MILLENNIUM COHORT STUDY

HEALTH VISITOR SURVEY

INTERIM REPORT

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February 2004

Child of the new Century

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ACKNOWLEDGEMENTS

We would like to thank members of the Millennium Cohort Study research and support team (Neville Butler, Ian Plewis, Shirley Dex, Kate Smith, Peter Shepherd, Jackie Goossens, Denise Brown and Kevin Dodwell) and our two external advisors (Helen Bedford and Ros Bryar) for their very helpful comments, advice and support in carrying out this research. Thanks are also due to Elizabeth Green at the Department for Education and Skills for her useful comments on an earlier draft of this report. We would like to thank Simon Capanda for assisting with administrative duties, and Peter Deane and Susana Mouzo for their help with the laborious task of data entry. We would also like to thank the Office for National Statistics (ONS), the International Centre for Child Studies (ICCS) and the Economic and Social Research Council (ESRC) for funding for this research. Finally, enormous thanks are due to the National Health Service staff, supervisors and health visitors for agreeing to facilitate and supply data for this project. This report would not have been possible without all of their help.

EXECUTIVE SUMMARY

1. This report presents an analysis of the results of a postal survey supplementing the Millennium Cohort Studies (MCS). Questionnaires for completion by health visitors were mailed mid-2002 to 398 localities throughout the UK. The purpose of the survey was to gather information about the available locally to young families living in those electoral wards selected for inclusion in the Millennium Cohort Study (MCS). Given their role in Needs Assessment it was envisaged that health visitors might be well placed to supply this information. The services considered to be especially relevant were: childcare; health; family support; leisure; and statutory initiatives. We also invited health visitors to comment on the good and bad things about the areas in which they worked. This was to add to the MCS information about the areas in which children of the new century are growing up. The data would enable us to explain better the health inequalities of these children with a view to improving the services that deal with them.

2. The health visitors who completed questionnaires were those with whom we had already made contact as part of the first main survey of the MCS at 9 months of age. They had originally been enlisted to help identify families with babies eligible for inclusion in the survey particularly those moving into their local area, as well as to reassure families already contacted by explaining the study to them. Babies who were eligible for inclusion in the MCS were living in 398 electoral wards or sampled to over-represent Scotland, Wales and Northern Ireland, disadvantaged areas in the UK, as well as areas in England with high ethnic minority populations. Thus MCS geography is described in terms of disadvantaged, ethnic and 'advantaged' strata.

3. Health visitors in Northern Ireland returned the highest percentage of questionnaires (nearly four-fifths) followed by Scotland, Wales and England (just under two-thirds). Response from 'advantaged' and disadvantaged areas was similar though in Northern Ireland more responses were received from disadvantaged areas.

4. Data used in this report relate to 274 or 69% of the 398 sampling points. In complete response was partly due to the survey taking place during the reorganisation of NHS Trust. This means that the views of the health visitors who participated in this survey may not be representative of all those to whom a

questionnaire was sent. In addition, the geography of their work is not organised by electoral ward boundaries and we cannot be sure that questionnaires were completed with strict adherence to the geographical boundaries in which we were interested. Thus, the results reflect what health visitors know about the areas in which they work, but have not been corroborated from other sources.

5. When access to all services was analysed it was found that there was more variation **between wards** reported by health visitors in Scotland. Health visitors in Northern Ireland reported access to fewer services overall. Access to all services in English disadvantaged and ethnic areas was greater than in the advantaged areas, whereas access in Scottish and Welsh advantaged areas was greater than in their disadvantaged areas. There was no variation in access to total services in Northern Ireland according to strata.

6. Specific services which were very widely available throughout the UK in all strata, included speech therapists, parent and toddler groups, child health clinics, Parent Craft classes, family planning services, child and adolescent mental health services, registered childminders, screening for postnatal depression and Book Start projects.

7. The services that were routinely more widely accessed in advantaged areas than disadvantaged and ethnic areas, throughout the UK, included private nurseries, mobile libraries and museums. Conversely, those more widely accessed in disadvantaged areas, throughout the UK, were (youth) family planning services and Drug Action Teams. All other services were accessed in less consistent patterns between countries and strata, indicating a level of patchy or random provision. There were no ethnic wards in Scotland, Wales and Northern Ireland. Ethnic wards in England seemed to be well catered for. Since only 9 questionnaires were received from these 19 wards, it would be difficult to generalise from this finding.

8. Looking at the specific service areas that were asked about, health visitors' knowledge was best for leisure services (i.e. this section attracted the smallest number of "don't know" or blank responses) followed by health services. Health visitors' knowledge was least complete for statutory initiatives.

9. Where availability of services was known, predictably available this appeared to be greatest for health services. Although health visitors knew little about the waiting times for many health specialists and services, where these were reported, they were in some cases alarmingly long, particularly for child and adolescent mental health services. There also tended to be longer waiting times in disadvantaged areas.

10. The service area with the lowest reported availability was statutory initiatives. The only initiative about which health visitors had particularly good knowledge was the Sure Start local programmes (SSLPs), which they reported was particularly accessible in advantaged wards of Wales and Scotland, where the programmes are apparently not targeted by disadvantaged area as much as in England. Consistent with the aims of the Sure Start Unit, disadvantaged areas of England, and Northern Ireland, had access to more SSLPs than advantaged areas. However, a good proportion of disadvantaged wards in Wales and Northern Ireland did not report coverage of any of the named statutory initiatives.

11. Around nine out of every ten respondents supplied comments relating to the bad and good things in their local areas. Things that were frequently mentioned as unsatisfactory in the areas included: inadequate public transport; inadequate housing; and lack of employment opportunities. Features that were consistently mentioned as good things in the area included: the availability of a good prevailing community spirit; and the presence of extended families who provided community support.

12. In interpreting these findings it appears as though there was ~~is~~ not a great deal of variation in the quantity of services provided throughout the UK and it seems as though needs are, on the whole, being met. However, whilst these results suggest conclusions about the accessibility of services by young families living in MCS wards, they tell us little about the quality of those services.

13. Policy makers may be particularly interested in the services which disadvantaged wards reported often in each country to be lacking since many of these are family-support and childcare services run by voluntary agencies. Policymakers might want to consider schemes which help these services attract more (government) investment, or develop statutory initiatives which emulate some of these services. These results should be of interest to policymakers in many government departments.

14. Consideration could be given to improving health visitors' knowledge about the statutory initiatives which impact on the young families with whom they are routinely in contact. This is one way in which local services might be better 'joined up'. Policy makers may also be interested in tackling the issues raised by health visitors concerning bad things in their areas, such as poor/inadequate public transport, housing and employment opportunities. Likewise, they may learn something from the answers given on the good things in their areas; of particular interest here might be the importance of a community spirit and support role of extended families.

15. The next stage of this research will be to compare these data to the information collected in the main survey directly from the MCS respondents, concerning their neighbourhoods. There is also scope for a more advanced statistical analysis data is included from the 38 additional questionnaires received after the present analysis was carried out. Additional neighbourhood statistics are also available for small areas, collected by the Office for National Statistics.

CHAPTER 1 INTRODUCTION

To gather information relating to the local services available to young families living in the electoral wards from which the Millennium Cohort Study (MCS) has drawn its sample, a short questionnaire was sent to the health visitors working in these areas. Given their role in Needs Assessment, it was felt that they might be well placed to provide an informed overview. Part of the rationale for this survey was that the results might enable us better to explain health inequalities of the children in the MCS and, ultimately, to improve the services dealing with them.

The health visitors approached to complete the questionnaire were those the MCS research team had already contacted to help identify babies eligible for inclusion in the study (see section 2). These health visitors were sent a questionnaire by post to complete and return in a prepaid envelope. This questionnaire aimed to gather factual information about the neighbourhood, as well as health visitors' personal opinions about local services; it did not ask about individual MCS cohort participants or individual's use of services. We obtained approval from the NHS multi-centre Medical Research Ethics Committee (MREC) conduct the survey and agreement from supervisor for health visitors to fill out the questionnaires.

1.1 The Millennium Cohort Study (MCS)

Before moving on to a more detailed account of the rationale for the health visitor survey, it's procedure, methodology and results, it is important to provide a brief description of the Millennium Cohort Study, its design, aims and objectives. The MCS is the fourth of Britain's world-renowned national longitudinal birth cohort studies, the others having been born in 1946, 1958 and 19780 respectively. Each one was designed to follows a large sample of individuals born over a limited period of time through the course of their lives, charting the effects of events and circumstances in early life on outcomes and achievements later on. They show how histories of health, wealth, education, family and employment are interwoven for individuals and vary between them, and the data collected are used for many scientific and policy purposes.

The MCS differs slightly from the national birth cohorts' studies of 1946, 1958 and 1970 in that this one includes a sample of children born over a full twelve months, rather than all children born in one week. This present sample, thus includes births in all seasons. It also covers the whole of the UK including Northern

Ireland, with an emphasis on the social and economic circumstances of the families, and gathering information from fathers as well as mothers. In addition, the sample was disproportionately stratified to ensure adequate representation and enough numbers for meaningful analysis, of the three smaller UK countries but also of disadvantaged areas, in each of the four countries; and additionally of wards in England with higher minority ethnic populations. It was decided therefore to use the geography of electoral wards, for which an up-to-date index of disadvantaged children receiving means-tested benefits by ward was available, as well as 1991 census evidence on ethnic groups. Given the different manner in which the sample was selected compared to previous cohorts, eligible babies were primarily identified from the Child Benefit Register with the cooperation of the Department for Work and Pensions (DWP), an exercise that also provided families with the possibility of opting-out of inclusion in the study.

The objectives of the first MCS survey were: (1) to chart the initial conditions of social, economic and health advantages and disadvantages facing new children in the new century; (2) to provide a basis for comparing patterns of development with the preceding cohorts; (3) to collect information on previously under-researched topics, such as fathers' involvement in the children's care and development; (4) to focus on the children's parents as the most immediate elements of the child's 'background'; (5) to emphasize intergenerational links including those dating back to the parents' own childhood; (6) to investigate the wider social ecology of the family, including, social networks, civic engagement and community facilities and services, splicing in geo-coded data when available; and, with extra government funding, (7) to provide control cases for the National Evaluation of Sure Start (NESS).

The sample for the first sweep of the MCS was babies born in England and Wales between 1st September 2000 and 31st August 2001, and in Scotland and Northern Ireland between November 24 2000 and January 11 2002, living in 398 single or aggregated electoral wards across the whole of the UK. Information was collected from their parent(s) when the babies were 9-months-old. A final sample size was achieved of 18,800 children living in 18,500 families. This was some 1,800 less than the target sample, owing firstly to an unanticipated drop in the number of births between when the sample was drawn and 2000-1, and secondly to larger than expected numbers of sample babies moving out of MCS electoral wards before their parent(s) were eligible for interview. In order to approach the target sample size in Scotland and Northern Ireland, the fieldwork period was extended by six weeks in those countries. Health visitors were asked to help recruit eligible

babies to the study (see section 2), Data collected from this first sweep is now available with documentation from the UK Data Archive, at Essex University, revealing the diversity of starting points from which these 'Children of the New Century' are setting out. The second sweep of the cohort is taking place at age 3, between September 2003 to January 2005.

1.2 Plan of the report

This report describes each stage of the Health Visitor Survey in successive chapters. The recruitment of health visitors is detailed in Chapter 2, and the pilot survey procedures and results are described in Chapter 3. The approach to the main survey is presented in Chapter 4, which is then followed by the presentation of the main findings in Chapters 6-13, divided according to the main subsections of the questionnaire. Finally a discussion and some conclusions are presented in Chapter 14. The comprehensive Appendices to which this report refers are listed at the very end of this report.

CHAPTER 2 APPROACHING HEALTH VISITORS

The target population for MCS sampling was defined as children resident in selected wards at age 9 months. In September 2000, it was decided to use Child Benefit records to find such children, but it was feared that this method would not cover families with babies approaching 9-months-old who had moved recently into study areas. A supplementary strategy for recruiting movers-in to sample wards was proposed through the help of health visitors, a profession which had played a central role in previous birth cohort studies. It was expected that health visitors would know about families transferring into the area, and could therefore augment the recruitment of Child Benefit claimants via the Department for Work and Pensions[1]. We envisaged that health visitors would be able to approach families with information about the survey, asking if they were willing to be contacted by an interviewer, and also to provide them with information about the study and reassurance to those families who may have already been approached by the DWP opt-out exercise. A third aim of approaching contacting health visitors was to establish contacts who might later be willing to participate in a postal survey relating to the neighbourhoods in which the MCS cohort members were growing up. The funding for this exercise was granted by the Office for National Statistics early in 2001 as an enhancement to the main survey.

There were a number of problems to overcome with this enterprise. In the first instance, helping us with the survey was not part of the health visitor's normal duties, which were often already demanding. Secondly, health visitors' caseloads do not neatly coincide with electoral wards, and thirdly, we could find no central list of health visitors to ensure rapid contact. Thus, the process of contacting health visitors was complex and involved a number of steps, namely:

- Initially, time was spent designing an information pack to be sent to health visitors, which would describe the MCS, explain its aims, and lays out exactly what help we required of them in relation to recruiting additional families to the study. This included lists of postcodes and in most cases also maps, of electoral wards. We hoped the latter would help health visitors to identify the boundaries of the areas in which we were interested.

[1] For further information on the Millennium Cohort Study recruitment of cohort families see Shepherd, P., Smith, K., Joshi, H. & Dex, S. (2003). *Millennium Cohort First Survey: Guide to the SPSS Data*. London: Centre for Longitudinal Studies, Institute of Education.

- The next step was to identify each of the Health Trusts which covered the study's wards. This was achieved through the use of health service directories, aided by knowledge obtained from the internet, and by tapping the knowledge of those on the research and advisory team with a background in the health visitors' profession. It transferred that 119 Health Trusts were responsible for the English wards, 15 Trusts for the Welsh wards, 14 Trusts for the Scottish wards and 11 Health Trusts for the Northern Irish wards, 159 in total.
- The Director of Nursing (or the equivalent) in each Health Trust was identified and a letter was sent explaining the aims of the MCS. This letter (see Appendix I) asked if the Trust would support our request for health visitors' collaboration in finding MCS babies and asked if they would send us details of individual health visitors or health visitor team leaders with whom we could correspond further. The letters enclosed a sample copy of the pack that we had already designed to send on to those health visitors or health professionals identified (see Appendix 2). Letters were originally mailed out to Trusts in England and Wales in April 2001, one month before the first wave of families would be approached for inclusion in the study. Seven English trusts and one Welsh Trust replied that they refused to join in. We re-approached Directors of Nursing in a telephone exercise in May to June 2001 involving 57 English Trust and 8 Welsh Trust from whom we had not received a reply.
- Of those Directors of Nursing from whom we received positive responses a minority supplied names and addresses of health visitors enabled us to send out some Health Visitor Packs in June 2001 (14 Trusts in England and 5 in Wales). In other instances further information and reassurance was requested before Trusts agreed to cooperate relating, for example, relating to workload or local ethical approval. These queries were answered on an individual basis. In other instances replies indicated that our correspondence had been forwarded to another person, was approached after details had been onto our 'Health Visitor Database'.
- Where our correspondence was returned unopened or apparently mailed to the wrong place, investigations continued until the correct addressee was located, and a new letter and sample health visitor pack was mailed. The same was true for those cases where Directors of Nursing wrote back stating that their Trust did not in fact cover the electoral ward(s) we had 'assigned' to them, from which further research using the internet and various directories helped to locate the correct Trust in most instances.

- In August 2001 we sent letters to ~~all~~ the senior health visitors in England and Wales whom Directors of Nursing had nominated to supervise the efforts of individual health visitors in their quest to find MCS babies. Supervisors were urged to place orders with us for Health Visitor Packs and we reminded them to keep us informed of any new babies found (so that they could be added to the interviewers' schedule). In a few instances Directors of Nursing had indicated that they themselves would continue to coordinate of the project locally Once again, in September 2001 we wrote to the 27 English and 1 Welsh Trust from whom we still had not had any reply.

