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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 7-20 months

Summary Report



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Baseline survey of families
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families with babies aged seven to 20 months
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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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Peer review

Peer review is an important process contributing to the maintenance of high standards for research publications. This report has been subject to 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 Welsh Index of Multiple Deprivation.
- **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.

Executive summary

The survey was carried out as part of the evaluation of Flying Start for the Welsh Government, in order to provide robust evidence about the nature of families and of need in Flying Start areas and the early influence of the programme, as well as to inform its future development.

Families in Flying Start areas receive higher levels of support from health visiting services, parenting programmes and Language and Play (LAP) than those in comparison areas and feel more positive about the services and support provided to parents. Users of such services have also reported positive impacts on themselves as parents and on their children. The findings also suggest that health visitors are proactive at signposting parents to other types of parenting support.

The survey indicates that in Flying Start areas parents with health support needs along with first time parents and, for some entitlements, those from socio-economically disadvantaged backgrounds are receiving more targeted support from local services.

Looking at parenting behaviours, the findings show that the proportion of families singing to their babies is higher in Flying Start areas than among the comparison group. By contrast, the analysis shows breastfeeding rates and immunisation take-up to be lower than in comparison areas.

Overview

- 1.1. The Flying Start Programme was launched in 2006/7 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 geographically targeted to some of the most deprived areas of Wales and is universally available to families with children aged up to three in those areas. It aims to improve child outcomes through the provision of four key service entitlements: enhanced health visiting support, evidence based parenting courses, Language and Play programmes, free childcare for two to three year olds and others, and also an overarching focus

on early identification of additional support needs. Although some of these services may be available in non-Flying Start areas, Flying Start would result in a much more intense level of support and be much more active in promoting these entitlements to parents.

- 1.2. This report presents findings from the first wave of a longitudinal survey of families with children aged under two² in Flying Start delivery areas and comparison sample areas, conducted by Ipsos MORI with support from SQW.
- 1.3. The survey was carried out as part of the evaluation of Flying Start for the Welsh Government, in order to provide robust evidence about the nature of families and of need in Flying Start areas and the early influence of the programme, as well as to inform its future development.

The evaluation of Flying Start – survey purpose and approach

- 1.4. Wave 1 survey fieldwork was conducted between 8 March and 11 August 2010. 3,591 families with children aged under 2 were randomly sampled from Child Benefit Records. 1,776 families were interviewed in Flying Start areas and 1,815 interviews were completed in comparison areas. The comparison area sample was 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) and thus to generate a quantitative measure of the effect Flying Start has had on each outcome measured.
- 1.5. The evaluation was commissioned after the roll-out of the Flying Start programme had begun. 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; therefore a randomised controlled trial (RCT) that would enable full attribution of the observed differences to Flying Start was not possible.
- 1.6. The evaluation team therefore used a quasi-experimental design to measure early impact by comparing the difference in outcomes between the Flying Start sample and a comparison group after programme delivery had begun.

² Children in the achieved sample were aged seven to 20 months, although it did include a small number of babies (28 in total) aged 21 – 26 months.

The comparison group was designed to be as similar as possible to the Flying Start group³, but inevitably some differences could not be controlled for.

- 1.7. The design and methods adopted were the most effective available. They are useful in allowing us to build a broad picture of the likely early influence of the programme, but some issues need to be borne in mind. Lack of baseline data and impossibility of ensuring a 100 per cent matched comparison group⁴ means that we cannot be totally confident about the extent to which any higher outcome scores in Flying Start areas are attributable to Flying Start or simply reflect differing starting points between the two samples and the limitations of the matching. However, given the higher levels of deprivation observed in Flying Start areas, it is reasonable to assume that starting points pre-Flying Start were lower in Flying Start areas than in comparison sample areas for many outcomes measured. **Given this, it is more likely that estimates under-estimate, rather than over-estimate the early influence of Flying Start on many outcome measures.**⁵
- 1.8. Furthermore, it is important to consider that at the time of the survey fieldwork the delivery of the Flying Start entitlements was variable (as reported in the interim evaluation of Flying Start report) but deemed to be progressing in the right direction to make a difference to children and families in Flying Start areas.⁶ 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 survey fieldwork.
- 1.9. 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. This report is not therefore based on the complete performance of Flying Start but is the first opportunity to report on quantitative data from families living in

³ Comparison sample areas were drawn from those that were as similar as possible to Flying Start areas (e.g. from among the next most deprived) and differences between the samples were minimised via comprehensive use of propensity score matching and regression analysis techniques.

