HMRC's child benefit records, attempts were made to trace them to their new address in order to secure an interview. A log was kept of these attempts, which shows that in total, five per cent of the Flying Start population had moved since the compilation of the records, compared with one per cent of the comparison sample population.

6.37. Despite their relatively low levels of Flying Start contact, there are no notable patterns amongst those parents with multiple socio-economic disadvantages.

6.38. Barriers to immunisation take-up among those not currently getting their child immunised might benefit from further exploration. Evidence shows that factors associated with low take-up include being a lone-parent as well as not being registered with a GP[92] and it may be worthwhile exploring in more depth the issues that are impacting on take-up in Flying Start areas.

Reading and singing to Baby

6.39. Reading and singing to children can have a beneficial impact on their development by aiding, for example, their language and communication skills. For this reason, Flying Start seeks to promote these behaviours amongst parents. Throughout the Flying Start programme there is a focus on developing language skills through singing. This is embedded across the entitlements, for example health visitors should be speaking to their families about singing to their children. Singing will also be an important activity at many parenting groups such as baby massage. This is a result of specific evidence on the importance of singing in child development.[93]

Reading and singing to Baby among the total population

6.40. As table 55 below, shows, parents are more likely to say that someone in their household sings to their child regularly than they are to read to them; nearly three quarters of parents (73 per cent) say that someone sings to their child at least once a day, whilst nearly half (49 per cent) say the same about reading to their child.

[92] For example see Falconer, M., 2008. *Vaccination and immunisation health equity audit toolkit*
[93] For example, Sally Goddard Blythe, a consultant in neuro-developmental education and director of the Institute for Neuro-Physiological Psychology recommends that parents should sing to their children every day to avoid language problems developing in later life.

Table 55: Frequency with which someone reads to and sings with children

	Parents in Flying Start areas who read/look at books with their child (%)	Parents in Flying Start areas who sing songs/nursery rhymes to their child (%)
Occasionally/less than once a week	12	5
Once a week	10	4
Several times a week	29	18
Once a day	22	15
More than once a day	27	58
Base: Parents who completed the self-completion section	*1,694*	*1,694*

6.41. In keeping with the fact that parents found LAP most helpful in enabling them to sing to their child, the impact analysis indicates that slightly more (four per cent) parents in Flying Start areas sing to their child at least once a day, compared with parents in the matched comparison group. Seven out of 10 (73 per cent) of parents say that someone does this once a day or more. There is no difference in the proportion of parents who read to their child between Flying Start families and those in the matched comparison group. Nearly half (49 per cent) of parents say that someone reads to their child once a day or more.

Table 56: Indicative impact of Flying Start on reading and singing to children

			Weighted results for impact analysis		
	Families in Flying Start areas (%)		**Families in Flying Start areas (%)**	**Estimate of the counterfactual from the matched comparison group (%)**	**Indication of impact (%)**
Reading/looking at books with Baby at least once a day	49		50.3	51.7	-1.4*
Base: All parents who completed the self-completion section	*1,694*				
Base: All matched parents who completed the self-completion section excluding those who responded don't know or refused			*1,642*	*1,502*	-
Singing songs/nursery rhymes to Baby at least once a day	73		74.7	70.3	4.4
Base: All parents who completed the self-completion section	*1,694*				
Base: All matched parents excluding those who responded don't know or refused			*1,585*	*1,292*	-

* Please note that this change is not statistically significant – results indicate no difference.

Reading to and singing with children among service user sub-groups

6.42. Although it is not possible to attribute the amount that parents read to children to their service use, there does appear to be some kind of relationship. Specifically, those who have received a high number of in-home health visits are more likely than those who have received none, or a low number, to say that they read to their baby more than once a day (31 per cent compared with 25 per cent). Additionally, and as might be expected, those who have attended LAP are more likely than average to say this (37 per cent compared with 27 per cent overall). In both of these cases, it may be that this is a result of the profile of service users rather than the services themselves. For example, LAP attendees tend to have higher levels of qualifications than the

average among parents as a whole in Flying Start areas, and may be more disposed to read to their child to start with than those who do not attend. Further analysis would be necessary to disentangle these issues.

6.43. Different levels of service do not coincide with different levels of regularity with which parents sing to their children.