The recruitment of health visitors in Scotland and Northern Ireland followed the same pattern as that detailed for England and Wales, although it started some three months later, taking into account the staggered MCS fieldwork start-date for these countries.

From this it will be evident that locating health visitors in our wards was a labour- and time-intensive undertaking, a situation which continued throughout the first sweep of data collection of the MCS. Personnel in each sector often changed, so we were constantly being informed new supervisors or health visitors with whom we should correspond. This necessitated a constant update of our Health Visitors database, on which we also recorded all of the contacts made with each Trust and the numbers of health visitor and supervisor packs mailed out. In the cases of Trusts which covered several sample wards or where difficulties arose visits were made in person by the research team to give a presentation to supervisors or to groups of health visitors and to engage their help in finding eligible babies in their wards. This included one or more visits during 2001 to all four countries.

The whole exercise was complicated further because organisation of the National Health Service underwent a fairly major change during the whole course of this exercise. Health Trusts were being dissolved and Primary Care Trusts (PCTs) were formed in their place. In some cases this necessitated a virtual complete reallocation of the sample wards to new PCTs. Of course, many personnel changes also occurred during this process and new contacts needed to be established with those who might be willing to cooperate with our requests and coordinate health visitors' help.

This exercise benefited vitally from the help and experience of the research team including Neville Butler and the financial support of the International Centre for Child Studies (ICCS) while ESRC made available for

electoral ward maps. In spite of the difficulties mentioned, the study was successful in securing the help of a large number of health visitors whose cooperation and that of their managers was purely voluntary, help which was greatly appreciated by the MCS research team. In all, in spite of a major health service reorganisation at Trust level, 151 Trusts agreed for their health visitors to join. Only four Trusts declined to take part (three in England covering seven wards and one in Scotland covering five wards), whilst four English wards were never successfully allocated to a Trust (often as a result of continued dispute between two or more trusts as to which one should take responsibility). Over 3,000 health visitor packs were mailed out in 2001 to Trusts and Health Visitors information which enabled health visitors to provide details and reassurance to a large number of participants in MCS I. This contact produced 56 new cohort members as well as identifying over 150 babies who had moved home though many of the latter were already known to the MCS research team but sometimes under a different address.

CHAPTER 3 PILOT SURVEY

3.1 Procedure and response data

Parallel to making contact with health visitors throughout the UK, we developed a questionnaire for health visitors to collect neighbourhood information from them. An advisory team was set up, consisting of members of the research team and two academics with expert knowledge of health visiting practices[2], in order to assess the design of a questionnaire before piloting. In March 2002 the South West Multi-Centre Research Ethics Committee Protocol Amendment Committee was informed of our intentions to pilot the questionnaire, and after receiving permission from them to proceed (with certain provisos), pilot questionnaires were sent to people we believed could report on forty electoral wards, in May 2002, throughout England, Wales, Scotland and Northern Ireland. Maps of the relevant electoral wards accompanied the questionnaires except for Northern Ireland where lists were sent of postcodes instead. A 'feedback' form was also enclosed allowing respondents to comment on the design and content of the pilot questionnaire. The wards selected varied in size and location and were covered by Health Trusts which most of whom the team had already established good relationships.

The responses to the pilot health visitor survey are shown in Table 1 below.

Table 1 Responses to the pilot health visitor survey, May 2002

	England	Wales	Scotland	Northern Ireland	Total
Total questionnaires and feedback forms sent out	24	4	6	6	40
Number of full questionnaires returned (per cent of total)	10 (42%)	2 (50%)	1 (17%)	5 (83%)	18 (45%)
Number of full feedback forms returned (per cent of total)	8 (33%)	1 (25%)	1 (17%)	5 (83%)	15 (38%)

[2] In addition to the second author, this included Neville Butler, Peter Shepherd, Kate Smith, Ian Plewis, Helen Bedford and Ros Bryar.

3.2 Conclusions from the Pilot

Shortage of time dictated that only two weeks could be allocated for return of pilot questionnaires. On the whole questionnaire which were completed and answered very well. Many interesting answers were given under the open-ended questions that asked what was good and bad about the area. In a few instances it was clear that some questions were left unanswered because tick boxes were a little too small or and blocks of questions were cramped. When asked for their contact address, health visitors had rarely included their postcode, so this would need to be requested more overtly, and a slightly larger window of response time would be needed since it occasionally took a whole fortnight for the questionnaire to arrive on the desks of some health visitors. All these modifications were included in the main-stage questionnaire and protocols.

The feedback regarding the questionnaire was very positive indeed and one or two comments were made concerning the MCS as a whole. Helpful suggestions were occasionally offered for further improvements. Some of the abbreviations, organisations and statutory initiatives mentioned in the questionnaire were not understood by some health visitors in Northern Ireland and we deduced that these were not relevant in this country. The questionnaire for Northern Ireland was adjusted to reflect these differences. Health visitors in Northern Ireland also stated that it was very difficult to complete the questionnaire with reference only to postcodes and would have preferred a map which was in fact made available for the main-stage survey.

Finally, the pilot identified that, in the case of large wards, it would be wise to send the questionnaire to a central clinic or surgery for completion by a number of health visitors who had joint knowledge of the whole area.

CHAPTER 4 MAIN SURVEY

4.1 Procedure

Following the pilot, the contact database was updated to ensure that the questionnaires would be sent to the right people. Where the team had details of a health visitor who was acting as a 'co-ordinator' for a ward, the relevant questionnaire was to be mailed directly to them. Otherwise, questionnaires were mailed to the local supervisor, for dissemination to relevant health visitors. The aim was that a single questionnaire should reach a health visitor for each MCS ward[3].

Three hundred and fifty three questionnaires were sent out in England, Wales and Scotland in early June 2002 with a closing date of late July 2002 (see Appendix 3). A black and white map of the ward to which the questionnaire related was included in the envelope. Questionnaires with maps were sent out for seventy Northern Irish wards in late June 2002, with a closing date of mid August (see Appendix 4). A further eleven questionnaires were sent out for Scottish wards at a similar time, for areas which had taken extra time to trace and print the relevant maps. All questionnaires were mailed with FREEPOST envelopes to encourage response. Questionnaires were not sent to those areas that had responded to the pilot survey, since the questionnaire content had barely changed. Questionnaires were also not sent to the three wards that had never successfully been allocated to a health trust during the main part of the MCS. Thus a total of 434 questionnaires were sent out in England, Wales, Scotland and Northern Ireland.

Reminder letters were sent to contacts in all English, Welsh and Scottish wards who had failed to return their questionnaires one week after the closing date, 144 in total. This prompted the return of more questionnaires and requests for duplicate questionnaires to be mailed out, many of which were completed and returned immediately. Postal reminders were sent out to Northern Ireland in September 2002, and in October 2002 the process of reminding all those who had still to respond, in all countries, began by telephone. This was an ongoing process and a second call was made in November 2002 to all those who still had not responded by November 2003. This continued beyond the date at which data for this report were captured for analysis (January 2003), since we aimed to continue adding questionnaire data to our database so that as complete a database as possible could be deposited with the archive. Once the reminder exercise

[3] We treated each electoral ward individually, even where they were amalgamated into clustered MCS sampling points.

was complete, a further 12 questionnaires had been returned in time for this report, and 38 questionnaires were received after January 2003. Details of these are incorporated in the database available for further research.

4.2 Weights for small wards

The questionnaire data were entered into a database (SPSS version 11.0[4]). Weights were attached because the original sample for the first sweep of the Millennium Cohort Study consisted of some sampling points made up of a combination of single wards and groups of merged (adjacent) wards (the latter called 'superwards' and grouped in this way due to very small numbers of expected births in each individual ward)[5] and the responses to the health visitor survey needed to be treated in a similar way. Weights were calculated according to whether a questionnaire was returned by a sampling point consisting only of a single ward (weight =1.0), or whether it had been returned by a ward from within a 'superward'. Where a questionnaire came from a sampling point consisting of a superward, and this was the only individual ward within the superward to have returned a questionnaire, the weight assigned to the data therein was also '1.0' (i.e. these data would have to represent the whole of that superward). Where questionnaires were returned by more than one ward within a superward, weights were assigned to each according to the proportion of births each represented within the issued sample.

4.3 Sampling stratification

The sampling points of the first sweep of the Millennium Cohort Study were also assigned to one of three strata in England and one of two strata in Wales, Scotland and Northern Ireland. There were 'advantaged' and 'disadvantaged' strata in all four countries, with ethnic areas forming a third stratum in England only. Likewise, the responses to the health visitor survey were coded using the same three strata.

[4] SPSS Inc. (2001). *Statistical Package for the Social Sciences*. Version 11.0. Chicago, Ill: SPSS Inc.
[5] For more information about the sampling frame used in the MCS, see Plewis, I. (2003). *The Millennium Study: Technical Report on Sampling, 2nd Edition*. London: Centre for Longitudinal Studies, Institute for Education, University of London.

4.4 Response data

In total, by mid January 2003, 302 questionnaires had been returned, representing 274 sampling points out of a total of 398[6]. Table 2 below shows the summary statistics for the response to the health visitor survey, compared to the total number of sampling points. These take into account the weights assigned (see 4.2), and are reported according to from which country and strata the response came. It is these data which form the basis of the analysis carried out and reported in the remainder of this report.

Table 2 Responses to the main health visitor survey, by country and strata, January 2003

		Total number of sampling points (where 'superwards' constitute a single point or cluster)	Number of sampling points responding to health visitor survey (also as %ge of total)
England	Advantaged	110*	71 (65%)
	Disadvantaged	71	47 (66%)
	Ethnic	19	9 (47%)
	Total	*200*	*127 (64%)*
Wales	Advantaged	23	16 (70%)
	Disadvantaged	50	36 (72%)
	Total	*73*	*52 (71%)*
Scotland	Advantaged	32	23 (72%)
	Disadvantaged	30	23 (77%)
	Total	*62*	*46 (74%)*
Northern Ireland	Advantaged	23	16 (70%)
	Disadvantaged	40	33 (83%)
	Total	*63*	*49 (78%)*
Total		***398***	***274 (69%)***

* Three advantaged sampling points all in England were not sent questionnaires in this survey and so the total possible number of returns for this category was 107. This raises the survey response rate in this category to 66%.

[6] The additional 38 questionnaires received beyond this date represent a further 32.5 sampling points.

4.5 Refusals

Health visitors in seven single wards in England refused or were unable to participate in the survey (representing six sampling points). In addition, health visitors in one ward (representing a single sampling point) in Scotland were unable to participate. No refusals were received from health visitors in Wales or Northern Ireland. Thus, outright refusals were received from less than 2% of the sampling points, and the main problem encountered was not getting a reply for an unknown reason.

4.6 Summary

Thus, the overall coverage of MCS sampling points from the HV survey, calculated at January 2003, was 69%. Health visitors in Northern Ireland tended to be most co-operative, with responses received from four out of every five sampling points. This might have been influenced by a timely visit by the survey team to Belfast be the result of having convened a meeting to explain the survey to health visitors representatives from participating wards from all over Northern Ireland. Responses in England were received from two out of every three sampling points. Response rates were similar from advantaged and disadvantaged areas, except in Northern Ireland where responses were more likely to come from a disadvantaged sampling point. Finally, the responses from English sampling points were lower from ethnic areas – these returned only half of their questionnaires.

From this point onwards, when 'wards' are referred to in this report, it is the weighted sampling points, including clusters of single wards or 'superwards', which form the survey sample that are alluded to (totalling 274 in number).

4.7 Caveats

Before moving on to the analysis of the data, a number of caveats should be borne in mind during the reading of these findings:

1. As a postal survey with a 69% response rate, we cannot guarantee that those health visitors who returned a questionnaire are representative of all health visitors to whom a questionnaire was (or should have been) sent, or that the wards in which they worked are representative of all wards for which questionnaires were sent out.

2. Given that health visitors do not organise the geography of their work based upon electoral wards, we cannot guarantee that the questionnaires they completed were done with strict adherence to the maps and postcodes to which each one related.

3. The survey is totally reliant on the knowledge of the health visitor completing the questionnaire. Where health visitors were new to the area (which was often the case given the current climate of high staff turnover) it is clear that they may not have known whether various services exist. It is equally true that, along with varying degrees of local knowledge, health visitors also possess varying degrees of time available and the motivation to complete this postal survey. This report will thus be, in part, a comment on what health visitors do and do not know about the areas in which they work, as well as what services are actually available to the young families living there.

4. We have not presented any tests of statistical significance of differences between strata or countries. Estimates are unweighted within the 9 strata, but weighted estimates are shown in Appendix 5 for the four countries of the UK and the UK as a whole in to correct for the over-sampling of certain strata.

CHAPTER 5 RESULTS: ALL SERVICES

The detailed answers received to each of the questions contained in the questionnaire are shown in Appendix 5. In this Chapter, we aims to summarise the main results, and give a broad overview of the information supplied by health visitors, including details on: services/topic areas in which health visitors were less well-informed; services which were widely available; services which were more sparse; and, where evident, the main differences between countries and strata. The results are presented in subsequent chapters according to the main sections/headings contained in the questionnaire (i.e. childcare, health, family support, leisure and statutory initiatives). In each of these sections health visitors had been asked to comment on the availability of a range of services which might be provided within the area itself or in adjacent areas which people in the survey area could use. We were mindful that the mere availability of a service did not mean that it was easily accessed by the local population and we were especially interested in the ability of young families without the use of a car to access the services identified. We thus asked health visitors to bear this in mind when completing the questionnaire, and so we refer to 'access to' a range of services in this report.

The questionnaire asked about access to a total of 92 named services. When these were summed for each ward, it was evident that access to all services was normally distributed with 86% of wards having access to between 30 and 59 services. Table 3 below shows how access varied across countries and strata.

Table 3 Access to the number of all 92 named services, by country and strata

Country	Strata	No. of wards	Mean number of services available	Range of number of services available	Standard deviation
England	Advantaged	71	44	21-65	9
	Disadvantaged	47	47	27-65	9
	Ethnic	9	49	35-69	11
Wales	Advantaged	16	43	31-65	10
	Disadvantaged	36	41	25-60	8
Scotland	Advantaged	23	45	19-72	13
	Disadvantaged	23	42	25-54	9
Northern Ireland	Advantaged	16	39	20-53	9
	Disadvantaged	33	39	24-54	8
	Total	***274***	***43***	***19-72***	***10***

Contrary to expectation there was no systematic tendency for service to be better in advantage wards. Availability in the English disadvantaged and ethnic wards was better than in the advantaged areas, whereas availability in the Scottish and Welsh advantaged wards was lower than in their disadvantaged wards. There was no differentiation in availability of total services in Northern Ireland according to strata. In fact country differences within stratum were found to be statistically significant. The lowest level of services in Northern Ireland significantly below England, as also was the intermediate level of services is the disadvantaged areas of Wales and Scotland compared to England.

Where figures are quoted throughout the remainder of the results section, these are as percentages of the total valid responses for that question, for that group of wards, i.e. the response denominator is always the number of wards, unless otherwise stated.

CHAPTER 6 RESULTS: CHILDCARE SERVICES

6.1 Access to all childcare services

A total of 16 named childcare services were asked about in this section of the questionnaire, listed in Box 1 below[7].

Box 1 Named childcare services listed in the questionnaire

1. Registered Childminders
2. Employer provided Childcare
3. LA provided Nurseries
4. Private Nurseries
5. Neighbourhood Nurseries
6. Social Services Sponsored Childminding Schemes
7. Early Excellence Centre
8. Pre-school Learning Alliance
9. Private Nursery School
10. L.A. Nursery School
11. Nursery Classes in Primary/Infants Schools
12. Playlink Scheme
13. Breakfast Clubs
14. After-school Clubs
15. Summer Play Schemes
16. Story-telling sessions

When access to childcare services was summed for each ward results showed that it was normally distributed, with 78% of areas accessing between 5 and 10 childcare services. Table 4 shows how access to numbers of services varied across countries and strata.