⁴ As is the case for many quasi-experimental design studies.

⁵ The ability to draw firmer conclusions from impact analysis at Wave 2 could be enhanced if fuller information on the pre-Flying Start position, and service delivery context was available from monitoring or administrative sources.

⁶ See <http://wales.gov.uk/about/aboutresearch/social/latestresearch/3641013/?lang=en>.

Flying Start areas and to be able to identify the early influences of the programme as far as possible.

- 1.10. Further detail on the analytical approach and its limitations are provided in the introduction to the main report.

What were the aims and focus of the Wave 1 survey?

- 1.11. Wave 1 of the survey was designed to examine the early influence of Flying Start on a limited range of indicators as well as provide a profile of Flying Start families and their needs.
- 1.12. Given the young age of children in the sample cohort (seven to 20 months)⁷ the use and experience of health visiting services and awareness and referral to other services was a priority within the analysis. Early *indicative* impacts were also explored on a narrow range of parenting behaviours, namely infant feeding, immunisations and a limited range of home learning activities. The second wave of the survey will explore a fuller range of impacts, for example, on child cognitive and social development, child wellbeing, parenting behaviour in relation to the home environment, home chaos and support networks.
- 1.13. Although Flying Start is universally available to families with children aged nought to three within the target area, the programme does aim to provide tailored support depending on individual family needs. Families with higher levels of need might be expected to receive higher levels of support from health visitors and referrals to other services than others.⁸ Therefore the analysis has examined how successful the programme has been at reaching higher need groups, some of whom have complex needs, and some of whom services find difficult to engage.

⁷ Rather than the full range up to three covered by the whole Flying Start offer.

⁸ This report discusses 'referral to other services'. 'Referral' means parents being asked if they would like to attend a service by a health visitor or Flying Start practitioner and then parents can decide whether or not they would like to attend a service rather than it being an official 'referral'.

Who are Flying Start families and what challenges do they face?

1.14. Families in Flying Start areas showed high levels of disadvantage and, as a result, many are likely to face challenges in terms of providing their children the best start in life.

Almost three-quarters of families (72 per cent) have at least one of the following 'risk factors':

- being a workless household (46 per cent of parents);
- no qualifications (23 per cent of parents);
- low income under £10,000 per year (28 per cent of parents);
- young parenthood aged 16 – 19 (seven per cent of parents);
- post-natal depression (33 per cent of parents);
- heavy drinking (one per cent of parents);
- lone-parenthood (39 per cent of families) and
- experience of domestic violence (four per cent of parents).

1.15. These types of families are less likely to have calm households (76 per cent agree their home is calm compared with 81 per cent of those who do not have one of the 'risk factors'), and to smoke (52 per cent compared with 25 per cent). As discussed further below, they are also less likely to wean their children at the optimum age or to engage in home learning (for example 26 per cent read to their child more than once a day compared with 31 per cent of other families).

Does an increased service offer result in increased service take-up?

1.16. Overall, families in Flying Start areas are more likely to access the Flying Start services relevant to young babies, than the matched comparison group. A higher number of health visitor contacts were reported in Flying Start areas, as well as greater awareness of and attendance at other types of parenting support. It is also apparent that health visitors in Flying Start areas are active in signposting and referral to other types of parenting support.