Reading to and singing with children among demographic sub-groups

6.44. The findings from the impact analysis suggest that there is no difference between lone-parents', first time parents', young parents' and parents experiencing multiple disadvantages in Flying Start areas and their counterparts in matched comparison samples in their likelihood to read or sing to their child.

6.45. Looking at differences between sub-groups within Flying Start areas, further reinforce the findings from the impact analysis as they show that potential higher need groups as a whole read less to their child than those who do not fall into this group. For example, a quarter (26 per cent) of those in the potential higher need group read to their child more than once a day, compared with a third (31 per cent) of those who are not in this group.

6.46. Parents experiencing multiple socio-economic disadvantages are less likely than others to both read and sing to their child on a regular basis than average. For example, two in 10 (20 per cent) of those who may be socio-economically disadvantaged say that someone reads to their child **more than** once a day, compared with an average of over a quarter (27 per cent). This group have previously been identified as not accessing very much additional help from health visitors and other Flying Start entitlements (see Chapter 3) and therefore may represent a key group for additional support.

6.47. When looking at parental age, there is no visible pattern in relation to reading to children. However, young parents are less likely to sing to their child more than once a day (58 per cent of 16 to 19 year olds say that this happens in their household, compared with 62 per cent of those aged 35 or over). As mentioned, young parents are less likely to attend LAP courses (eight per

cent compared with 12 per cent respectively) and encouraging them to attend LAP might help to improve these outcomes.

6.48. A greater proportion of first time parents (31 per cent) say that they read to their child more than once a day than among parents with other children (25 per cent). Parents who have already had children therefore require greater focus with regards to this aspect.

6.49. Those ‘high risk’ parents do not show any notable differences in likelihood of reading and singing to their child compared to other group, despite the higher levels of support that they receive from health visitors and other Flying Start services.

6.50. As discussed in Chapter 3, LAP is the least commonly used Flying Start service among families with multiple socio-economic disadvantage. Increasing awareness of LAP and encouraging attendance amongst those groups who are currently singing with and reading to their children less might help to change behaviour, and hence improve child outcomes.

Table 57: Behaviour outcomes, health visitor use and experience by sub-group

	Total (%)	First time parent (%)	Young parent (%)	'High risk' parents (%)	Parents experiencing multiple socio-economic disadvantage (%)	Potential higher need groups (%)	Base*
Tried to breastfeed	47	51	34	49	32	43	*1,776 parents in Flying Start areas*
Able to breastfeed	82	81	78	80	76	81	*783 biological mothers who tried to breastfeed*
Started weaning at 4 months or under	45	44	53	47	51	48	*1,776 parents in Flying Start areas*
Started weaning at 5 – 7 months	48	50	43	48	44	46	*1,776 parents in Flying Start areas*
Started weaning at 8 months or more	6	6	4	5	5	6	*1,776 parents in Flying Start areas*
Child received all of combined tetanus, diphtheria and whooping cough, polio and haemophilias influenza B immunisations	91	89	89	88	92	90	*1,776 parents in Flying Start areas*
Someone reads to child a least once a day	47	54	46	48	40	47	*1,694 parents who completed the self-completion section*
Someone sings to child once a day or more	73	75	68	70	63	71	*1,694 parents who completed the self-completion section*
HV team helpful	90	89	90	89	92	90	*1,776 parents in Flying Start areas*
Would have liked more support from HV team	21	25	25	24	21	22	*1,776 parents in Flying Start areas*
Received enough support from HV team	79	75	75	76	79	78	*1,776 parents in Flying Start areas*
Number of HV visits in home or clinic (mean)	17.7	19.4	18.2	19	17.4	17.9	*1,776 parents in Flying Start areas*

* Please note that the bases provided are at the overall level; base sizes for individual sub-groups vary for each issue.

7. Family needs

Summary

- In general, parents are confident in their parenting abilities. They show a high degree of confidence in emotion and affection, play and enjoyment, empathy and understanding, self-acceptance and learning and knowledge. However, parents have less confidence in the following areas: parental control, boundary setting and pressure.

- The majority of parents also report having a relatively organised and calm home environment, have many types of safety equipment in the home and display positive health behaviours by not smoking or drinking more than recommended amounts.