[7] For the purposes of this analysis, questions 1.10 and 1.11 have been merged to form one question (namely access to any Local Authority-provided nursery classes).

Table 4 Access to the number of all 15 named childcare services by country and strata

Country	Strata	No. of wards	Mean number of services available	Range of number of services available	Standard deviation
England	Advantaged	71	7	1-14	3
	Disadvantaged	47	10	2-13	3
	Ethnic	9	9	5-14	3
Wales	Advantaged	16	7	2-11	3
	Disadvantaged	36	7	3-11	2
Scotland	Advantaged	23	8	2-14	3
	Disadvantaged	23	8	1-11	2
Northern Ireland	Advantaged	16	6	2-10	2
	Disadvantaged	33	7	2-10	2
	Total	***274***	***7***	***1-14***	***2***

The number of accessible childcare services was slightly higher in England and slightly lower in Northern Ireland. The only country in which access was different for the various strata was in England, where access to childcare facilities was slightly greater in the disadvantaged and ethnic areas than in advantaged areas.

6.2 Access to specific childcare services

Almost half of the individual questions were answered well (response from at least 90% of health visitors). Questions that health visitors knew least about availability included Playlink schemes; Pre-School Learning Alliance (PLA); Neighbourhood Nurseries; Breakfast Clubs; and, Early Excellence Centres. It is possible that this was partly due to some of these being country-specific (i.e. located only in England, such as the PLA).

Overall, most health visitors reported their areas had access to: registered childminders (92%); Local Authority nursery school/classes (89%); summer play schemes (82%); and, private nurseries (75%). Access was much lower for: Playlink schemes (13%); employer-provided childcare (22%); and, Neighbourhood Nurseries (26%).

Further analysis by country and strata showed:

- There was widespread access to **registered childminders** and **local authority nursery classes/schools** throughout the UK, in all areas.
- There was a distinct lack of **employer-provided childcare** in Northern Ireland, whilst provision was greatest in the advantaged wards of Scotland and Wales, and in the English ethnic areas.
- **Local Authority** day nurseries tended to be accessible in disadvantaged and ethnic wards, except in Northern Ireland where provision was fairly equal across strata.
- There was particularly high access to **private nurseries** in England. The advantaged areas had greater access, except in Wales where greater access was reported in the disadvantaged areas.
- The greatest access to **Neighbourhood Nurseries** was in the disadvantaged areas of Scotland. Access was greater in all disadvantaged areas, except for Wales, where access was similar across strata. This was an interesting finding given that this initiative was set up originally only in England.

Neighbourhood Nurseries are part of the Government's National Childcare Strategy, a strategy which aims to create one million new childcare places for 1.6 million children across the country by 2004. This involves creating 45,000 new day-care places in 'neighbourhood nurseries', which are those that are located in the most disadvantaged areas of the country where many families have not been able to access childcare previously. Thus, this initiative aims to support children and families in the most disadvantaged areas by providing new childcare services, and, although nurseries will normally be located in the 20% most deprived wards in England, pockets of deprivation in more affluent areas have also been considered.

- The best access to **Social Services-sponsored childminding schemes** was in English ethnic and Scottish disadvantaged wards.
- Most **Early Excellence Centres** were accessible from English disadvantaged and ethnic wards. Accessibility seemed to be very limited in other countries, which is to be expected given that these centres were set up originally only in England.

Early Excellence Centres (EECs) are part of a Government programme, originally introduced in England in 1997 to develop and promote models of high quality, integrated, early years services for young children and families. Specifically, they seek to demonstrate and disseminate models of excellence in the delivery of centre-based integrated multi-agency services, which meet the needs of children and families, raise educational standards, increase opportunities, support families, reduce social exclusion, increase the health of the nation and address child poverty. This is done through offering models of high quality one-stop-shop integrated education and day care for young children, and of services and opportunities for parents, carers, families and the wider community both directly and in co-operation with other providers. Approximately half of the EECs in England to date are in disadvantaged areas.

- The **Pre-School Learning Alliance (PLA)** tended to be most accessible in England, which is not surprising given that the PLA is a charitable organisation based in England. However, it is interesting to note that, in light of this fact, at least one health visitor in all of the other countries stated that this childcare service was accessible by the people in their area. It is possible that there are equivalents to the PLA in the other UK countries, however, given the very small numbers responding "Yes" to this question in Wales, Scotland and Northern Ireland, the equivalents, if they exist, are seemingly very sparse.

The Pre-School Learning Alliance (PLA) represents and supports 16,000 community pre-schools in England. Registered as an educational charity, the Alliance is the national dimension of the pre-school movement, which began in 1961 when, in the absence of state provision, parents started their own self-help nursery schools. It supports the work of community pre-schools through training courses, quality assurance systems, local visiting by skilled advisers, publications and other merchandise, advice and helplines, advocacy, and help with PR and fundraising.

- There was greater access to **private nursery schools** in England and Scotland. Access also tended to be greater in advantaged areas and English ethnic wards.
- **Playlink Schemes** were mainly accessible from English wards, especially the disadvantaged and ethnic areas. See Appendix 5.

Playlink has over forty years experience in free play provision, working with local communities to support provision of high quality opportunities for children's play that are stimulating, inclusive, and fun. It supports local play service providers across the country, promoting and disseminating the values and playwork practice learnt in the free play environment of adventure playgrounds. Their work includes advice and information, services and publications and lobbying and advice to the Government.

- There was high access to **breakfast clubs** in ethnic and disadvantaged areas of England. Access was far lower in Northern Ireland, although greater there in the disadvantaged areas than the advantaged. In Wales and Scotland, access was greater in the advantaged areas.
- There was fairly high access to **after-school clubs** across all countries and in all strata. Access was particularly high in English ethnic areas and throughout Wales and Scotland.
- Once again, there was very high access to **summer play schemes** across all countries and in all strata, but particularly so in English disadvantaged and ethnic areas.
- Access to story-telling sessions was very high throughout England. Elsewhere access to these sessions was fairly high and very even.

6.3 Access to other forms of childcare services

At the end of each section of the questionnaire was an open-ended question in which health visitors could report additional services in their area, over and above those pre-coded. This information is restricted to those who volunteered it. Write-in answers were received from 39 health visitors (representing 37 wards - 14% of the sample) concerning additional childcare services. Their comments, shown in Table 1.18 in Appendix 5, confirm family and friends provided an important source of childcare, especially in areas where other services were thin on ground. As one health visitor put it, "Lots of grandparents [provide childcare] due to lack of provision". Another comment was that families tended to accessed childcare at the places they were visiting as part of their everyday routine, e.g. adult education, church, sports centre, and library.

CHAPTER 7 RESULTS: HEALTH SPECIALISTS AND SERVICES

7.1 Access to all health specialists and services

This section of the questionnaire asked about a total of 18 named health specialists or services, listed in Box 2 below.

Box 2. Named health specialists and services listed in the questionnaire.

1. Clinical Psychologist
2. Speech Therapist
3. Physiotherapist
4. Occupational Therapist
5. Ear, Nose & Throat Specialist
6. Child and Adolescent Mental Health Services
7. Counselling Services, including Family Therapy
8. Screening for postnatal depression using relevant instrument
9. Identification of parents with episodic psychotic mental illness
10. Specialist provision for disabled children
11. Portage Services *(home-visiting for preschool children with special needs)*
12. Child Health Clinic
13. Lay Mothers' Breast-feeding Group
14. Community Mothers' Scheme
15. Family Planning Service
16. Youth family planning advisory service, e.g. Sexcare
17. Well Woman Clinic
18. Self-help groups

When these were summed for each ward it was evident that access to these services was positively skewed, with 87% of wards accessing between 12 and 17 health specialists or services. Table 5 shows how access varied across countries and strata.

Table 5 Access to the number of all 18 named health specialists and services by country and strata

Country	Strata	No. of wards	Mean number of services available	Range of number of services available	Standard deviation
England	Advantaged	71	14	7-17	2
	Disadvantaged	47	14	8-17	2
	Ethnic	9	14	12-17	2
Wales	Advantaged	16	15	10-17	2
	Disadvantaged	36	14	5-17	3
Scotland	Advantaged	23	14	6-17	2
	Disadvantaged	23	15	8-18	3
Northern Ireland	Advantaged	16	14	7-18	2
	Disadvantaged	33	13	7-17	3
	Total	***274***	***14***	***5-18***	***3***

These figures show that access to health specialists or services was very similar across countries and across strata.

7.2 Access to specific health specialists and services

Approximately two thirds of the individual health services questions were answered well (response from at least 90% of health visitors). Those that were not so well answered were all of those relating to waiting times for various health specialists and services, and the question relating to services about episodic psychotic mental illness.

Each ward had good access to: speech therapists (99%); clinical psychologists (91%); occupational therapists (91%); and, ear, nose and throat specialists (90%). Again, where information was provided, overall access was lower, although still fairly high, for physiotherapists (69%).

There was also particularly high access to: child health clinics (97%); family planning services (94%); child and adolescent mental health services (93%); postnatal depression screening (92%); specialist provision for disabled children (86%); counselling services (84%); and Well Woman clinics (81%). Access was much lower for Community Mothers' Schemes (16%).

Further analysis by country and strata of which details can be found in Appendix 5, Tables 1-30 showed:

- There was very high access to **all named specialists**, and **child health clinics**, across all countries and strata.
- **Waiting times** for named specialists tended to be slightly longer for disadvantaged areas, except in the case of occupational therapists and child and adolescent mental health services (CAMHS) where waiting times were the same, and for counselling services where waiting times tended to be longer for advantaged areas.
- Access to **CAMHS** was high across countries and strata, although slightly lower in disadvantaged parts of Scotland and in advantaged parts of Northern Ireland.

- CAMHS were the health services for which most wards reported waiting times of longer than one year. Very few places reported waiting times of less than one month (all located in England and Northern Ireland). Waiting times were much longer in Northern Ireland, and disadvantaged parts of Wales and Scotland.

- Access to **counselling services** was equally high across countries and strata, although slightly lower in disadvantaged parts of Wales.

- On the whole, people tended to wait between one and six months for **counselling services** throughout the UK. Waiting times of less than one month were only reported in England and in disadvantaged parts of Northern Ireland. They tended to be longer in Scotland, in disadvantaged parts of Wales and in advantaged parts of Northern Ireland.

- Few places reported access to a **clinical psychologist** in less than one month. Waiting times tended to be between one month and one year, although they were longer in Northern Ireland and Wales. A fair number of health visitors in disadvantaged parts of Wales and Northern Ireland reported waiting times of more than one year.

- People were more likely to be seen by a **speech therapist** in less than one month if they lived in England or Scotland. Waiting times were longest in Wales and Northern Ireland.

- Very few areas reported that people living there have to wait more than six months to see a physiotherapist. The places where people were more likely to be seen in less than one month were the advantaged areas of England and Scotland.

- On the whole, waiting times for **occupational therapists** were shorter, i.e. one to six months. In Wales, waiting times were more varied and sometimes extended to over one year. People were also more likely to wait longer to see an occupational therapist if they lived in Northern Ireland.

- In England and Scotland, waiting times to see an **ear, nose and throat (ENT) specialist** were between one and six months. They were slightly longer in these countries in the advantaged areas. In Wales and Northern Ireland waiting times were longer, and clustered more broadly between one and twelve months. They tended to be longer, in these countries, in the disadvantaged areas. Indeed, people were most likely to wait to see an ENT specialist for longer than one year in the disadvantaged areas of Northern Ireland.

- Access to **postnatal depression screening** services was reported to be equally highly available across all countries and strata, except in the ethnic areas of England.
- Although access to services which deal with the identification of **episodic psychotic mental illness** reported very high in disadvantaged parts of Scotland, there was, otherwise, less accessibility to these services in other parts of the UK, especially in disadvantaged parts of Wales England.
- Access to **specialist provision for disabled children** was greater in the advantaged wards of all countries except for England.
- There was lower access to **Portage services** in Northern Ireland, compared to the other UK countries, where access was fairly even with regard to country and strata. English ethnic areas had reported very high access.

Portage is a home-visiting educational service for pre-school children with additional support needs and their families, of which 140 are now registered with the National Portage Association in Britain. The aim of Portage is to support the development of young children's play, communication and relationships and to encourage full participation in day to day life within the family and beyond the home. Portage services are committed to securing inclusion in the wider community for all children and families in their own right. Support offered through Portage is based on the principle that parents are the key figures in the care and development of their child and Portage aims to help parents to be confident in this role whatever their child's needs may be.

- There was slightly greater access to **lay mothers' breastfeeding groups** in disadvantaged areas of Northern Ireland and Scotland, when compared to advantaged areas. In England and Wales the reverse was true.
- English ethnic and disadvantaged areas in England and Scotland had greater access to **Community Mothers' Schemes**. In Wales this difference was not quite as marked, in Northern Ireland access was slightly greater for those in advantaged areas.

Community Mothers Schemes are home visiting programmes co-ordinated by health visitors in local areas, the first of which was set up in Dublin in the 1980s. It recruits experienced parents to visit first-time parents to deliver an educational support package, the aims of which might be to: support families with young children; reduce inequalities in health; improve nutritional status of mothers and babies; and, reduce post-natal depression and childhood accidents.

- Access to **family planning services** was equally high across all countries and strata, although slightly lower in Scotland, especially in the advantaged wards.
- There was greater access to youth **family planning services** in England and much lower access in Northern Ireland. There was a slight tendency for there to be greater accessibility to this service in all disadvantaged areas.
- On the whole, access to **Well Woman Clinics** was high across countries and strata. Slightly lower access existed in disadvantaged areas of Northern Ireland, whilst access to these clinics was particularly high in advantaged parts of Wales and in all parts of Scotland.
- Access to **self-help groups** was fairly high and even across all countries and strata, although these groups were slightly less accessible in Northern Ireland.

7.3 Access to other health specialists and services

Write-in answers about access to other local health specialists were received from 70 health visitors (representing 70 wards - 24%), who supplied 91 answers, the contents of which are shown in Table 2.12 in Appendix 5. The most commonly reported single answer was 'Paediatrician/Paediatric Clinic' (27% of all answers given, and reported by 36% of health visitors supplying further information).

7.4 Access to other health services

Write-in answers about access to other local health services were received from 84 health visitors (representing 75 wards **or** - 27%), who supplied 148 answers, the contents of which are shown in Table 2.30 of Appendix 5.

The most frequent answer given in this section was postnatal services and other baby/child-related services (in total, 40% of all write-in answers to this question).

CHAPTER 8 RESULTS: FAMILY SUPPORT SERVICES

8.1 Access to all family support services

A total of 26 named family support services were asked about in this section of the questionnaire, listed in Box 3 below.

Box 3 Named family support services listed in the questionnaire

1. National Childbirth Trust Groups
2. Family Welfare Association
3. Family Centre (voluntary or statutory sector), e.g. Barnardos
4. Family Befriending Services
5. Home Start (provides family support through home visiting)
6. Ormiston Trust (provides support for families and children)
7. Link workers/Interpreters
8. Family Service Units (provides services for disadvantaged families and communities)
9. Welcare (provides information, advice and counselling for families)
10. Newpin (works to protect and preserve mental health in parents and children, and to prevent child abuse)
11. Women's Aid (works to end domestic violence)
12. KIDS (provides help for children with disabilities and their families)
13. BREAK (provides residential and day care services for families with special needs)
14. Children's Society
15. NCH Action for Children
16. Kids Club Network
17. Minority ethnically specific, e.g. Bangladeshi Welfare Association, Society of Asian Disabled
18. Religion specific, e.g. Catholic Child Welfare, Muslim Welfare Association
19. Parent Craft classes
20. Parenting Programmes
21. Pippin (Parents In Partnership Parent Infant Network)
22. Father Groups/Projects
23. Grandparents' Group
24. Swap-shop for children's clothes
25. Equipment Loan Service
26. Credit Unions

When these were summed for each ward it was evident that access to these services was slightly negatively skewed, with 75% of wards accessing between 5 and 11 family support services. Table 6 below shows how access to family support services varied across countries and strata.