Health visiting and relevant wider support activities

- 1.17. **Families in Flying Start areas have had a higher number of health visitor contacts – an average of 17.7 contacts per family, which represents, on average, an estimated additional 1.1 contacts compared with families in the comparison group.** Families are also receiving a higher number of in-home visits – an average of 8.5 visits, which represents an additional 1.5 more visits. 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. Given that levels of health visiting support are dependent on need, this level of average contacts may represent a higher number of contacts targeted at a smaller group of families who are the most in need. The generic health visiting service is also delivered on the basis of need. This limited number of additional visits in Flying Start areas could be a result of families in comparison areas being relatively disadvantaged and therefore also receiving a higher than average number of visits from the generic health visiting service. **Furthermore, 64 per cent of parents have engaged in additional relevant support groups (for example, baby massage) or other informal parent support groups, or received free products, such as home safety packs.** The impact analysis showed that this includes an estimated additional 25.4 per cent of parents who are likely to be using these services, compared with the matched comparison sample.
- 1.18. **Flying Start health visitors are proactive at encouraging parents to take-up wider parenting support.** Three-quarters of parents who are aware of parenting groups and initiatives have been asked to take-up one of these activities by their health visitor (75 per cent), which includes an estimated 28.4 per cent more doing so in Flying Start areas, compared with those in the comparison group. Similarly, one fifth (20 per cent) of parents have been asked to attend Language and Play (LAP)⁹ by their health visitor which includes an estimated extra 12.9 per cent in Flying Start areas.¹⁰ Indeed,

⁹ Language and Play (LAP) involves parents/carers and their learning together through play and fun activities. Access to LAP should be offered in all Flying Start areas and as with parenting courses sessions are open to all parents in theory, while in practice they are again targeted towards need and in many cases they are linked to other services such as clinics, parenting courses and childcare.

¹⁰ Take-up of LAP was not expected to be high at this stage given the age of children in the sample.

health visitors are vital in raising awareness of parenting programmes and LAP – they are the most common way in which families report finding out about these entitlements.

Parenting courses and LAP

1.19. Significant proportions of parents are now aware of and using parenting courses.

Almost one third of parents are aware of parenting courses (30 per cent) and nine per cent are using them. It is estimated that this includes 11.5 per cent more who are aware of them and up to four per cent more who are using them in Flying Start areas, compared with the matched comparison group. These findings are positive given that limited impact was expected at this stage because of the age of children included in the survey and that many of the parenting courses are designed for older children.

1.20. Furthermore, just over one third of parents (37 per cent) are aware of LAP programmes in their area, including up to an estimated additional 22.8 per cent who are aware of this in Flying Start areas. Around one in 10 (12 per cent) of families have attended a LAP course.

Parents' experiences of Flying Start and its perceived impact on their children

Support for parents overall

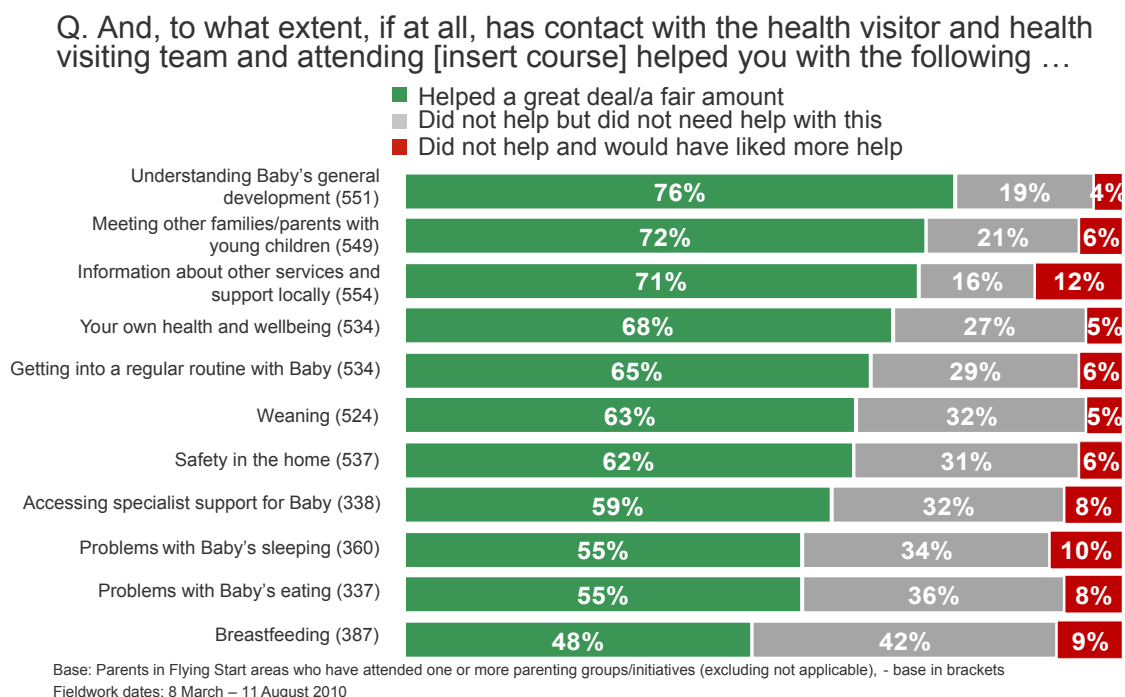
1.21. **Most families in Flying Start areas feel well supported.** The majority of parents are positive about the standard of their local parenting services with around two-thirds rating the facilities, services and support available for families and the local advice and support about caring for a child as 'very' or 'fairly' good (64 per cent and 68 per cent respectively). The impact analysis estimates that this includes an additional six per cent and 11 per cent respectively of parents rating these as 'very' or 'fairly' good in Flying Start areas, relative to the comparison sample.