- However, a key theme which runs through this chapter is the link between disadvantage and family need. Parents who potentially would benefit from additional support (that is, those who are unemployed, with low incomes, who are young parents or who have multiple children), are less likely to own safety equipment to protect their children; more likely to have suffered from depression; more likely to smoke and binge drink; are less confident about their parenting abilities; and more likely to report a chaotic home environment. All of these factors impact on child outcomes and these findings show that, if outcomes for the children of these families are to be improved, there are distinct groups of parents within Flying Start areas who may require specific or targeted help. At Wave 2, the evaluation team will examine the degree to which Flying Start has had an impact on these and other associated areas.

Introduction

7.1. This section describes a range of features of childcare and parent wellbeing and behaviours in Flying Start areas. It includes parenting self-efficacy; partner involvement in childcare; the home learning environment; the

presence and use of safety equipment; parental health behaviours; and child accidents, health concerns and physical development.

7.2. Given that the Flying Start programme has only been running for a relatively short period of time, and also taking into account the young age of the children at the time of the interview, and the fact that some of the areas addressed below are peripheral to Flying Start, it was not expected that the programme would have a significant impact on these aspects on the young survey cohort at this stage and therefore no impact analysis has been undertaken. However, some of the areas discussed below will become more relevant for older children, and therefore will be analysed in greater detail in Wave 2 of the survey.

Parenting self-efficacy

7.3. Increasing parental confidence is an important aspect of Flying Start's parenting programmes and, whilst it is not expected to see any impacts at this stage, it is important to understand how confident those living in Flying Start areas are about their parenting ability.

7.4. As a result of the need to evaluate parenting programmes effectively, Linda Bloomfield and Sally Kendall at the University of Hertfordshire developed a Tool to Measure Parenting Self-Efficacy (TOPSE). Unlike many other evaluation tools, it has been found that the results from TOPSE's self-reporting measures are good indicators of actual parental behaviour.[94]

[94] TOPSE questions aim to understand parents' confidence in their parenting ability. They consist of a mix of positive and negative questions, and responses are given on a scale of nought to 10, where nought is completely disagree and 10 is completely agree. Due to the sensitive nature of some of the questions, and the need to keep this section of the study as similar as possible to other research projects in which TOPSE has been used, these questions were asked around halfway through the interview as part of a self-completion section. Parents were offered the chance to complete the section themselves, have the interviewer complete the section for them or refuse to answer the section completely. Nearly all parents (96 per cent) completed the TOPSE section; four in five (79 per cent) opted to complete the section themselves, while 17 per cent opted for the interviewer to continue asking them the questions for this section. Just two per cent of parents refused to answer the section completely, while for the same proportion it was felt not appropriate for them to complete the section.

7.5. TOPSE questions are used to generate aggregate scores which give an indication of parents' confidence in each of the following eight areas

- emotion and affection
- play and enjoyment
- empathy and understanding
- control
- discipline and setting boundaries
- pressure
- self acceptance
- and learning and knowledge.

7.6. As Table 58, below, shows parents express the most confidence in play and enjoyment (with an overall average score of 57 out of 60). They are least confident about pressure (an overall average score of 43 out of 60).

Table 58: TOPSE aggregate scores

	Aggregate Score
Play and enjoyment	57
Emotion and affection	56
Self-acceptance	54
Empathy and understanding	53
Learning and knowledge	53
Discipline and setting boundaries	47
Control	47
Pressures	43
Base: 1,694 respondents in Flying Start areas who completed the self-completion section	

7.7. Parents in potential higher need groups are less confident across a range of areas than those who are not in such groups. For example, they are less confident about their ability to control their child (average score of 46

compared with 49), about their ability to discipline (46 compared with 49) and their ability to withstand pressure (42 compared with 45).

7.8. Similarly, parents with multiple socio-economic disadvantages also display lower parenting confidence, with lower-than-average scores in many of the same areas as those parents in potential higher need groups. These parents have less confidence than average about their ability to control and discipline their child, to resist pressure and about learning and knowledge than average (44, 44, 40 and 51, compared with 47, 47, 43 and 53 respectively. This group might benefit from additional support, particularly since, as discussed elsewhere, they are not currently receiving very much support from health visitors and other Flying Start entitlements.

7.9. 'High risk' parents generally display similar levels of confidence in their parenting skills as other parents, which may be a consequence of the higher levels of support that they receive from Flying Start services. An exception relates to their ability to withstand pressure; the mean score for this measure is 39, compared with an average of 43.

7.10. Young parents display lower confidence in their parenting skills than older parents across a range of measures. These include empathy and understanding (51 compared with 54), discipline and setting boundaries (44 compared with 47) and pressure (40 compared with 45). Young parents are not currently receiving additional support from Flying Start services; tailored support might help improve their confidence in their parenting skills.