Table 6. Access to the number of all 26 named family support services by country and strata.

Country	Strata	No. of wards	Mean number of services available	Range of number of services available	Standard deviation
England	Advantaged	71	8	3-14	3
	Disadvantaged	47	9	4-17	3
	Ethnic	9	11	8-18	3
Wales	Advantaged	16	8	3-15	4
	Disadvantaged	36	8	3-20	3
Scotland	Advantaged	23	8	1-16	4
	Disadvantaged	23	8	3-15	3
Northern Ireland	Advantaged	16	8	3-12	3
	Disadvantaged	33	7	3-15	3
	Total	***274***	***8***	***1-20***	***3***

There were a higher number of family support services accessed in ethnic areas of England. Elsewhere, access to overall family support services was very similar, though there is a marginally lower level of services in Northern Ireland disadvantaged areas.

8.2 Access to specific family support services

Approximately one quarter of these questions were answered well (response from at least 90% of health visitors). Questions that health visitors knew least about were those concerning access to: the Family Welfare Association; the Kids Club Network; and the Ormiston Trust.

Among responders, there was particularly high availability reported to: Parent Craft Classes (95%); Parenting Programmes (88%); Women's Aid (84%); and, Home Start (70%). Access was much lower to: Ormiston Trust (3%); Grandparent's Groups (3%); and, Newpin (7%).

Further analysis by country and strata shown in Tables 3.1-3.28 of Appendix 5 showed:

- Access to **National Childbirth Trust** groups was greater in England compared to the rest of the UK. Access tended to be greater in advantaged areas, except in Wales where access was slightly skewed towards disadvantaged areas.

The National Childbirth Trust is a registered charity, in contact with 300,000 parents and parents-to-be throughout the UK, through a range of antenatal classes, helplines and social and educational events. The Trust aims to help all parents to enjoy an experience of pregnancy, birth and early parenthood, which enriches their lives and gives them confidence in being a parent.

- There were lower levels of access to the **Family Welfare Association** in disadvantaged areas of Wales, Scotland and Northern Ireland. Access to the services this organisation provides was highest in the English ethnic wards.

The Family Welfare Association is a registered charity, which was originally set up in 1869, and now works in the following areas: mental health services for adults; children and family services; community resource centres; WellFamily services in GP practices; general family advice, counselling and information; grants for families in need; and, educational grants advice. It provides family and day centres where people can seek support and join in a variety of activities and training programmes.

- Access to **family centres**, such as those supplied by Barnardos, was greater in the disadvantaged areas of England, Scotland and Wales, than in the advantaged areas of these countries. In Northern Ireland access was quite high and even across strata. Overall, access was least in Scotland.
- **Family befriending services** were best accessed in Scotland. Access was much lower in disadvantaged areas of Wales and Northern Ireland.
- **Home Start** was particularly widely accessed in Wales and ethnic areas of England. In Scotland, access tended to be greater in disadvantaged wards, whereas in Northern Ireland, access was greater from the advantaged wards.

Home Start is a national charity, set up thirty years ago, that recruits volunteers to visit families regularly, in their own homes, usually once a week for a few hours. The visits are flexible and the volunteer and family together decide how the time will be spent. Over 300 of these schemes now exist throughout the UK.

- Access to the **Ormiston Trust** was very low, even in England which is the only country in which the charity operates.

The Ormiston Trust operates a number of charitable projects in England, principally in the area of the welfare of disadvantaged children and families. These projects often provide support and information for children and families, including drop-ins, toddler groups and one-to-one support for parents.

- There was high access reported to **link workers/interpreters** in ethnic and disadvantaged areas of England and in disadvantaged areas of Scotland. Access to these workers was much lower in Wales.

- Overall access to **Family Service Units**, **Welcare** and **KIDS** was low, although slightly greater in ethnic English wards.

  - *Since 1948 Family Service Units (FSUs) have consistently led and developed new methods that have become mainstream in family services, building foundations for support to a range of communities and developing services in: family support; early years; social inclusion; and work with schools. Situated within areas of deprivation FSUs often pioneer innovative projects and services that work to the direct needs of the local community. They recognise that poverty and inner city life are not the only form of disadvantage, having worked with survivors of sexual abuse, black families, lone and young parents, parents with learning disability, men and boys. They promote an ethos of anti-poverty, anti-violence and anti-discrimination.*
  - *Welcare is a Christian Charity set up to help families, who are experiencing some form of hardship or difficulty (e.g. one-parent families), to achieve a better quality of life. It aims to facilitate healthy family relationships and to provide opportunities for parents and children to fulfil their potential.*
  - *KIDS is an organisation which for thirty years has been dedicated to helping children with disabilities, and their families. It operates throughout most of England. Its services focus upon all of the child's needs including educational, social, developmental and emotional, and upon the whole family and not just on the child with disabilities.*

- Overall access to **NEWPIN** was low, although slightly greater in ethnic English wards, and in Northern Ireland as a whole.

  NEWPIN is a voluntary organisation working with families to help break the cycle of destructive family behaviour by: placing emphasis on emotional abuse as a precursor to physical and/or sexual abuse; developing the self-esteem and emotional maturity of parents; bring about lasting change in the quality of life for both parents and children; and, empowering parents and children to take care of their lives. It works through a network of centres where parents and their children develop in an atmosphere of equality, empathy and respect.

- Access to **Women's Aid** was particularly high in Wales, as a whole. It was also even across strata in Wales and Scotland. In Northern Ireland access was lower for the advantaged areas, and in England for the ethnic areas.

  Women's Aid is a national charity working to end domestic violence against women and children. Their mission is to advocate for abused women and children and to ensure their safety by working locally and nationally to: offer support and a place of safety to abused women and children by providing refuges and other services; empower women affected by domestic violence to determine their own lives; recognise and meet the needs of children affected by domestic violence; promote policies and practices to prevent domestic violence; and, raise awareness of the extent and impact of domestic violence in society.

- Overall access to **BREAK** was low, although slightly greater in advantaged areas of Scotland.

BREAK is a registered charity that provides help for children, adults and families with special needs, such as challenging behaviour or physical and learning disabilities. The help that BREAK can offer includes respite care, specialist child care and UK holidays in Norfolk and the West Country. The charity also provides a wide range of services such as: homes for children; family assessments; and, day care for adults with learning disabilities.

- Access to the **Children's Society** was not reported in Northern Ireland. Elsewhere, access was greater in disadvantaged parts of England and in advantaged parts of Wales.

The Children's Society has been striving to help children and young people since 1881 and has played an important role in addressing the injustices of society, past and present. Today it helps to: protect children who runaway from home; identify and rectify the causes of disruptive behaviour in schools; protect children in the youth justice system; and, get children involved in their communities.

- There was fairly high access to **NCH Action for Children** in Wales, where disadvantaged areas were particularly well served. Northern Ireland had very limited access to this family support service (or an equivalent).

NCH Action for Children works to improve the lives of the UK's most vulnerable children and young people by offering them diverse, innovative and responsive services and by campaigning for change. Their projects are developed in response to local needs, and fall into three broad categories: those for children at risk; those for families in need of support; and, those for vulnerable young people.

- Access to the **Kids' Club Network** was greater in England than in the other UK countries. There was very limited access elsewhere.

The Kids' Clubs Network is the national organisation for out-of-school childcare. Established twenty years ago as the 'National Out of School Childcare Alliance', Kids' Clubs Network has raised the profile of out-of-school childcare at local, regional, and national level. The organisation offers advice and support to out of school clubs, parents, children, childcare providers, Government, local authorities, employers and Early Years Development and Childcare Partnerships.

- Not surprisingly, **minority ethnically-specific** family support services were best accessed in the ethnic English wards. They were also mainly found in disadvantaged areas of England.
- **Religion-specific** family support services were best accessed in the ethnic English areas. Elsewhere they were mainly found in disadvantaged parts of Wales.

- There were no obvious differences in access to **Parentcraft Classes** according to country or strata; access was very high wherever the health visitor was based.

Parentcraft classes, or antenatal classes, are provided for expectant mothers and their partners so that they can educate themselves in preparation for labour, the birth and the care of their new-born infant. These classes are offered to all pregnant women, regardless of age, marital status, nationality or occupation.

- Access to **Parenting Programmes** was also high throughout the UK, although ethnic English wards were slightly less well catered for.

Parenting programmes are a form of support, which has grown rapidly in the UK over the last 5-10 years, specifically aimed to help parents improve their parenting skills. Some of these have been developed by national organisations and are widely offered in local communities. Others rely on the expertise and interest of particular professionals and are still quite locally based. They are generally offered on an open-access basis to parents who learn about them through local schools, churches or other community organisations.

- Overall access to **Pippin** was low, although slightly greater in advantaged parts of England.

PIPPIN (Parents In Partnership - Parent Infant Network) is a national charity whose main aim is to maintain and improve the emotional health of families during the period surrounding the birth of a new baby. Through trained facilitators (e.g. midwives, health visitors, family and social workers, childbirth and parenting educators, counsellors, nursery nurses, childcare workers), PIPPIN are introducing parenting classes as standalone courses, and integrated with conventional Parentcraft classes, in many parts of the country.

- Access to **father groups and projects** was mainly the sole province of English wards, and even here, was fairly limited.
- **Grandparent's groups** were equally sparse, and once again, mainly found in English wards.
- **Swap-shops for children's clothes** were mainly found in England and Scotland and are, again, few in number. There were none, however, in ethnic English wards and advantaged parts of Wales and Northern Ireland.
- Access to **equipment loan services** was greater in England than elsewhere. Access was slightly greater in Welsh and Scottish disadvantaged areas, compared to their advantaged areas. In Northern Ireland, the reverse was true.

- **Credit Unions** were particularly well accessed in Northern Ireland. They were also found in reasonable numbers in England's disadvantaged and ethnic wards.

A credit union is a financial co-operative, which is owned and controlled by its members who save in a common fund. As well as being a good savings option, with successful credit unions paying an annual dividend of up to 8%, the money saved can be used to make low interest loans to other credit union members. Only those who come within the common bond of the credit union can join it and make use of its services. The government and many other organisations see credit unions as a valuable tool in their mission to tackle financial exclusion. Credit Unions are active in over 80 countries with over 100 million members worldwide.

8.3 Access to other family support services

Write-in answers about access to other local family support services were received from 58 health visitors (representing 54 wards - 20%), who supplied 81 answers, the contents of which are shown in Table 3.28 in Appendix 5. A large number of both named and general family support services were mentioned here, with an indication of the variety of agencies supplying these services, from the formal (e.g. Social Services), through the voluntary and charitable (e.g. SNID, furniture recycling), to the very informal (e.g. neighbours, friends).

CHAPTER 9 RESULTS: LEISURE SERVICES

9.1 Access to all leisure services

A total of 18 named leisure services were asked about in this section of the questionnaire, listed in Box 4 below.

Box 4. Named leisure services listed in the questionnaire.

1. Open spaces with safe play areas
2. Adventure playground, skateboarding/roller-skating area
3. Private Leisure Centre (members-only)
4. Public Leisure Centre
5. Public Swimming Pool
6. Bowling Alley
7. Junior sports schemes, e.g. gymnastics
8. Activity centre, e.g. Whacky Warehouse, Jungle Gym
9. Parent and Toddler Group
10. Tumble Tots Groups/Baby Gym/Crescendo
11. Playbus
12. Toy Library
13. Mobile Library
14. Book Start Schemes
15. Music-making groups
16. Cinema
17. Museum
18. Zoo/City Farm

When these were summed for each ward it was evident that access to these services was slightly positively skewed, with 70% of wards accessing between 9 and 15 leisure services. Table 7 below shows how access varied across countries and strata.

Table 7 Access to the number of all 18 named leisure services by country and strata

Country	Strata	No. of wards	Mean number of services available	Range of number of services available	Standard deviation
England	Advantaged	71	12	3-18	3
	Disadvantaged	47	12	3-18	4
	Ethnic	9	10	5-15	4
Wales	Advantaged	16	12	4-18	4
	Disadvantaged	36	11	0-17	4
Scotland	Advantaged	23	13	5-17	3
	Disadvantaged	23	9	3-14	3
Northern Ireland	Advantaged	16	10	4-17	3
	Disadvantaged	33	10	5-16	3
	Total	***274***	***11***	***0-18***	***4***

Availability was fairly even in Wales and in non-ethnic areas of England. It was lower for Northern Ireland as a whole, and far more varied in Scotland, in which it was lowest for the disadvantaged areas and greatest for the advantaged wards.

9.2 Access to specific leisure services

Nearly three-quarters of questions about access to specific leisure services were answered fully (response from at least 90% of health visitors). Questions that health visitors knew least about included those concerning availability of music making groups; mobile libraries; junior sports schemes; Playbus; and, activity centres such as Whacky Warehouses or Jungle Gyms.

Overall, a particularly high local availability was reported parent and toddler groups (99%); Book Start schemes (92%); open spaces with safe play areas (92%); public swimming pools (88%); and, public leisure centres (86%).

Further analysis by country and strata reported in Tables 4.1 to 4.20 of Appendix 5 showed:

- Although access to **open spaces with safe play areas** was, on the whole, very high, the places in which it was more limited were the ethnic English wards, disadvantaged parts of Scotland and all parts of Northern Ireland.
- Advantaged parts of Scotland, and the advantaged and disadvantaged parts of England, reported had the most access to **adventure playgrounds** (including skateboarding parks, etc.) and **private leisure centres**.
- **Public leisure centres** seemed to be particularly available to families living in the disadvantaged parts of both Wales and Northern Ireland.
- Disadvantaged parts of Wales also had the best access to **public swimming pools**, whilst access to this service was lowest in disadvantaged parts of Scotland.
- Access to **bowling alleys** was highly in ethnic English wards, yet particularly low in disadvantaged parts of both Wales and Scotland. In Wales and Scotland, access to bowling alleys was much greater in the advantaged wards, whereas in Northern Ireland the reverse was true.

- **Junior sports schemes** were particularly available in advantaged parts of both Scotland and Northern Ireland and disadvantaged parts of Wales. Availability of these schemes was lowest in ethnic English wards.
- Availability to **activity centres**, such as ***Whacky Warehouses*** or ***Jungle Gyms*** were greater in non-ethnic parts of England and advantaged parts of Wales. It was lowest in advantaged parts of Northern Ireland.
- Groups such as **Tumble Tots, Crescendo and baby gyms** were most available for families living in advantaged parts of England and Scotland. Northern Ireland availability was much lower, most especially in disadvantaged wards.
- Access to a **Playbus** was low throughout the UK, although, where it existed, was most accessible in England and advantaged parts of Scotland.

The National Playbus Association promotes the use of converted vehicles for community, social and recreational purposes. Thus, a Playbus can be likened to a mobile nursery classroom which is timetabled to visit various areas within a community considered to have particular educational/recreational/social needs. The aim is often to provide exciting play opportunities for all users, and to meet each child's individual educational needs.