Health visiting

- 1.22. **The vast majority of parents in Flying Start areas are positive about health visiting support. Parents also report benefits for them and their children as a result of using these services. However, around one in five parents want even more support.**
- 1.23. Almost three-quarters of parents (73 per cent) say they can contact their health visitor easily most of the time, including an additional 9.7 per cent in Flying Start areas. Nine in 10 (90 per cent) say the support is helpful, including six in 10 (61 per cent) who say the support is *very* helpful. Impact analysis estimates that this is higher in Flying Start areas (by six percentage points). Furthermore eight in 10 (79 per cent) say they have enough support, (including an additional four per cent in Flying Start areas, relative to the matched comparison group). However, among those who want more support the changes required to achieve this are more focused on ensuring individual needs are met (mentioned by 39 per cent of those who would like more support), ensuring families are able to contact their health visitor easily (24 per cent) and making clinic opening hours more convenient (eight per cent).
- 1.24. Among the two-thirds of parents (64 per cent) who have received support from parenting groups and initiatives as well as health visitors, the vast majority are positive that the services they have received have helped with parenting: eight in 10 say they have increased their confidence as a parent (79 per cent) and three-quarters (75 per cent) say they have helped them make decisions about how to look after their baby.
- 1.25. Looking at other aspects high proportions also say they have helped them understand their child's general development (76 per cent) and how to get the baby into a regular routine (65 per cent) as shown in the chart below. Lower proportions have been helped with breastfeeding, problems with the eating, and sleeping of the baby. These aspects, along with a desire for more information about other advice and support available locally, are the issues with the highest proportions wanting more help with (around one in 10 for each). Given that breastfeeding and weaning are key indicators for the programme, it will be helpful for policy makers and partnerships to reflect on what these findings mean going forwards. Indeed, the lower proportions

reporting that they would like more help with breastfeeding may be related to the variability in the delivery of breastfeeding support at the time of Wave 1 fieldwork that has been reported by the Flying Start policy team.

Figure 1: Users' self-report of the helpfulness of health visitor, health visiting team and other parenting initiatives in 11 key areas



Parenting courses and LAP

1.26. **Most of the parents who have used Flying Start parenting courses and LAP programmes are positive about them, and many report positive impacts for them and their children.**

1.27. Among the nine per cent of parents who had used parenting courses, most say the course(s) has helped them a great deal or fair amount with their confidence as a parent (83 per cent), their ability to understand their child (80 per cent) and their relationship with their child (79 per cent), as shown in the table below. Furthermore, around two in five parents (42 per cent) say they have seen a change in the behaviour of their child since attending the course.

1.28. Likewise, among the 12 per cent of parents who have used LAP around half of parents say as a result of attending LAP their baby shows more interest in

books or stories (55 per cent), counting things (48 per cent) and that their baby knows more songs and rhymes than they did before (57 per cent).

Table 1: Users' self-report of the impact of LAP on the amount of educational play activities parents undertake with children¹¹

	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
<i>Base: 220 parents in Flying Start areas who have attended a LAP session</i>				

Has Flying Start been successfully targeted to meet the needs of higher need groups?