7.11. There are no notable differences in confidence between first time parents and non-first time parents. Whilst it is not possible to be certain, it may be that the additional health visitor support received by this group has bolstered their confidence.

7.12. A summary of the aggregate TOPSE scores for key sub-groups is provided in Table 59.

Table 59: TOPSE mean scores

	Total	First time parents	Non-first time parents	Young parents	Parents aged 35+	Parents facing multiple socio-economic dis-advantage	Potential higher need group	Potential lower need group	'High risk' parents
Emotion and Affection	56	56	56	56	57	56	56	57	56
Play and Enjoyment	57	58	57	57	57	57	57	58	57
Empathy and Understanding	53	53	53	51	54	52	53	54	52
Control	47	47	46	46	47	44	46	49	45
Discipline and Setting Boundaries	47	47	47	44	47	44	46	49	45
Pressures	43	43	43	40	45	40	42	45	39
Self-acceptance	54	54	54	54	54	54	54	55	52
Learning and knowledge	53	53	52	52	52	51	52	54	52

Base: 1,694 respondents in Flying Start areas who completed the self-completion section

Household chaos

7.13. The 15-item 'Confusion, Hubbub and Order' scale is an instrument designed to assess the degree of disorder in a child's home. Importantly, the home environment has been linked to behaviour problems, poor attention and cognitive development problems in children.[95]

7.14. As seen in Table 60, a majority of parents report having a relatively organised and calm home environment. In particular, they feel that they have a regular morning routine at home, with over nine in 10 parents (92 per cent) either agreeing or strongly agreeing with this.

[95] See, for example, Deater-Deckard, Kate et al, 2009. Anger 'frustration, task persistence, and conduct problems in childhood: a behavioural genetic analysis. *Journal of Child Psychology and Psychiatry* [online]. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2659560/>. [Accessed 6 September 2011].

Table 60: Household chaos

	In the morning we have a regular routine (%)	It's really disorganised in our home (%)	You can't hear yourself think in our home (%)	The atmosphere in our home is calm (%)
Strongly agree	50	3	3	24
Agree	42	10	14	54
Neither agree nor disagree	4	13	16	16
Disagree	3	43	43	5
Strongly disagree	1	30	24	1
Refused	*	*	*	*
Agree	92	13	18	77
Disagree	4	73	66	7
Base: all parents (1,776)				

7.15. As shown in Table 60, above, scores for the other home environment measures are slightly lower but still high: nearly a quarter (73 per cent) of parents disagree or strongly disagree that their home is really disorganised; two-thirds (66 per cent) disagree or strongly disagree that they cannot hear themselves think in their home; and over three quarters (77 per cent) of parents either agree or strongly agree that the atmosphere in their home is calm.

7.16. Parents in the potential higher need group are more likely than others to report high levels of home chaos. For example, 91 per cent of those in this group agree that they have a regular morning routine whilst 14 per cent agree that their home is really disorganised (compared with 95 per cent and 11 per cent of those who are not in this group respectively).

7.17. Parents facing multiple socio-economic disadvantage are more likely than average to disagree that they have a regular morning routine (eight per cent compared with four per cent), more likely to agree that their home is disorganised (21 per cent compared with 13 per cent). Given that this group is currently not receiving much support from Flying Start entitlements, it may be that the degree of home chaos would decline if they received greater support.

It should be noted that an exception to the high degree of home chaos described by this group relates to their ability to hear themselves think at home. They are more likely than average to say that they can hear themselves think at home (61 per cent disagree that they cannot hear themselves think at home compared with an average of 66 per cent).

7.18. In general, 'high risk' parents do not describe levels of home chaos that are notably different from other groups, possibly a result of the higher levels of support that they receive from health visitors and other Flying Start entitlements. However, they are more likely than other groups to say that they cannot hear themselves think at home (22 per cent compared with an average of 18 per cent), and perhaps might benefit from more support in relation to this area.

7.19. Young parents do not report any notably different levels of home chaos compared with other groups.

7.20. First time parents do not report any difference in relation to their morning routine as compared with non-first time parents. However, across all other measures they report lower levels of home chaos. For example, they are significantly less likely to agree that their home is disorganised (10 per cent compared with 16 per cent) and they are also more likely to agree that the atmosphere of their home is calm (86 per cent compared with 72 per cent). Whilst this may be a result of the higher levels of support received by this group, it may also be a consequence of their having only one child.