- **Toy libraries** were highly available in all parts of England, and also in disadvantaged Welsh wards and advantaged Scottish wards. Access was generally lower throughout Northern Ireland.
- Health visitors in Northern Ireland **reported the greatest availability of mobile libraries**. In all advantaged wards availability was greater when compared to the disadvantaged wards in each country.
- Advantaged wards in England reported much higher availability to **music-making groups** than elsewhere in the UK. Access was particularly low in Northern Ireland and in disadvantaged wards in Scotland.
- **Cinemas** were widely accessible in Northern Ireland and advantaged parts of both England and Scotland. Access was much lower in disadvantaged Scottish wards.
- Access to **museums** in advantaged areas outstripped that of disadvantaged/ethnic areas. It was especially high in advantaged parts of both Scotland and England.
- **Zoos and city farms** were more widely available to those families living in ethnic English wards and advantaged Scottish wards. Access was lowest in disadvantaged Scottish wards.

9.3 Access to other leisure services

Write-in answers about access to other local leisure services were received from 47 health visitors (representing 45 wards - 16%), who supplied 62 answers, the contents of which are shown in Table 4.20 in Appendix 5.

Just over one third of the write-in answers given in this section related to sport/hobby-related services. It was encouraging to see that health visitors named standard libraries as an important 'other' leisure service, highlighting the pleasurable and educative entertaining side of this educational resource.

CHAPTER 10 RESULTS: STATUTORY INITIATIVES

10.1 Access to all statutory initiatives

A total of 15 named statutory initiatives were asked about in this section of the questionnaire, listed in Box 5 below.

Box 5. Named statutory initiatives listed in the questionnaire.

1. Health Action Zone (HAZ)
2. Healthy Living Centre
3. Health Improvement Programme
4. Sure Start local programmes
5. Healthy Schools Initiative/Programme
6. Education Action Zone
7. Employment Zone
8. Housing Action Zone/Trust
9. Single Regeneration Budget
10. New Deal for Communities
11. Local Government Associations' New Commitment to Regeneration
12. Neighbourhood Renewal Fund
13. Local Agenda 21 *(promotes sustainable development and improves urban environments)*
14. Crime Reduction Programme
15. Drug Action Team

Health visitors were asked to state whether specified schemes were available *within* the ward in question, i.e. we did not ask whether these initiatives were accessible in an adjacent ward, as we had done previously with all of the other services. Since a certain number of these initiatives operate only in England, or England and Wales, the questionnaire asked health visitors also to consider equivalent initiatives or projects available to the families in their ward. In spite of the results showed that when these were summed for each ward, availability reported to these services was very negatively skewed, with 78% of wards accessing four or less initiatives. Table 8 below shows how access varied across countries and strata.

Table 8 Access to the number of all 15 named statutory initiatives by country and strata

Country	Strata	No. of wards	Mean number of initiatives operating	Range of number of initiatives operating	Standard deviation
England	Advantaged	71	2	0-10	2
	Disadvantaged	47	5	0-11	3
	Ethnic	9	5	1-12	4
Wales	Advantaged	16	3	0-15	4
	Disadvantaged	36	3	0-8	2
Scotland	Advantaged	23	3	0-14	3
	Disadvantaged	23	3	0-8	3
Northern Ireland	Advantaged	16	1	0-3	1
	Disadvantaged	33	2	0-8	2
	Total	***274***	***3***	***0-15***	***3***

The range and mean number of statutory initiatives reported as accessible in Northern Ireland was even lower than in the other UK countries, especially in its advantaged wards. These initiatives are more common in the English disadvantaged and ethnic wards. Although the range of initiatives accessed in Welsh and Scottish advantaged wards was high (15 and 14 initiatives respectively), these figures accounted for just two separate wards; the upper range for the other wards in these areas was 5 or 6 initiatives.

10.2 Coverage of specific statutory initiatives

Only one out of the fifteen questions that constituted this section was answered well (response of 'Yes' or 'No' from at least 90% of health visitors). This initiative related to access to Sure Start local programmes (see section 10 of this report). Questions that health visitors knew least about – perhaps predictably were those concerning access to: Local Agenda 21; Local Government Associations' New Commitment to Regeneration; and, the Neighbourhood Renewal Fund.

Overall among those initiatives known to health visitors there was greater access to: Healthy Schools Initiatives/Programmes (56%); Drug Action Teams (55%); and, Crime Reduction Programmes (47%). Further analysis by country and strata showed (see Tables 5.1 to 5.17 of Appendix 5):

- Access to **Health Action Zones** were more likely to be declared by the health visitors in English ethnic and disadvantaged wards. This is to be expected given that nearly all HAZs are located in England and have been designed to target deprived areas.

In late 1997, the government established twenty-six Health Action Zones (HAZs) in England, in areas of deprivation and poor health to tackle health inequalities and to modernise services through local innovation. Although the HAZ communities vary significantly in their local characteristics, they face common problems of ill-health and disadvantage. HAZs represent areas of the country with some of the highest levels of deprivation and the poorest levels of health. In total, HAZs included 34 health authorities and 73 local authorities but since then there have been many changes within both health and local authority structures. The recent changes in the health services have led to HAZs being aligned with a Primary Care Trust in their locality. In 1999 a HAZ was also set up in Northern Ireland.

- Disadvantaged Scottish wards had greater access to **Healthy Living Centre** initiatives than elsewhere in the UK.

The Healthy Living Centre initiative is managed by the New Opportunities Fund (NOF) and was launched in January 1999. The initiative had a budget of £300 million from Lottery funds to develop a network of Healthy Living Centres UK-wide, with the aim of contributing to the reduction of inequalities in health and complementing national and local health plans. Areas and groups that represent the most disadvantaged sectors of the population have been targeted, mainly to focus on tackling the wider determinants of ill health and address factors such as social exclusion, mental health and poor access to services and diet and fitness.

- There were more **Health Improvement Programmes** in England than the other UK countries. There were also relatively more in disadvantaged parts of Scotland. Northern Ireland had much lower provision of these programmes.

Health Improvement Programmes (HImPs) were introduced in a White Paper late in 1997, and, over the course of the Local Modernisation Reviews within the NHS, have since developed into 'Health Improvement and Modernisation Plans' (HIMPs). HIMPs currently provide the process and vehicle for three-year, strategic planning across the local health system on both health improvement (and tackling the wider determinants of health) and NHS modernisation. Primary Care Trusts now have lead responsibility for the NHS working in partnership with other stakeholders, ensuring the involvement, from the outset, of local partner organisations including NHS Trusts, Local Authorities, the voluntary sector and local communities. Current Health Improvement and Modernisation Plans aim to: improve health and tackle inequalities; modernise and improve local services; provide a more comprehensive and effective planning process within the local health care system; and, support the development of partnerships with local authorities, the voluntary sector and other organisations.

- The **Healthy Schools Initiative** was most available to those living in disadvantaged and ethnic parts of England and in advantaged parts of Scotland. It was much lower in Northern Ireland as a whole.

The Healthy Schools Initiative is a nationally accredited scheme to help schools become healthier places. It was developed in 1999 to support the aim of improving the health of children in schools (originally launched through the 'Healthy Schools Programme' in 1998). The initiative sets a national quality standard that contains the criteria and level of achievement in health work which schools need to reach, in order to attain "Healthy School" status. Major topic areas affecting the health of children and young people in schools include: tackling inequalities at an early age; safety; sex and relationships; emotional health and well-being; drugs, alcohol and tobacco; healthy eating; school meals; physical activity; and, education for parenting and citizenship. Local healthy schools programmes, managed by partnerships between education and health, support schools in working towards addressing these issues.

- **Education Action Zones** were found mainly in English ethnic and disadvantaged wards. They were completely absent in Northern Ireland.

Education Action Zones (EAZs) were set up in England to allow local partnerships between schools, parents, the community, businesses and local authorities, to find radical and innovative solutions to their problems. Each zone originally received up to £1 million a year, for at least three years, a quarter of which was from business partners. The duration of funding for statutory EAZs has since been extended to a maximum statutory period of five years.

- There was no provision of **Employment Zones** in the Northern Ireland wards. Elsewhere provision was very sparse.

Employment Zones (EZs) represent a new approach by government to the long established problem of many people facing extended periods of unemployment, which has a high social and economic cost. In England Wales and Scotland, EZs address the intractable problems of long-term unemployment in the areas in which it is concentrated and attempt to break the cycle of unemployment and poverty which still afflicts many communities, through innovative and flexible partnerships between private and public sector organisations. Thus, the main aim is to help the long-term unemployed find new jobs.

- **Housing Action Trusts** were not widely available anywhere in the UK. Access was slightly greater in Wales than elsewhere. Access was also generally greater in the disadvantaged areas, except for in Wales where advantaged areas had greatest access.

Six Housing Action Trusts (HATs) were set up under the provisions of the Housing Act 1988 to regenerate some of the most deprived local authority estates in England. They are Non-Departmental Public Bodies (NDPBs), each managed by a board appointed by the Secretary of State for the Department for Transport, Local Government and the Regions (DTLR). The boards include elected representatives of residents on the estates and members of the local authority. Their main aim is to achieve a sustainable and long lasting improvement in the living conditions in their areas. They have four statutory objectives set out in Section 63(1) of the Housing Act 1988: to repair and improve their housing; to manage their housing effectively; to encourage diversity of tenure; and to improve the social, environmental and living conditions of their areas.

- Access to the **Single Regeneration Budget** was mainly in non-ethnic parts of England.

The Single Regeneration Budget (SRB) provides resources to support regeneration initiatives in England (although equivalents exist elsewhere, e.g. Strategic Development Scheme in Wales). It began in 1994, and brought together a number of programmes from several Government Departments, with the aim of simplifying and streamlining the assistance available for regeneration. The programmes have been carried out by local regeneration partnerships, the priority of which has been to enhance the quality of life of local people in areas of need by reducing the gap between deprived and other areas, and between different groups.

- The **Local Government Association's 'New Commitment to Regeneration'** was another initiative that was not widely accessed throughout the UK. Access was greater in Wales and Scotland compared to England and Northern Ireland. Access was also greater in disadvantaged areas, except for in Wales where the advantaged areas had best access.

New Commitment to Regeneration is a central government and Local Government Association (LGA) initiative, designed to encourage all sectors to work together in partnership to improve and maintain the quality of life of all who live and work in an area. It is concerned with regeneration in its widest sense, embracing social, economic and environmental issues. It seeks to establish a new relationship between central and local government, the private and community sectors, through local partnerships, so enhancing local accountability and transparency. Twenty-two 'Pathfinder' Authorities were originally set up, in diverse rural and urban areas throughout England, which have served as a model for subsequent Local Strategic Partnerships.

- Access to the **Neighbourhood Renewal Fund** and the **New Deal for Communities** was found mainly in ethnic and disadvantaged parts of England.

> - *The **Neighbourhood Renewal Fund** (NRF) aims to enable the 88 most deprived authorities in England, in collaboration with their Local Strategic Partnership (LSP), to improve services related to employment, economic performance, crime, educational attainment, health and housing, in order to narrow the gap between deprived areas and the rest of the country. Following the Spending Review 2000, the Government set targets for improved outcomes by public services in deprived neighbourhoods, which mean that Government departments, local authorities and other service providers are being judged for the first time on their performance in the areas where they are doing worst.*
> - ***New Deal for Communities** (NDC) is a key programme in the Government's strategy to tackle multiple deprivation in the most deprived neighbourhoods in England, giving some of the poorest communities the resources to tackle their problems in an intensive and coordinated way. The aim is to bridge the gap between these neighbourhoods and the rest of England, through partnerships who are required to tackle five key issues: poor job prospects; high levels of crime; educational under-achievement; poor health; and problems with housing and the physical environment.*

- **Local Agenda 21** was applied largely in England.

> *In 1992 world leaders met at The Earth Summit in Rio, Brazil. This summit marked an important milestone in the history of the relationship between humankind and the planet Earth because for the first time development throughout the world was considered with future generations and the planet in mind. This resulted in a document being drawn up, chapter 28 of which called on local authorities to work with their local communities to achieve a local action plan - a 'Local Agenda 21'. This strategy was to be developed out of a discussion with local citizens about what they think is important for the area, and should address the principle of sustainable development as its central issue. This process recognises the role local communities have to play in shaping their own future and it is an attempt to empower local communities in the decision making process. Local Agenda 21 operates in England, Wales, Scotland and Northern Ireland.*

- Health visitors report that **crime reduction programmes** were particularly evident in disadvantaged and ethnic wards in England, and in all parts of Scotland. They were much less evident in Northern Ireland.
- Disadvantaged (and English ethnic) areas were better served by **Drug Action Teams** than corresponding advantaged areas in all UK countries. Access in Northern Ireland to these teams was lower than elsewhere.

10.3 Sure Start local programmes

Since the MCS is being used as a control for the national evaluation of Sure Start local programmes (SSLPs), these initiatives are worthy of a separate section in this report. SSLPs are part of the government's programme to support children, parents and communities through the integration of early education, childcare and health and family support services. They are managed by the Sure Start Unit, along with other pre-school services and childcare. The first SSLP, which was announced in 1998, has worked by bringing together early education, childcare, health and family support to give a sure start to young children living in disadvantaged areas. These programmes start prenatally and provide services for children up to the age of four; they also provide childcare for children up to age fourteen, and in the case of those with special educational needs and disabilities up to age sixteen. The overall aims of the Sure Start Unit is to bring together universal, free, early education and more and better childcare, with greater support where there is greater need through childcare tax credit and children's centres, and by ongoing support for SSLPs.

Although SSLPs were in operation throughout the UK at the time of the MCS study, they were managed differently in Wales, Scotland and Northern Ireland than they are in England. In England, SSLP catchment areas could be identified by postcodes for analytic purposes, allowing some comparison to MCS areas, although the boundaries do not coincide with words. Outside England, SSLPs have been delivered very differently and are managed by the relevant country's assembly rather than the SSLP team themselves.

In validating the answers given by health visitors concerning access to SSLPs (through information relating to the presence of SSLPs in various wards, provided by the National Evaluation of Sure Start team (NESS)[8]), we have only been able to check the details supplied by health visitors in England by means of comparability of postcodes and the fact that a national evaluation is taking part in England. Mention should also be made of the fact that SSLPs have been 'rolled out' in several waves, and it is possible that at the time health visitors were questioned, a Sure Start local programme was not in operation in the area in question, yet this state of affairs could have changed by the time the validation data from the NESS team was available. As SSLPs do not always co-terminous boundaries, some health visitors may not

[8] This team, directed by Edward Melhuish, is based at Institute for the Study of Children, Families and Social Issues at Birkbeck College, University of London.

have known about a programme which covered only a small part of the ward about which they were questioned.

Bearing these points in mind, we asked health visitors if families had access to a SSLP whether it covered the whole or part of the ward in which we were interested. The results showed that, according to health visitors, access to SSLPs was particularly high in disadvantaged wards in England and Northern Ireland and ethnic wards in England, which is consistent with the fact that these programmes have targeted children in disadvantaged areas. However, access was particularly high in all parts of Wales, and was lower yet even across strata in Wales and Scotland, indicating that the targeting process may not work in a similar way or may not have been as successful.

Table 9 shows how the information supplied by health visitors in England compares with that of the NESS team:

Table 9 Comparison of information concerning access to Sure Start local programmes (SSLPs) in England provided by health visitors and the National Evaluation of Sure Start team (NESS)

				Access to SSLPs according to health visitors			
				Yes	No	Don't know	Total
Yes – SSLP in the ward according to NESS	Stratum	Adv.	Count	3	3		6
			% within Stratum	50.0%	50.0%		100.0%
		Disadv.	Count	24	6		30
			% within Stratum	80.0%	20.0%		100.0%
		Ethnic	Count	3	1		4
			% within Stratum	75.0%	25.0%		100.0%
	Total		Count	30	10		40
			% within Stratum	75.0%	25.0%		100.0%
No – no SSLP in the ward according to NESS	Stratum	Adv.	Count	4	59	2	65
			% within Stratum	6.2%	90.8%	3.1%	100.0%
		Disadv.	Count	4	13		17
			% within Stratum	23.5%	76.5%		100.0%
		Ethnic	Count	2	3		5
			% within Stratum	40.0%	60.0%		100.0%
	Total		Count	10	75	2	87
			% within Stratum	11.5%	86.2%	2.3%	100.0%

There was agreement between NESS and the health visitors in 105 out of 127 cases (83%). We can see that three-quarters of the NESS identified English SSLP wards were correctly identified by health visitors. Of the ten reports that SSLPs were not operating when NESS information states otherwise, it is possible that these represent SSLPs that were initiated after the health visitors were questioned, or the consequence of a lack of knowledge concerning ward boundaries, or part ward coverage. Health visitors were slightly more accurate in their reporting of an absence of access to a SSLP in their ward. However, there were ten health visitors who stated at the time that a programme was in operation in their ward who were contradicted subsequently by the NESS information.