1.29. **The extent to which Flying Start is successful in maximising support provided to groups with highest levels of need is mixed.**

1.30. **Currently enhanced Flying Start health visiting and other support tends to be most successful in reaching parents with additional health needs:** parents with a limiting long-term condition or post-natal depression have received more health visitor visits than average and are more likely to have attended parenting programmes. **Flying Start has also had some success providing additional support to first time parents.** This group have received a higher number of health visitor contacts than experienced parents and are more likely than others to report that support has had a positive impact on helping them to care for their baby. This is positive because the survey also found that this group are less likely to breastfeed or take part in home learning activities. However, this group are also among the most likely to say they would like *even more* support from their health visitor (25 per cent compared with 21 per cent on average). Furthermore, first time parents are no

¹¹ Please note the data in this table are based on parents' perceived impact of LAP on their child, and is not measured through the statistical impact analysis.

more likely to be using parenting groups or attending parenting programmes and are less likely to be attending LAP.

- 1.31. **Parents aged 20 – 24** receive a higher number of health visitor contacts although they are no more likely to participate in parenting groups or initiatives, parenting programmes or LAP than parents in general.
- 1.32. **Parents with a gross household income of under £10,000 per annum** and those in **workless households** have received more contacts with health visitors than families on average.
- 1.33. **More generally it seems that LAP usage tends to be more common among the relatively more advantaged and educated groups with lowest take-up among the most disadvantaged groups. However, it is often parents who have greater needs who are most positive about the impact of LAP on their child and more likely to put what they have learnt into practice at home.** For example, parents who have multiple socio-economic disadvantages are particularly likely to report understanding what their baby is saying or is doing since attending LAP. It is encouraging that the most impact is being reported by parents who have the greatest needs. This suggests that LAP is well designed in helping those who need the most help. However, it will be important to address the lower levels of access reported by more needy groups and perhaps to assess how the programme is promoted to parents in this position.
- 1.34. These findings highlight the benefit of reviewing how health visitors' time is allocated in terms of their focus on different groups, as well as the approaches being used to engage parents in difficult circumstances and those who may be less aware of the benefits of support with health visiting and other support services. For example, additional engagement work may be beneficial among some sections of the community.

Has Flying Start helped to improve parenting behaviours relevant to care and development of young infants?

- 1.35. **Many parents in Flying Start areas are engaged in home learning activities with their children and there are higher proportions of parents in Flying Start areas who are singing to their child than among the**

matched comparison sample. Reading and singing to children can have a beneficial impact on the development of children's language and communication skills. For this reason, Flying Start seeks to promote these behaviours amongst parents.

- 1.36. Overall nearly three-quarters of parents sing to their child at least once a day (73 per cent).¹² The analysis indicates this includes an additional four per cent of parents doing this in Flying Start areas. However, further research exploring what aspects of the Flying Start service have driven these increases may be helpful for informing the ongoing development of the programme.
- 1.37. **The proportions of parents who are breastfeeding, weaning their children at the appropriate age or taking their children to be immunised are historically low in Flying Start areas, and they remained so among families at the time of the survey.**
- 1.38. At the time of the survey, 39 per cent of all mothers of children in Flying Start areas had been able to breastfeed compared with 71 per cent who were able to breastfeed on at least one occasion across Wales as a whole¹³. Almost half of Flying Start parents (48 per cent) wean their child within one month of the advised timescales (six months). A minority wean their child earlier or less commonly later than is recommended and these parents tend to be from more disadvantaged groups. The vast majority of Flying Start parents are up to date with their immunisations. However, there is evidence that uptake is slightly lower in Flying Start areas compared with nationally.¹⁴
- 1.39. The survey results are inconclusive about the impact of Flying Start on these behaviours. There are no statistically positive or negative differences between Flying Start and comparison group families on these factors. On breastfeeding the 'starting point' among families in Flying Start areas is lower than among

¹² Results are based on those parents who completed the self completion section (1,694)

¹³ Source: The Infant Feeding Survey 2010.