Safety

Ownership and use of safety equipment

7.21. The presence and use of safety equipment both within and outside the home is important in keeping children safe. It is encouraging, therefore, that, as shown in table 62, below, a majority of parents own and, importantly, use a variety of safety devices.

7.22. As Table 61 shows, the most commonly owned and used devices are smoke alarms and safety gate/barriers (owned by 95 per cent and 84 per cent of parents respectively). In contrast, families are less likely to own and use electric socket covers.

Table 61: Ownership and use of safety equipment

	Ownership (%)	Use (%)
Smoke alarm	95	94
Safety gate/barrier	84	81
Electric socket covers	64	59
Base: all parents (1,776)		

7.23. In general, there are no notable differences in ownership of safety equipment. There are, however, a couple of exceptions to this: parents with characteristics indicative of disadvantage are less likely to own electric socket covers than others. For example those earning under £10,000 per annum are less likely than those earning £30,000 or more to own electric socket covers (62 per cent compared with 72 per cent). Similarly, those with multiple socio-economic disadvantages are less likely than average to own them (55 per cent compared with 64 per cent).

Parental health behaviours

7.24. Parental behaviours, such as smoking and alcohol consumption can impact not only on parent health but also, in some cases, on parenting behaviour and therefore on child health and outcomes. It is important, therefore, to understand the prevalence of such behaviours amongst families living in Flying Start areas.

Smoking

7.25. Although the majority (56 per cent) of parents in Flying Start areas do not smoke, over two in five (44 per cent) do.[96] In contrast, the 2009 Welsh Health

[96] The mean number of cigarettes smoked per day is 10.97.

Survey found that 27 per cent of those aged 16 – 24 and 34 per cent of those aged 25 – 34, (age groups roughly comparable with the age of the parents surveyed), smoke.[97] Although not a direct comparison, it does help to place the findings in a wider context, with those in Flying Start areas apparently more likely to be damaging both their health and, if they smoke in front of them, that of their children.

7.26. The group where smoking is particularly prevalent, is those not in work (73 per cent of those in work do not smoke compared with 47 per cent of those out of work).

7.27. The presence of anyone in the household who smokes is of interest because of the impact that second-hand smoke can have on children's health and wellbeing. In addition to the 44 per cent of parents in Flying Start areas who smoke, over a third (35 per cent) also live with someone who smokes. The same links to disadvantage seen in relation to parental smoking apply in relation to this; parents who do not work are more likely to live with a smoker than those who do work (38 per cent compared with 27 per cent), whilst young parents are more likely to live with a smoker than average (58 per cent of those aged 16 – 19 and 40 per cent of those aged 20 – 24).

Smoking during pregnancy

7.28. There is a link between smoking during pregnancy and the likelihood of giving birth to a low birth weight baby,[98] and of the baby dying of Sudden Infant Death Syndrome. Furthermore, children of mothers who smoke during this time are more likely to be at risk of early illness. Conversely, when mothers stop smoking during pregnancy this can have a powerful and positive impact upon the health of the unborn child. This is a particular issue in Wales where smoking levels of mothers before and during pregnancy are the highest in the

[97] See Welsh Government, *Welsh Health Survey 2009*. Available at <http://wales.gov.uk/topics/statistics/publications/healthsurvey2009/?lang=en>. [Accessed 5 September 2011].
[98] Which in turn is one of the main causes of infant illness and disability, and of stillbirth.

UK. In 2010 a third of mothers in Wales (33 per cent) smoked before or during their pregnancy, while 16 per cent smoked throughout their pregnancy[99].

7.29. Among parents who are the biological mothers of their child, half (49 per cent) smoked prior to becoming pregnant[100], a greater proportion than in Wales as a whole. Of this group, four in five (80 per cent) went on to change the amount they smoked during their pregnancy, with over a third (35 per cent) giving up smoking entirely during their pregnancy. In total, two in five (39 per cent) biological mothers smoked during their pregnancy.