We were interested to see whether those wards which were not covered in whole or part by a SSLP (according to health visitors) had access to the other named statutory initiatives, since this would have implications for the national evaluation of the SSLPs. Table 10 below shows this comparison. (It should be noted that these figures are affected by the fact that health visitors did not always know whether a particular initiative was present in their ward).

Table 10 Health visitors' report of the presence of Sure Start local programmes (SSLPs) compared to the presence of other named statutory initiatives

SSLP present?	Country				Other statutory initiatives present? No or Don't know	Other statutory initiatives present? Yes	Total
Yes	England	Stratum	Adv.	Count		7	7
				% within Stratum		100.0%	100.0%
			Disadv.	Count	3	25	28
				% within Stratum	10.7%	89.3%	100.0%
			Ethnic	Count		5	5
				% within Stratum		100.0%	100.0%
		Total		Count	3	37	40
				% within Stratum	7.5%	92.5%	100.0%
	Wales	Stratum	Adv.	Count	3	6	9
				% within Stratum	33.3%	66.7%	100.0%
			Disadv.	Count	3	19	22
				% within Stratum	13.6%	86.4%	100.0%
		Total		Count	6	25	31
				% within Stratum	19.4%	80.6%	100.0%
	Scotland	Stratum	Adv.	Count	1	10	11
				% within Stratum	9.1%	90.9%	100.0%
			Disadv.	Count		10	10
				% within Stratum		100.0%	100.0%
		Total		Count	1	20	21
				% within Stratum	4.8%	95.2%	100.0%
	Northern Ireland	Stratum	Disadv.	Count	5	5	10
				% within Stratum	50.0%	50.0%	100.0%
		Total		Count	5	5	10
				% within Stratum	50.0%	50.0%	100.0%
No	England	Stratum	Adv.	Count	16	46	62
				% within Stratum	25.8%	74.2%	100.0%
			Disadv.	Count	2	17	19
				% within Stratum	10.5%	89.5%	100.0%
			Ethnic	Count	1	3	4
				% within Stratum	25.0%	75.0%	100.0%
		Total		Count	19	66	85
				% within Stratum	22.4%	77.6%	100.0%
	Wales	Stratum	Adv.	Count	2	5	7
				% within Stratum	28.6%	71.4%	100.0%
			Disadv.	Count	8	5	13
				% within Stratum	61.5%	38.5%	100.0%
		Total		Count	10	10	20
				% within Stratum	50.0%	50.0%	100.0%
	Scotland	Stratum	Adv.	Count	5	7	12
				% within Stratum	41.7%	58.3%	100.0%
			Disadv.	Count	3	9	12
				% within Stratum	25.0%	75.0%	100.0%
		Total		Count	8	16	24
				% within Stratum	33.3%	66.7%	100.0%
	Northern Ireland	Stratum	Adv.	Count	10	6	16
				% within Stratum	62.5%	37.5%	100.0%

We can see that, where health visitors reported that a SSLP was present, there was a high likelihood of other named statutory initiatives in operation. This was the case in all parts of England, Scotland and Wales, and to a lesser extent in disadvantaged parts of Northern Ireland. Where SSLPs were not present, there were still many statutory initiatives apparently operating throughout England, in advantaged areas of Wales and in disadvantaged areas of Scotland. Slightly more disadvantaged areas in Northern Ireland reported other statutory initiatives operating than its advantaged areas, but these figures were lower than in other countries. When interpreting these results one should be cognisant of the very different manner in which SSLPs have been rolled out in each country, and the different modes of delivery and coverage, making comparisons across countries very problematic. However, one conclusion that could be drawn is that there was a sizeable group of disadvantaged wards in Northern Ireland and Wales that appeared away from health visitors report, to be without a SSLP or any other named statutory initiative.

10.4 Access to other statutory initiatives

Write-in answers about access to other local statutory initiatives were received from 14 health visitors (representing 13 wards - 5%), who supplied 14 write-in answers, the contents of which are shown in Table 5.17 in Appendix 5.

CHAPTER 11 RESULTS: BAD THINGS

When health visitors were invited to supply details concerning some of the bad things about the particular ward in question, in an open-ended question towards the end of the questionnaire, 273 write-in answers were received (representing a response from 90% of health visitors). These consisted of 1,440 separate comments (an average of approximately 5 comments per health visitor. Table 11 below shows how these responses varied between countries and strata.

Table 11. Numbers of responses to the question 'What are the bad things in your area?' by country and strata.

Country	Strata	No. of wards (percentages within stratum)
England	Advantaged	67 (94%)
	Disadvantaged	46 (98%)
	Ethnic	9 (100%)
Wales	Advantaged	13 (81%)
	Disadvantaged	31 (86%)
Scotland	Advantaged	19 (83%)
	Disadvantaged	20 (87%)
Northern Ireland	Advantaged	14 (88%)
	Disadvantaged	30 (91%)
	Total	***249 (91%)***

Overall, more bad things were listed by health visitors in English wards than health visitors from other countries. Within the other countries, there were fairly similar numbers of wards from each stratum for which bad things were listed, although there were consistently more bad things listed in disadvantaged wards than advantaged wards.

The comments about bad things in local areas have been grouped and are shown in Table 12 below. The single most frequent response concerning the bad things in the areas in which MCS babies are growing up related to inadequate public transport, followed by inadequate housing, and then lack of employment opportunities. Then followed lack of affordable childcare, lack of safe play areas, drug abuse and rural isolation. The most frequent topic of response received related to comments on service provision, followed by transport and roads and then crime.

Table 12 Features that health visitors regard as bad things for families with young children living in MCS areas

Bad things about the area		No. of responses
Service provision		-
Lack of affordable childcare		53
Lack of safe play areas		52
Lack of family/community centre		25
Lack of parent-toddler groups		16
Lack of Sure Start local programmes		16
Lack of statutory family support		16
Lack of free services		12
Lack of statutory funding/initiatives		11
Lack of after-school clubs		11
Inadequate Social Services		8
No parenting groups/programmes		7
Lack of school holiday schemes		5
Lack of Home Start		4
Poor multi-disciplinary team work		4
Overstretched services		4
Fragmented/patchy services		3
Lack of home safety equipment loan		2
Lack of breast-feeding support groups		2
Lack of places to breastfeed in shops		1
Lack of baby-changing facilities in shops		1
Lack of afternoon activities		1
Lack of evening facilities		1
Lack of wet-weather facilities		1
Lack of family-friendly cafes/restaurants		1
Lack of Citizen's Advice Bureau		1
Lack of visible policing		1
Poor Parish and Council provision		1
Lack of respite care		1
Provision for certain groups		-
Lack of facilities for -	Teenagers	35
	Young children	9
	Children with Special Needs	8
	Lone parents	8
	Young families	6
	Ethnic minorities	3
	Vulnerable families	2

Drug users	2
Travellers	2
Fathers	1
Elderly	1
Homeless	1
Characteristics of local residents	-
Lack of community spirit	12
Religious tension	12
Lack of extended family support	6
Overpopulated	6
Parents in full-time employment with little time for children	6
Lack of communication between community groups	5
Hostility to newcomers	5
Large student population	4
Little interest in services/community	4
High rates of accidents to young children	4
Low aspirations	4
Teenage pregnancy	3
Racism	3
Residents reluctant to walk	2
Uneducated parents	2
Language barriers	2
Poor diets	2
Concentration of problem families	2
Few young families	1
High numbers of disabled	1
Lack of foster carers	1
Young men disengaged	1
Low self-esteem	1
Relationship problems	1
Few professionals	1
High rates of Child Protection	1
Becoming depopulated	1
Wary of change	1
Housing	-
Inadequate housing	58
Expensive housing	15
Council Estates	7
Derelict housing	6
Inappropriately allocated housing	2
Families housed in Bed and Breakfast	1

Roads and Transport		-
Inadequate public transport		90
Residents need a car to access services		33
Heavy traffic		30
Expensive public transport		10
Expensive/lack of parking		9
Lack of pavements		8
Speeding cars		6
Poor access for pushchairs on public transport		4
Lack of traffic claming measures		4
Poor road planning		4
Lack of trains/rail links		4
Lack of safe road crossings		3
Lack of cycle routes		2
Amenities		-
Lack of shops		39
Lack of leisure/sports/recreational facilities		19
Expensive shops		10
Expensive leisure/sports/recreational facilities		5
Lack of fresh fruit and vegetables from local shops		5
Lack of swimming pool		4
Lack of public library		3
Lack of cinema		1
Health		-
Physical -	Lack of GPS	23
	Lack of Child Health Clinic/Health Centres	14
	Generally inadequate health services	13
	Lack of hospital	12
	Lack of NHS Dentist	9
	Long waiting lists	9
	Lack of Health Visitors	5
	Lack of Pharmacy	3
	Lack of link workers	3
	Lack of Midwives	1
	Lack of Speech Therapist	1
	High staff turnover – many vacant posts	1
Mental -	High rates of post-natal depression	7
	Rising mental health problems	4
	Rising suicide rates in young males	2
	Poor support for those with mental health problems	1

Education	-
Lack of pre-school provision	18
Lack of schools	8
Truancy	3
Overcrowded schools	1
Bullying	1
Lack of religion-specific schools	1
Lack of school nurses	1
Lack of adult education	1
Employment	-
High unemployment/lack of employment opportunities	57
Low wages	3
Long travel-to-work distances	3
Lack of manpower	1
Crime	-
Drug abuse	49
High crime rate	27
Alcohol abuse	18
Anti-social behaviour	16
Vandalism/graffiti	13
Domestic violence	6
Youth crime	5
Joy-riding	3
Car theft	2
Burglary	2
Mugging	1
Prostitution	1
Cheap French imported cigarettes	1
Deprivation	-
Poverty/social exclusion	18
Pockets of deprivation unrecognised in affluent area	17
Contrast between 'haves' and 'have-nots'	7
Rural poverty	1
Isolation	-
General social isolation	18
Isolation of - Young families	14
Young mothers	7
Ethnic groups	5
Disadvantaged families	1
Elderly	1

Physical Environment		-
Natural -	Rural area/geographic isolation	41
	Lack of green spaces	15
	Hilly	2
	High rain fall	2
	Rat infestation	2
	Flood plain	1
	Salt mines	1
	Cut off in winter	1
	Foot and mouth	1
	Seagull fouling	1
Man-made -	Dog fouling	8
	Pollution	8
	Run down area	5
	Litter	5
	Lack of community focal point	5
	Poor street lighting	4
	Airport noise and pollution	3
	Lack of public toilets	2
	Too many pubs	2
	No footpath/bridge to access services	2
	Noise	2
	Stray dogs	1
	Proximity to waste disposal	1
	Lack of rubbish bins	1
	Steps to accommodation	1
Business		-
Industrial area		3
Loss of small businesses		1
Local business unsupported by residents		1
General/Miscellaneous		-
Need to travel to next town to access services		33
Generally poor services		22
Bad reputation		3
Located on border between two places – 'in between'		3
High cost of living		2
Too competitive for young children		1

Some direct quotes from health visitors help to demonstrate the breadth and diversity of their concerns:

"Social isolation and reduced health benefits for families on low income who do not have own transport to access services; Although this area is considered to be affluent, there are small pockets of poverty with some of the problems including domestic violence, relationship breakdown and one-parent families. All these impact more on families living in a rural area as access to services is difficult unless the families have transport."

"Families who live in private rented accommodation - poor safety conditions - quite appalling - nobody inspects these premises; Reduced stock of LA accommodation; Lack of support from Social Services in respect of funding for childcare when parents have to attend court/hospital and they have no family support; [There] is a very congested main road; An area between initiatives, i.e. Sure Start covers only a few roads in ward; Very varied property - some poor privately rented accommodation; Shortage of GPs."

"Poor public transport; Distant from some facilities, e.g. hospital, child and family psychiatry; Long waiting lists for some services, e.g. OT, child and family psychiatry, psychology, educational psychology; High unemployment; Huge travel-to-work distances; Many employment opportunities are abroad or offshore (i.e. absent fathers); Poor outreach facilities, e.g. for learning disabilities (few paediatric, OT or physios); Rising drug and alcohol problems; Rising mental health and domestic violence problems; Extremely overstretched, understaffed and under-resourced Social Services - heavy reliance on health workers and voluntary services; Expensive food, e.g. fruit and veg."

"Families can't manage without private transport; Young families find older parts of the community hostile and intolerant so find it difficult to integrate especially if they have problems; Some families live in isolated cottages a long way from friends and other facilities; Few statutory resources."

CHAPTER 12 RESULTS: GOOD THINGS

In an open-ended question towards the end of the questionnaire health visitors were invited to supply details concerning the good things about the particular ward in question. This resulted in the receipt of 270 write-in answers (representing a response from 89% of health visitors), consisting of 1,276 separate comments (an average of approximately 5 comments per health visitor). Table 13 below shows how these responses varied between countries and strata.

Table 13 'What are the good things about living in this area for families with your children': responses by area and stratum

Country	Strata	No. of wards (percentages within stratum)
England	Advantaged	66 (93%)
	Disadvantaged	46 (98%)
	Ethnic	8 (89%)
Wales	Advantaged	13 (81%)
	Disadvantaged	29 (81%)
Scotland	Advantaged	19 (83%)
	Disadvantaged	19 (83%)
Northern Ireland	Advantaged	15 (94%)
	Disadvantaged	31 (94%)
	Total	***246 (90%)***

A very similar number of wards had good things listed as compared to the number listing bad things. Overall, more good things were listed by the health visitors in England and Northern Ireland than elsewhere. Within countries, exactly the same number of disadvantaged and advantaged wards had good things listed, except in England where good things were more likely to have been listed by health visitors in disadvantaged wards.

Comments about the good things in local areas have been grouped and are shown in Table 14 below. The single most frequent response concerning the good things in the areas in which MCS babies were growing up related to the schools available, followed by the prevailing community spirit, and then the existence

of extended families who provided community support. The most frequent topic of response received related to the physical environment, followed by educational services, and then the type of residents in the area.