¹⁴ For example, 95.8 per cent of children in Wales at age 1 have had the combined diphtheria, tetanus and whooping cough vaccinations, the polio vaccination and the haemophilias influenza B vaccination compared with 91 per cent of children in Flying Start areas. This figure is taken from the 'National immunisation uptake data' for Wales in the financial year 2010 – 11 which is the closest match to our fieldwork period. This data is based on uptake at one year of age so is not strictly comparable with the age of children in our sample (around seven to 20 months). However, it does provide useful context for judging immunisation take-up in Flying Start areas.

families in comparison areas.¹⁵ This means that improvements may have been made in increasing breastfeeding rates in Flying Start areas but this could not be measured in the analysis. On immunisations the evidence on the 'starting point' of Flying Start families is more mixed¹⁶ and it seems less plausible that this is the case here.

- 1.40. Furthermore it is important to be aware that behaviour change in relation to these activities can take a relatively long time – and certainly longer than the time period that had elapsed up until the time of the Wave 1 survey. Therefore the range and level of behavioural change that it is realistic to expect as a result of Flying Start is limited at this stage. Furthermore, at the time of the survey in 2010 there was variation in the health visiting entitlement (not all Local Authorities were meeting the 1:110 ratio set in the Flying Start guidance). There was also variation the level of breastfeeding support available than there has been over the last year which may contribute to the difficulty in detecting impact at Wave 1.

Conclusions

- 1.41. It seems likely that the Flying Start programme has succeeded in increasing access to health visiting services and resulted in a more positive user experience. Evidence from this survey suggests there has been success in providing parents with a more holistic service with health visitors playing a crucial role in signposting to other types of support designed to improve parent and child outcomes. The key question to explore further at Wave 2 is whether increased service provision results in improved child and parent outcomes in the future.
- 1.42. The embedding of a strong focus on early language development throughout the programme appears to have been successful with slightly more parents singing to their children in Flying Start areas. The impact of such activities will be explored further at Wave 2 when children's language abilities are assessed to see if Flying Start has resulted in improvements.

¹⁵ This is apparent in Child Health data which shows breastfeeding rates are lower in Flying Start than comparison areas.

¹⁶ For example, Child Health data shows no difference in immunisation rates between Flying Start and comparison areas.

- 1.43. The survey has highlighted the ongoing challenge to increase the already very low breastfeeding rates among Flying Start families. Changing parenting behaviour in relation to breastfeeding requires deep cultural change which is likely to take many years – this also applies to immunisation take-up and weaning to a lesser extent. The success of the programme in changing these behaviours cannot be judged until a future time.
- 1.44. Flying Start is geographically targeted to some of the most deprived areas of Wales, is universally available to families with children aged nought to three in those areas and aims to identify need and refer families on to additional services and types of support where needed. It may be important for policy makers to reflect on how effectively the programme is reaching ‘high need’ groups given the mixed picture of success presented by the survey findings. First time parents and young parents have received higher levels of support, but there has been mixed success at reaching those experiencing multiple disadvantages who by their very nature are often the hardest to reach. Policy-makers may want to reflect on whether even more focus might be warranted on these groups, through additional engagement work for example.
- 1.45. The Wave 1 survey has provided great insight into the nature of Flying Start families and the challenges they face. A wealth of evidence has been uncovered on the extent to which Flying Start services are reaching their designated populations and how families are engaging with the programme. Further detailed work to explore the nature of the Flying Start offer in more detail (for example looking in greater depth at the quality of services provided) may be useful in providing further evidence on effectiveness of the programme from a service delivery perspective.
- 1.46. Going forwards it will be important for policy makers and local partnerships to consider what developments may be necessary to ensure that the programme is focused on the activities that are most effective in improving child outcomes. Consideration should also be given to ensuring that resource allocation and implementation approaches are sufficient and effective in enabling practitioners to effectively engage with and meet the more complex needs of the most disadvantaged families.
- 1.47. Whether Flying Start meets its ultimate aim to improve the life chances of children living in deprived areas in Wales will only become apparent in years

to come. However, the Wave 2 survey will be a key source of evidence on how far along the programme is in improving children's early developmental outcomes and thus hopefully contributing to this overall aim.