7.30. As with smoking in general, the likelihood of giving up during pregnancy also varies. For example, first time parents are significantly more likely to have changed the amount they smoked than those who are not first time parents (85 per cent and 76 per cent, respectively). Similarly, nine in 10 (92 per cent) mothers aged 16-19 smoked during pregnancy and changed the amount they smoked, which is significantly higher than the three quarters (79 per cent) of those in the 35+ age group who did the same. It is possible that this reflects the number of anti-smoking campaigns that have been targeted at the young, highlighting the health risks posed by cigarettes. This finding also highlights the potential benefits of targeting younger and first time parents (who also show other more positive health behaviours) and who may be more open to influence than older and non-first time parents.

7.31. Given the fact that the majority of mothers who smoke reported changing the amount that they smoked during pregnancy, these findings are clearly encouraging. However, they also indicate that there is work to be done to increase the proportion of mothers who give up smoking completely rather than just reduce the amount they smoke, as well as finding a way to encourage the minority of mothers who did not change their smoking behaviour, to do so. The incorporation of education, advice and support to

[99] This is in contrast to mothers across the UK as a whole where just over a quarter (26 per cent) smoked before or during pregnancy and 12 per cent smoked throughout their pregnancy. Infant Feeding Survey (2010), see: http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/IFS_2010_early_results/Infant_Feeding_Survey_2010_headline_report2.pdf.

[100] It is worth noting that Flying Start is a programme from the child's birth so it is not expected that Flying Start will impact on pre-pregnancy or pregnancy rates of smoking.

stop smoking as part of the Flying Start health visitor offer may well have a positive impact in the future, especially if targeted towards households at greatest risk such as those most likely to smoke and least likely to change their behaviour.

Alcohol consumption

7.32. Consuming excessive quantities of alcohol is likely to increase the chances of developing health complaints, as well as raising concerns if excessive alcohol is consumed while looking after children. Almost a third (31 per cent) of parents in Flying Start areas do not drink. Whilst the figures are not directly comparable, the 2009 Welsh Health Survey found that 44 per cent of those aged 16 – 24 and 37 per cent of those aged 25 – 34 do not drink, suggesting that alcohol consumption is higher in Flying Start areas than in Wales as a whole.[101]

7.33. In total, eight in 10 (80 per cent) parents in Flying Start areas either do not drink or do so less than once a week. Fewer than one in five (17 per cent) drink once or twice per week and very few report that they drink three or more times per week (four per cent).

7.34. The consumption of more than 50 units of alcohol per week is deemed to be harmful to men, whilst for women the threshold is 35 units.[102] One per cent of men and less than one per cent of women interviewed consume this volume of alcohol.

7.35. However, a smaller quantity of alcohol, whilst not necessarily harmful to an individual's health may affect their behaviour, and therefore their children. The Department of Health recommends that men drink no more than 21 units of alcohol per week (and no more than four in one day), and that women drink no more than 14 units per week (and no more than three in one day). On this

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[101] See Welsh Government, *Welsh Health Survey 2009*. Available at <http://wales.gov.uk/topics/statistics/publications/healthsurvey2009/?lang=en>.. [Accessed 5 September 2011].

[102] See Drinkaware,co.uk, 2008. *Alcohol and your health.* Available at < http://www.drinkaware.co.uk/facts/factsheets/alcohol-and-your-health>. [Accessed 5 September 2011.

basis, eight per cent of male parents in Flying Start areas and seven per cent of female parents drink over the recommended number of units per week.[103]

7.36. Binge drinking is even more likely to have negative consequences for the children of parents who engage in this kind of behaviour. In order to assess the levels of alcohol consumption per drinking episode, parents who drink once a week or more were asked how much, on average, they drink on days when they consume alcohol. Three quarters (76 per cent) drink one to five units, one in five (18 per cent) drink six to 10 units, while just four per cent drink more than 11 units. One in five parents (21 per cent) can be classified as binge drinkers.[104]

7.37. Whilst a greater proportion of relatively less disadvantaged households are more likely to consume alcohol on a regular basis, (seven per cent of those with an annual household income of £30,000 or more are classified as regular drinkers, compared with an average of four per cent), groups that are at risk of being disadvantaged are more likely to have problem drinking behaviours. For example, a quarter (26 per cent) of those with an income of less than £9,999 qualify as binge drinkers, compared with seven per cent of those earning in excess of £30,000. Similarly, parents who are not working are significantly more likely to be binge drinkers than those who are working (28 per cent and nine per cent, respectively).