Table 14 Things that health visitors regard as good about MCS areas

Good things about the area	No. of responses
Physical environment:	-
Low crime rate – safe area	31
Clean, fresh air – low pollution	28
Not crowded	5
Affluent/desirable	5
Well-maintained	5
Cycle paths	4
Semi-rural	4
Drug free	3
Litter-free	3
Quiet	3
Low vandalism	2
Less traffic	2
Mainly residential	2
Traffic calming measures	1
Pedestrian-friendly	1
Wardens with neighbourhood watch	1
Rural - Open spaces	40
Countryside	31
Rural area	27
Country walks, footpaths	23
Near beach/coast	22
Beautiful – scenic	21
Rivers, canals, lakes, ponds	10
Trees, woodland	4
Area of historic interest	3
Area of local natural interest	2
Wildlife	2
Greenbelt	1
Near mountains	1
Open farm	1

Type of residents:	-
Good community spirit	71
Close knit families, extended family support	59
Established, stable population	10
Motivated, resilient, involved	8
Lots of children together	7
Friendly, welcoming	7
Owner-occupiers	5
Mix of cultures, religions	5
Mix of social classes	4
Environmentally aware	3
Accepting of alternative lifestyles	2
Popular area for families	2
Mix of ages	2
Sense of pride and respect in their community	1
Children stay children – no pressure to grow up	1
Education:	-
Schools	92
Parent-child/play groups	46
Nurseries and early years provision	45
Further and Adult Education	6
Classes taught in other languages	5
Small class sizes	4
Special Needs schools	3
Schools within walking distance	2
Educational centre	1
School nurses	1
Child-related:	-
After-school clubs	11
Childcare available	9
Youth centre/projects	6
Holiday and summer schemes	4
Breakfast clubs	2
Shops and amenities:	-
Shops	54
Access to towns/cities	33
Parks with playgrounds	24
Library	21
Churches	15
Post Office	8
Chemist	6

Toy library	5
Pubs	3
Petrol garage	2
Cinema	2
Theatre	1
Museum	1
Car parks	1
Power station	1
Healthcare:	-
Healthcare provision	40
GP and primary care	26
Health visitors	19
Hospitals	11
Paediatric services	6
Dentist	4
High rates of breastfeeding	2
Good immunisation uptake	2
Chiropodist	1
Baby massage	1
Community support:	-
Government services/initiatives - Sure Start local programmes	25
Miscellaneous initiatives	6
Social Services	5
Home Start	4
Other - Family/community centre	18
Good multidisciplinary work – enthusiastic professionals	10
Charitable support	9
Support groups, e.g. Alcoholics Anonymous	7
Link worker/interpreters	5
Women's support	3
Parenting courses	2
Fathers' project	1
Counselling	1
Traveller support	1
Ethnic minority centres	1
Safety equipment loan	1
Food co-op	1
Transport:	-
Good public transport	39
Railway station	7
Airport accessible	4

Motorways accessible	3
Low-line buses	2
Taxis	2
Most families have a car	2
Road network	1
Leisure:	-
Sports and leisure facilities, e.g. sports centre, football stadium	31
Swimming pool	8
Outdoor activities, e.g. horse riding	5
Holiday facilities, e.g. caravan park	2
Free leisure facilities	1
Fairground visits yearly	1
Firework display	1
Zoo	1
Housing and built environment:	-
Good housing mix and/or planning	35
Area of investment and regeneration	11
Low house prices	2
Employment	-
Local employment opportunities	10
General:	-
Many, varied facilities	6
"Its potential"	1

Some direct quotes from health visitors will demonstrate the breadth and diversity of the things that, in their opinion, were positive about the areas in which they worked:

"Lot of open spaces; Walk/cycle areas; No air pollution; Low crime area; Plenty of nursery/playgroup provision."

"Easy access to mountains and seaside; Bilingual health professionals available; Excellent 'baby club' to mothers with babies under 1-year-old to socialise and seek professional advice; Extended families still support young parents; Good professional links between HV and local schools for teenage sexual health clinics, breast feeding road shows, etc."

"Sense of community evident; Rural area - lots of open spaces, canal walks, fields, etc.; Generally good standard of education - primary and senior; Attractive area to live; Health centre - offers a variety of community services - focal point to village; Friendly welcoming community (on the whole!)."

"Sure Start designated area - this has provided numerous services over the past year - mother and toddler drop-in schemes, additional playgroups, toy library, community mothers, community childminding, home safety loan (fireguards and stair-gates), relate service; Home Start services also available - support in the home and group available with free crèche facilities."

"Good standard of housing with excellent education opportunities up to 11 years; There tend to be extended families nearby supplying support and help with childcare; Sure Start from a neighbouring area is in the process of extending its boundaries and will be incorporating this area."

CHAPTER 13 RESULTS: OTHER COMMENTS

In the final open-ended question at the end of the questionnaire health visitors were invited to supply any further comments. This resulted in the receipt of 63 write-in answers (representing a response from 21% of health visitors), consisting of 91 separate comments. Table 15 below shows how these responses varied between countries and strata.

Table 15 Numbers of responses to the question 'Do you have any other comments?', by country and strata

Country	Strata	No. of wards (percentages within stratum)
England	Advantaged	11 (16%)
	Disadvantaged	8 (17%)
	Ethnic	2 (22%)
Wales	Advantaged	1 (6%)
	Disadvantaged	10 (28%)
Scotland	Advantaged	5 (22%)
	Disadvantaged	6 (26%)
Northern Ireland	Advantaged	7 (44%)
	Disadvantaged	5 (15%)
	Total	***55 (20%)***

Far fewer write-in answers were received in this section of the questionnaire compared to the sections asked about good and bad things in local areas. Proportionally, more 'other comments' were made by health visitors in Northern Ireland and Scotland than those in the other countries. Within countries, similar responses were received from English advantaged and disadvantaged wards, although there was a greater response from ethnic wards. There was a slightly greater response from Scotland's disadvantaged wards than from its advantaged wards. In Wales there was a much greater response from disadvantaged wards, whilst in Northern Ireland there was a much greater response from advantaged wards.

The other comments received have been grouped and are shown in Table 16 below. Forty-four comments related to the manner in which the questionnaire had been completed (e.g. "I had no map available to

complete this questionnaire but have done so to the best of my ability", "Apologies for the late response; I did not receive this questionnaire until 19th August"). Twenty-three comments related to additional information about the area in question and/or the problems faced by resident young families (e.g. "The ward has been renamed in recent boundary changes", "I must point out that my area has a very transient population, particularly in the summer months when there is a lot of mobility with people employed in the hotel and tourist industry"). Eleven comments related to specific questions asked in the main body of the questionnaire (e.g. "Re. question 2 (b) 1: Screening for postnatal depression will become available later this year").

Most of these are self-evident

Table 16 Other comments supplied by health visitors

Other comments	No. of responses
Additional information	-
Additional description of area, people, problems faced, needs.	23
Elaboration of an answer to a question in the questionnaire	11
Information about who to contact in the future	1
Information about ward name change	1
Comments concerning manner in which form completed	-
Apologies for delay returning questionnaire	10
Did not have all the knowledge necessary to complete questionnaire	9
Did not have time necessary to complete questionnaire	7
Problems experienced with instructions/maps/postcodes	6
Enjoyed completing the questionnaire – made me more aware	5
Clarification of manner in which 'adjacent' areas defined	4
Questionnaire completed through collaboration with colleagues	3
Other comments	-
Reference made to MCS main study	4
Criticism of manner in which community-based agencies communicate	3
Problems encountered in work of health visitors	3
Question raised about predicted outcome of survey and impact of results	1

Once again, some direct quotes from health visitors will give a flavour of the extra information they supplied at the end of the questionnaire:

> *"I will be very interested in results as I have a keen interest in developing the community development aspect of this new post as Sure Start HV."*

"I do enjoy doing these questionnaires but they do not take a few minutes. I am a health visitor working from [named area] across [other named areas] - well beyond the reaches of the map - hence my knowledge of this particular area needed verification with other colleagues, and that took time."

"This area is seen by others in [local area] as being an affluent middle-class area. If problems occur they are undoubtedly different in emphasis - less related to economic deprivation on the whole but more related to social and emotional deprivation. Often problems are hidden until they become severe. Parents often spoil their children, e.g. no boundaries, and this presents many issues of parenting [and] support."

"Facilities that local families request regularly are: affordable child care; affordable nursery and pre-school places; mother and toddler groups; safe play area; toy library, expansion of library service (child themes, story telling, music, etc.); more NHS dentists; community drop-in; "community mother" schemes; more crèche facilities for shopping etc; more affordable leisure facilities."

CHAPTER 14 DISCUSSION

14.1 Background

As stated earlier, the Health Visitor Survey (HVS) was carried out as an enhancement to the Millennium Cohort Study (MCS), the aim being to discover more about the geographical areas in which the cohort babies were living. This would enable neighbourhood information to be used alongside that gathered directly from the individual cohort members' caregiver(s), to help answer questions pertaining to, for example, health inequalities, poverty and wealth, the quality of life and its support by public policy and the broader community. This study thus aimed to gather information concerning the local services available to young families in five separate areas: childcare; family support; health services; leisure facilities; and specific statutory initiatives. This was achieved through the help of health visitors throughout the UK who completed a postal questionnaire.

Completed postal questionnaires were received from 302 health visitors. These responses constitute the data in this report, representing 274 MCS wards or sampling points (69% of all MCS sampling points). These results have provided us with an idea of what health visitors knew about the areas in which they work, what differences there were ~~are~~ between services available to young families in each country within the strata of advantaged and disadvantaged wards plus in England a sample of ethnic wards

14.2 Interpreting the Results

For this report, simple descriptive statistics have been produced, along with a content analysis of the answers supplied to a number of open-ended questions.

14.2.1 Access to total services

Contrary to expectation there was little systematic difference in provision between advantage and disadvantaged (and ethnic) wards, within country. Overall between countries, the greatest variation in access to services was within Scotland and that there was access to fewer services in Northern Ireland. There was no variation in access to total numbers of services in Northern Ireland according

to strata but overall fewer services were available in that country, particularly statutory initiatives and leisure services.

14.2.2 Access to individual services

Services which were reported as very widely accessed throughout the UK in all types of ward included speech therapists, parent and toddler groups, child health clinics, Parent Craft classes, family planning services, child and adolescent mental health services, registered childminders, screening for postnatal depression and Book Start projects. The only services that were routinely more widely accessed in advantaged areas over disadvantaged and ethnic areas, were private nurseries, mobile libraries and museums. Conversely, the only services that were routinely more widely accessed in disadvantaged areas over advantaged areas, throughout the UK, were youth family planning services and Drug Action Teams. All the other services were accessed in less consistent patterns between countries and strata, indicating perhaps a level of patchy or random provision. Since many health visitors stated in their open-ended answers that pockets of deprivation lay hidden in areas of apparent affluence, it is possible that where advantaged areas appeared to have greater access to things such as Home Start (in Northern Ireland), Pippin (in England), Children's Society (in Wales) and Healthy Schools Initiatives (in Scotland), these were being provided for, or accessed by, families in these pockets of deprivation. Ethnic areas seemed to be very well catered for; however, since only a few questionnaires (9) were received from these wards it would be difficult to generalise from this finding.

14.2.3 Access to type of services

Looking at the five main service areas that were asked about, health visitors' knowledge was highest for leisure services followed by health services (although they knew little about waiting times for these services). Knowledge was lowest regarding statutory initiatives. Overall availability reported to be best for health services and then for childcare. Again, it was worst for statutory initiatives within which. Indeed the only question about which they had volunteered the most answers in this area related to Sure Start local programmes (SSLPs). They told us that Sure Start were particularly accessible in advantaged parts of Wales and Scotland, which is in contrast to the design of the programmes in England to target children in disadvantaged areas. It seems that a sizeable

percentage of disadvantaged wards in Wales and Northern Ireland are without coverage of any named statutory initiative. It is possible that this is because those initiatives asked about do not operate in these countries; however, our questionnaire specifically asked health visitors to consider equivalent versions of these initiatives in their area. Alternatively, it is possible that health visitors simply did not know enough about the presence of these projects, and although this is not a criticism, if they were better informed, especially in terms of the health initiatives such as Health Action Zones, Healthy Schools Initiatives, Healthy Living Centres and Health Improvement Programmes, they may be even more able to help the disadvantaged families with whom they work.

14.2.4 Additional Information Supplied

Health visitors in approximately nine out of every ten wards supplied comments relating to the bad and good things in their local areas. Things that were consistently mentioned as bad features of an area included: lack of affordable childcare inadequate public transport; inadequate housing; and lack of employment opportunities. Things that were consistently mentioned as good things in an area included: the schools available; the prevailing community spirit; and the existence of extended families who provided community support.

14.3 Limitations of the survey

In interpreting these findings, it should be reiterated that this study cannot guarantee that those health visitors who returned a questionnaire were representative of all health visitors to whom a questionnaire was sent, or that the wards in which they worked were representative of all wards for which questionnaires were sent out let alone all wards in the UK. The survey relies on the knowledge of the health visitors completing the questionnaires who clearly not all have had the same degree of local knowledge, or the same degree of motivation/time to complete the survey. However, a national picture has been gained of the services available to young families in these MCS wards across the UK. It is clear that health visitors seem to know a great deal about the services available to the young families in the areas in which they work. It appears as though there is not a great deal of variation in the quantity of services provided throughout the UK and it seems as though needs are, on the whole, being met or at least that unmet need is fairly evenly spread between area type. However, whilst these results allow us to draw conclusions about the accessibility of

services by young families living in MCS wards, they tell us little about the quality of those services or their uptake by MCS families; this might be the subject of further research.

14.4 Lessons for Policy Makers, and the future

Due to the breadth of the questions asked in this survey, these results should be of interest to policymakers in virtually all government departments. Policymakers might be particularly interested in the family support and childcare services which disadvantaged wards in each country are lacking, e.g. Preschool Learning Alliance, Family Welfare Association, BREAK, Family Service Units, Ormiston Trust, NEWPIN, Playlink schemes, PIPPIN. Since many of these services are run by voluntary agencies, policymakers might want to consider schemes which promote their establishment, or develop statutory initiatives which emulate some of these services. Although childcare provision is far more widespread than it would have been as recently as the mid-1990s, a substantial minority of health visitors still mentioned lack of affordable childcare as affecting their areas. Policymakers may be interested in some of the alarming waiting times reported by health visitors for some health specialists and services, particularly for child and adolescent mental health services, as well as the generally longer waiting times in disadvantaged areas. They may also consider whether health visitors can be better informed about statutory initiatives which impact on the young families with whom they are routinely in contact. Finally, they may be interested in tackling the issues raised by health visitors concerning bad things in MCS wards, such as poor/inadequate public transport, housing and employment opportunities. Likewise, they may learn something from the answers supplied on the 'good things about your area' and consider emulating these in future planning; of particular interest here might be the importance of a community spirit and use of extended family for support (where family is defined in the broadest sense).

The next stage of this research could focus upon a more advanced statistical analysis of the data, including data from the additional questionnaires that have been received since this initial analysis was carried out. These data will be compared to the information collected directly from the MCS cohort members' parents in the main survey, concerning their neighbourhoods. Additional neighbourhood statistics for small areas, collected by the Office for National Statistics, will also added to these data, to augment the data for the first sweep of local neighbourhood information. This could be used in future longitudinal research as data subsequent sweeps at 3, 5 and 7 years.

Appendix 1: Sample letter to Directors of Nursing (or equivalents) seeking health visitors' collaboration.

July 2001

Dear > <,

Child of the New Century
The Millennium Cohort Study

I am writing to ask for your help, and that of health visitors, in the first sweep of a new Millennium Cohort Study, known as 'Child of the New Century'. This is a longitudinal study which will follow the lives of over 20,000 babies born in the year beginning 1st September 2000, in England and Wales, and beginning 1st December in Scotland and Northern Ireland. It is being carried out by the *Centre for Longitudinal Studies* based in the *Institute of Education, University of London* and the *National Centre for Social Research.* The study has the full backing of the CPHVA, and with the support of local health visitors its value can be strengthened. The study has received Multi-centre Research Ethics Committee (MREC) approval at national level and all Local Research Ethics Committees (LREC) have been informed.

The sample consists of all babies of 9-months, resident in nearly 400 electoral wards, selected to ensure adequate representation of each UK country and of families from deprived and ethnic minority backgrounds. The following wards lying within your Community NHS Trust /Primary Care Trust have been selected for the study: > <. We estimate that over a year there are about > < births in the ward(s). In order to help identify the ward(s) involved I enclose a map of your Trust area with the study ward(s) marked in black and also an enlarged map of each ward involved. Within the health visitor pack, also provided, is a list of the postcodes of all residences within each ward.

The plan is for a trained interviewer from the National Centre for Social Research to carry out a home interview with the parent(s) of each 'eligible' baby when s/he is around 9-months-old. Participation will, of course, be completely voluntary and confidential, and no medical examination or tests will be involved.