7.38. The findings indicate that the majority of those in Flying Start areas are currently not consuming alcohol in levels or frequency that exceeds recommended levels. That said, there are specific groups who are drinking excessively either in one sitting or in general and as such are likely to be increasing their chances of developing health complaints in the future. Those most likely to consume excessive quantities of alcohol are also those who are more likely to smoke (for example parents who are out of work). As is often

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[103] See Patient.co.uk, 2010. *Recommended Safe Units of* Alcohol. Available at <http://www.patient.co.uk/health/Recommended-Safe-Limits-of-Alcohol.htm>. [Accessed 5 September 2011].

[104] Whilst there is no fixed definition of a 'binge drinker', the term usually refers to drinking too much alcohol over a short period of time, leading to drunkenness. In this survey, a binge drinker was defined as a man who reports drinking 10 or more units on days when he drinks alcohol, or a woman who drinks six or more units on days when she drinks alcohol.

the case, there are particular sections of the population who combine multiple unhealthy behaviours. Trying to change the outcomes of this group is likely to be particularly challenging for the Flying Start programme, but if successful it is also likely to make a big difference in improving parental health.

Child health

Seeking medical help for accidents

7.39. In order to get an indication of the number and type of accidents that children have had, parents were asked whether they have ever sought medical help for their child as a result of an accident or injury; over eight in 10 parents (82 per cent) say they have not. Seventeen per cent of parents say that their child has had one or two accidents or injuries for which they have been taken to the doctor, health centre, clinic or hospital, while a further one per cent say that their child has had three or more accidents where medical help was sought.

7.40. The most commonly reported reason given by parents for seeking medical help for their child was for a bang on the head: as shown by Table 62, below, 13 per cent of parents have sought help for an accident of this nature.

Table 62: Top five reasons for seeking medical help for children

	Parents who sought help (%)
Bang on the head	13
Cut or graze	2
Burn or scald	1
Broken bone	1
Animal or insect bite or sting	1
Base: all parents (1,776)	

7.41. Young and first time parents are most likely to have sought medical help for accidents that their children have had, possibly reflecting lower levels of parenting experience amongst these groups. First time parents and those aged 16 – 19 are more likely than others to say that their child has had one or

more accidents or injuries (23 per cent and 25 per cent compared with 18 per cent).

7.42. In addition, parents with long-standing conditions are another group who are also particularly likely to have sought medical help for accidents that their child has had, perhaps highlighting a specific need for support in this area for this group. A quarter (24 per cent) of this group have sought help for one or more accidents, compared with an average of 18 per cent.

7.43. 'High risk' parents who are facing health or safety risks, that is those with post-natal depression, those who drink or who have experienced domestic violence within their relationship, are more likely than average to say that they have sought help for an accident (22 per cent compared with 18 per cent).

Seeking medical help for health concerns

7.44. Parents were also asked about instances other than accidents or injuries, such as health problems, where they have sought medical advice for their child. As shown in table 63, the most common health problem for which parents have sought help is a chest infection (32 per cent of parents have sought help for this). In addition, one in five (22 per cent) have sought help for skin problems. Over a quarter of parents (27 per cent) say that their child has not had any health problems.

Table 63: Top 10 health problems for which parents have sought help

	Parents who sought help (%)
Chest infections	32
Skin problems	22
Ear infections	16
Wheezing or asthma	16
Persistent or severe vomiting	11
Persistent or severe diarrhoea	11
Feeding problems	8
Sight or eye problems	6
Sleeping problems	6
Failure to gain weight or grow	5
Base: all parents (1,776)	

Child physical development

7.45. As might be expected given the young age of the children in the sample, as yet few parents report having concerns about the longer term health and development of their child since they were born. However, when prompted with a list, a small proportion mentioned one or more such concerns, with problems with their child's hearing the most commonly mentioned (12 per cent), followed by concerns about their child's eyesight (five per cent), talking or growth (three per cent), or clumsiness, movement or coordination (two per cent).

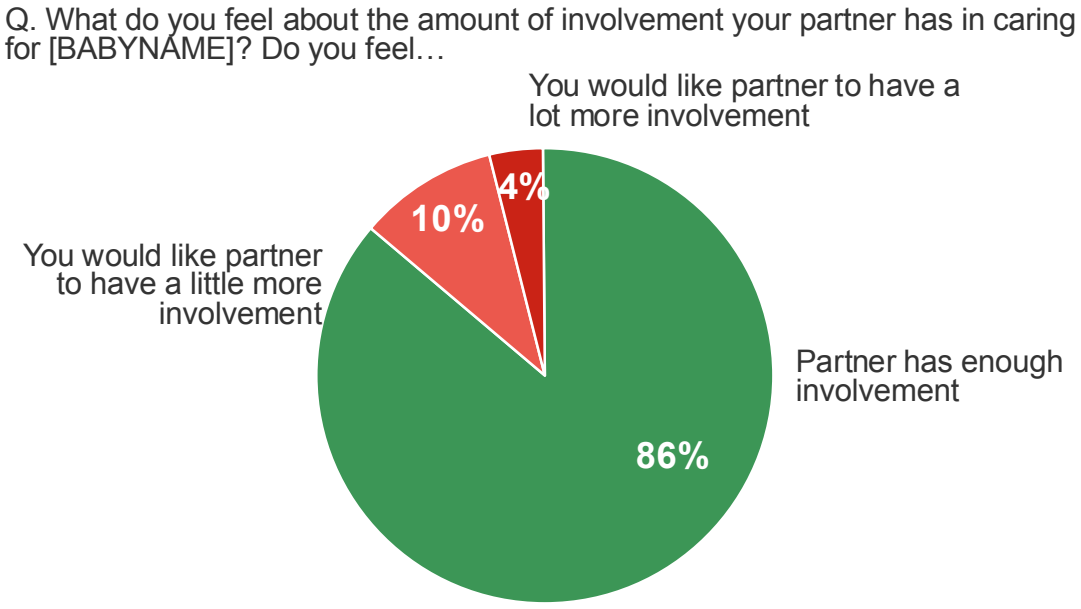
Partner involvement in childcare

7.46. Having a partner who is involved in helping to raise children and who can lend their support is important not only for primary carers, but also often for children themselves.

7.47. When considering the kind of relationship that their partner shares with their child, nearly all parents who live with a partner (99 per cent) agree that their partner's relationship with their child is warm and affectionate. Of these, nine in 10 (91 per cent), strongly agree with this.

7.48. As Figure 7 below, shows, the vast majority of parents (86 per cent) who live with a spouse, partner or cohabitee say they feel that their partner has enough involvement in caring for their child.

Figure 7: Desire for additional support from partner



Base: 908 respondents in Flying Start areas with a spouse or civil partner living in the household. Fieldwork: 8 March – 11 August 2010. Source: Ipsos MORI

7.49. 'High risk' parents are more likely than average to say that they would like their partner to be more involved in caring for their child (22 per cent compared with 13 per cent). This suggests that this already-vulnerable group may be in need of additional parenting help.

7.50. Table 64 shows that although over a third of parents with a cohabiting partner (37 per cent) say that their partners looks after their child at least once a day, for the majority this is not the case.

Table 64: Frequency with which partner helps with child

	How often partner looks after baby on their own (%)	How often partner changes Baby's nappy (%)	How often partner feeds Baby (%)	How often partner gets up in the night for Baby (%)
More than once a day	27	54	43	16
Once a day	10	14	19	4
A few times a week	27	17	20	14
Once or twice a week	19	5	6	7
Less than once a week	10	3	3	8
Never	6	7	6	19
Baby does not need this anymore	*	-	4	31
Don't know	*	*	*	*
Base: 908 parents in Flying Start areas with a spouse/civil partner/cohabitee in the household				

7.51. As above, Table 64 shows that the specific type of help that partners provide to parents varies considerably by task. Parents report receiving more help from their cohabiting partner to change nappies than looking after their child by themselves. More than half (54 per cent) say that their partner changes their child's nappy more than once a day.

7.52. Parents report receiving the least help from their partners when their child wakes during the night. One in five (19 per cent) parents say that they partner never does this.

7.53. Male parents are particularly likely to report receiving help from their partners. Over six in 10 (63 per cent) say that their partner looks after their child on their own more than once a day; this is significantly higher than the quarter (24 per cent) of female parents who say the same thing.

7.54. Overall, a large majority of parents who live with their partner say that they are able to rely on their partner when it comes to looking after their child (97 per cent). Just one per cent say that they cannot do this. Worryingly, however, parents who are high need, either because of their socio-economic

circumstances or because of their health and domestic circumstances are less likely than average to say that they can rely on their partner (three per cent and two per cent respectively) suggesting that there is a need to make sure that these parents are receiving the support that they need.