Recruitment of cases

We would be so grateful if you could help us in our request for the collaboration of the health visiting service in order to ensure completeness of the recruitment process. We first wrote to you about this in May 2001, but fear that our earlier letter went astray or was wrongly addressed. To reiterate, families eligible for the survey are those with babies born between 1st September 2000 and 31st August 2001 who are resident in the above ward(s) as they approach 9-months of age. The majority will be identified from official Child Benefit records by the Department of Work and Pensions (formerly the DSS). The DWP will send out letters inviting participation in the survey, when the baby is 7–8-months-old, asking parents to let them know if they wish to opt out - failing which an interviewer will call. The collaboration of health visitors is absolutely essential if the survey is going to be a success.

Health Visitor's Pack

Exactly what we would like to ask of the health visitor(s) in the selected ward(s) is set out in the enclosed Health Visitor Pack. We hope that you can provide crucial help by informing the relevant health visitor(s) of babies living in the selected wards and in giving your blessing to their participation in the survey.

Distribution of Health Visitor Packs

To get the health visitor involvement going, it is urgent now to get the packs distributed. It had been our intention to send a pack to each individual health visitor and to this end we asked for a list of the names and addresses of every health visitor in each ward to be sent to us. Many Trusts have complied, but the returns so

far have indicated that though some wards have only a few health visitors, many have much larger numbers, up to nearly 50 in the case of one urban ward. With nearly 400 wards involved, it would prove an enormous logistic problem for us to locate all the relevant health visitors and to send separate packs. If there is a convenient way that you or your nominee could arrange distribution locally, this would be of great help and we will send you the requisite number of packs by return. If this is not convenient for you we will fall back on the original plan and will send out separate packs when we receive the names and addresses of the individual health visitors. We are enclosing a 'Chain of Communication Form' on which you might like to indicate your preference (Section D).

Chain of Communication Form

Perhaps you could be kind enough to complete the above-mentioned form to also confirm who is concerned with the study at your end and with whom we may need to be in communication (Sections A-C)? Finally, it would also be helpful if you could continue to advise us of any future change of management or personnel that may take place over the coming year if this is likely to have an impact on the survey operation.

I am afraid we are running on a very tight timetable, so I would appreciate it if you could get back in touch with us within a week, or as soon as possible. I really apologise for the short notice.

I do hope you will be able to help us and join in this important cohort study, which is the fourth in the UK, but the first for 30 years. I am very conscious that you and your staff have already got plenty to do, and would deeply appreciate any contribution you were able to make. We look forward to hearing from you. Please feel free to contact the study team by freephone (0800 092 1250), fax (020 7612 6880) or e-mail childnc@cls.ioe.ac.uk if you would like any further information.

Yours sincerely,

PROFESSOR HEATHER JOSHI
Project Leader

Appendix 2: Sample Health Visitors Pack

2.1 Document A: Letter to health visitors with instructions

January 2002

Dear Health Visitor,

Millennium Cohort Study – Child of the New Century

Your Community Nursing Service have suggested that you might be willing to help us with the first sweep of the new Millennium Cohort Study known as 'Child of the New Century'. This important study, which has the support of the CPHVA, is being planned and analysed by the Centre for Longitudinal Studies at the Institute of Education, London University and the National Centre for Social Research. Further information is in the enclosed Health Visitor Pack including a summary of the survey questions (in Doc. J).

Health visitors have a long history of participation in every one of Britain's unique cohort studies, of which this is the fourth. This time we hope the commitment required of health visitors, though vital to the success of the survey, will not prove too onerous, as professional interviewers will be completing the questionnaires. May I now explain about the study and then outline what we are asking you to do.

Families whose babies are eligible for the study are/will be all those with a baby born between 1st September 2000 and 31st August 2001 who, when the baby reaches 9-months of age, are living in any one of 273 selected localities (electoral wards) in England and Wales. It is vitally important for us to identify as soon as possible every eligible baby resident in each ward, in order to recruit parents for the 9-month home interview.

Pre-fieldwork It is essential to ensure that parents of all eligible babies are informed of the study and are given the option to participate. We are seeking the help of health visitors to encourage all eligible families to join the survey. We know names, addresses and birth-dates for most of these babies from the Department of Social Security (now Department of Work and Pensions) based on child benefit claims. We are seeking further vital help from the Health Visiting Service to tell us about all eligible families who move into, or within, the ward with a child aged 5-8 months inclusive, as these families may not be recorded in the Child Benefit records at their new address.

Fieldwork The interviews, which started in June 2001, will continue for a whole year as each baby reaches 9-months of age. An interviewer from the *National Centre for Social Research* will be in contact with the parent(s) of eligible babies already known to us just before the interview is due. The interviewer will invite the mother to participate in a home interview (lasting a little over an hour) at a mutually convenient time and date. There will also be an interview for fathers (lasting about half an hour). Participation will be completely voluntary and identities of individuals will never be revealed. There will be no medical examination, no measurements or tests and no handling of the baby.

In confidence All information provided will, of course, be treated with absolute confidentiality by the survey team. Even the identity of the selected wards will not be known publicly except to participants. Strict confidentiality will be ensured.

How can you help? More details of exactly how you can help are given on the back of this letter. We have obtained the necessary ethical approval for the study nationally and local research ethical committees have been informed, which means we have permission to approach NHS staff and parents for this specific help. Health visitors have already helped to make the pilot surveys a success, and generally enjoyed by the parents. With your vital help in promoting the survey and in identifying and giving us advance notice of families moving into or within your ward, the success of the main study will be greatly enhanced.

Presentation of results Finally, it is our intention to produce a summary report based upon the findings as quickly as we can after the final interviews. This will be made available to the relevant NHS Trusts and their staff. Copies will be lodged with the CPHVA as another source of reference.

Thank you and every good wish,

PROFESSOR HEATHER JOSHI
Project Leader

Doc. A

Millennium Cohort Study – Child of the New Century

How you can help?

1. Eligible babies

We are aiming to find every eligible baby in every participating ward so that an interview with the parents can take place when the baby is 9-months-old. The interviewing will continue until the survey ends in July 2002. Eligible babies are those with birth dates between the 1st September 2000 and 31st August 2001 who have addresses within the study wards at 9-months-old.

From now until the survey ends, please check from your practice/clinic records whether there are any eligible babies resident within your ward. For help in identification, a list of all postcodes in the ward is enclosed (Doc. C). Due to frequent postcode changes, you may find a few eligible families living in the ward whose postcodes do not appear on our list.

2. Approaching parents of eligible babies

Among those for whom we need your cooperation, are babies who have moved *into the ward* (inward transfers) between the age of 5- and 9-months, and those whose address has changed *within* the ward. It will help us greatly if you could inform moving families about the survey, so if you have a baby in either of these groups on your list, we would be grateful if you would contact the parents concerned as their baby approaches 8-months of age. Families who move with babies aged 7- and 8-months will definitely not be identified for us from the Child Benefit Register, and those who move at 5- and 6-months of age are also likely to be missed.

Ideally it would save special effort if this contact can be made to coincide with a routine screening appointment or other consultation. Alternatively, where this task is not onerous, please make contact by other methods, e.g. telephone. Contact after the baby is 9-months of age would be too late for us to arrange an interview. Last dates for informing us are given in the '***Key Dates***' document (Doc. B).

There is no need for you to ask parent(s) to agree to take part in the study at this stage. However, we would be very grateful if you could give to them a '***Parent Pack***', which contains a letter of invitation to take part in the study (Doc. G) and a study information sheet (Doc. H).

3. Notifying us

Please notify us of any of the above cases as the babies approach 8-months of age, and any point thereafter when babies older than 8-months-old are found. This can be achieved by using the '***Moving Family Form***' (Doc. F), which is in your Health Visitor Pack. Please first ask the parent(s) to indicate their agreement for us to know their address (this is simply to allow an interviewer to call to find out whether they wish to join in) and, if they are in agreement, please complete a 'Moving Family Form' and return it to us immediately.

If the family is non-English speaking please complete a '***Non-English Speaking Family Form***' (Doc. E) and return it to us.

4. Answering questions about the survey

The majority of parents will have received a letter of invitation from the Department of Work and Pensions (a copy of which is enclosed – Doc. D). Those who have already been invited to join in the survey may make contact with you when their baby is between 7- and 9-months-old. If so, please explain about the survey and encourage the family to join in.

Please remind the parent(s) that they will receive a letter giving the name of the interviewer, who will contact them shortly to arrange an appointment for an interview at a day and time convenient to the family, unless they have already opted out.

If the parent(s) is/are worried in any way, please explain that you know about the survey and emphasise that the survey consists only of a single interview at which time he/she can decline to take part. Families can also contact the research team at the contact details below.

5. Updating Personal Child Health Records

We would be very grateful if you could try to ensure that the '***Personal Child Health Record***' (PCHR) for all survey babies is kept up to date as fully as possible, especially in relation to immunisations and developmental checks, if necessary by referring to your own records. This record should be produced for reference at the 9-month interview. It is very important that this record is accurate since it will be used at the next follow-up of the study, at 2 ½ years.

6. Passing a letter to GPs

Although GPs will not be directly involved in the study, I would be very grateful if you could pass a copy of the enclosed '***GP Pack***' (which contains a letter of information (Doc. I) and a summary of the study (Doc. J)) to each practice with whom an eligible baby is registered.

Please remember to return to us, *as urgently as possible*, **Moving Family Forms** and **Non-English Speaking Family Forms.**

If you have a designated supervisor, please contact them with any queries.

Alternatively, please get in touch with the survey team if you have any queries or observations, or if you would like further copies of any documentation: freephone 0800 092 1250, fax. 020 7612 6880 or e-mail childnc@cls.ioe.ac.uk

2.2 Document B: Key Dates Timetable

Child of the New Century

The Millennium Cohort Study

Doc. B

Key Dates for Survey (England and Wales)

This document should be read in conjunction with 'Instructions for Health Visitors' (Doc A). It refers to each of the thirteen 4-week waves of survey births from 1st September 2000 – 31st August 2001. For each wave of births, an optimum date is shown up to which health visitors can notify us of special cases in time for inclusion in the interview program. Failing this, a second date is shown which is the final date for ensuring a 'late' interview. Please note that for each birth wave a date is also shown on which mothers who claim child benefit become eligible to be sent a letter from the Department of Social Security (now renamed the Department for Work & Pensions), informing them of the study.

We greatly appreciate your help and the efforts you make to notify us as speedily as possible of those babies you identify for inclusion in our study. Thank-you.

Wave	Born in 4 weeks beginning		DWP letters sent out	The date by which you can report cases for interview at 9-months	The date at which interviewer begins to make contact with families	The last date to report cases to ensure interview at 10-months
		Babies aged:				
		Months (approx)	7-8	8 ½	8-9	9 ½
		Weeks	32-35	35-38	37-40	39-42
1	1-Sep-00		8-May-01	25-May	11-Jun	22-Jun
2	29-Sep-00		4-Jun-01	22-Jun	9-Jul	20-Jul
3	27-Oct-00		2-Jul-01	20-Jul	6-Aug	17-Aug
4	24-Nov-00		30-Jul-01	17-Aug	3-Sep	14-Sep
5	22-Dec-00		28-Aug-01	14-Sep	1-Oct	12-Oct
6	19-Jan-01		24-Sep-01	12-Oct	29-Oct	9-Nov
7	16-Feb-01		22-Oct-01	9-Nov	26-Nov	7-Dec
8	16-Mar-01		19-Nov-01	7-Dec	24-Dec	4-Jan
9	12-Apr-01		17-Dec-01	4-Jan	21-Jan	1-Feb
10	11-May-01		14-Jan-02	1-Feb	18-Feb	1-Mar
11	8-Jun-01		11-Feb-02	1-Mar	18-Mar	28-Mar
12	6-Jul-01		11-Mar-02	28-Mar	15-Apr	26-Apr
13	3-Aug-01		8-Apr-02	26-Apr	13-May	24-May

2.3 Document C: Postcodes – anonymised sample

CHILD OF THE NEW CENTURY

Ward Name: Xxxxxxx

Health Authority: Xxxxxxxxxx

Ward Code: XX11

Point Number: 111

Tel: 020 7612 6902
Fax: 020 7612 6880
Email: cnc@cls.ioe.ac.uk

CONFIDENTIAL

Doc. C

CHILD OF THE NEW CENTURY

List of Postcodes (England) XX11 111

XX1 11XX	XX1 11XX	XX1 11XX	XX1 11XX	XX1 11XX
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XX1 11XX	XX1 11XX	XX1 11XX	XX1 11XX	XX1 11XX
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Tel: 020 7612 6902
Fax: 020 7612 6880
Email: cnc@cls.ioe.ac.uk

CONFIDENTIAL

2.4 Document D: Department of Work and Pensions' letter to parents

Department for
Work and Pensions

Millennium Cohort Study
ASD Information Centre
FREEPOST HQ5
Room BP5 201
Benton Park View
Benton Park Road
Newcastle upon Tyne
NE98 1YB

«TITLE_1» «FORENAME» «SURNAME_»
«ADDRESS_»
«ADDRESS0»
«ADDRESS1» «ADDRESS2»
«ORIGPCD»

Reference No:
«REFNO»

Date: 27 July 2001

Dear «TITLE_1» «SURNAME_»

CHILD OF THE NEW CENTURY

The Millennium Cohort Study

We are writing to invite you to take part in a new study of babies in the United Kingdom, which is going to be vitally important in getting good services for children growing up in the 21st century. The *Centre for Longitudinal Studies at the Institute of Education, London University* and the *National Centre for Social Research* are carrying out the study. The enclosed leaflet from the research team explains what it is about and why it is so important. The team has also told GPs and health visitors in your area about the study.

The study will collect information about the lives of up to 20,000 babies. This will be done by interviewing parents. It will not involve any medical examination or tests.

You may wish to know why your baby has been chosen from our records for 'Child of the New Century'. Firstly, the study only includes babies born between 1 September 2000 and 30 November 2001. Secondly, you live in one of the areas chosen by chance to be part of the study.

An interviewer from the *National Centre* will be calling on you at home some time during the next month or so. He or she will explain more about the study, confirm whether you will be taking part, and arrange a convenient time for the interview.

Whether or not you take part will not affect your benefit entitlement or any dealings you have with DSS or Benefits Agency, now or in the future. Anything you tell the interviewer will be treated in the **strictest confidence**. No report will ever identify you or your family.

We hope very much that you will help with this important study. If, however, you do not wish an interviewer to contact you, please let us know before 10th August 2001, either by writing to the FREEPOST address above or telephoning the Project Team during office hours (Monday-Thursday 9:00a.m. to 4:30 p.m. Friday 9:00 a.m. to 4:00 p.m.) on 0800 015 0524. If you do write or phone, **please remember to give your name and the reference number at the top of this letter.**

Thank you for your co-operation. We hope you will enjoy talking to the interviewer.

Yours sincerely

Katie Dodd

Doc. D

2.5 Document E: Non-English-speaking Family Form

Doc. E

Child of the New Century
The Millennium Cohort Study

NON-ENGLISH-SPEAKING FAMILY FORM

Please complete a form for each family in the Survey where the respondent does not speak English.

Name of parent(s) PLEASE PRINT
(Please include title, forename and surname)

Is this the Mother or Father?
PLEASE WRITE IN RELATIONSHIP TO BABY

Name of baby(ies) PLEASE PRINT
(Please give forename and surname)

Date of baby(ies) birth PLEASE PRINT
(Please write in day, month and year)

Address & postcode
PLEASE PRINT

Address	
Town	
County	
Postcode	

Telephone number (if known)
PLEASE PRINT

What is the mother's (or other respondent's) native language?

Is this the only language the mother (or other respondent) speaks? *No* ☐ *Yes* ☐

Do other member(s) of the household speak English? *No* ☐ *Yes* ☐

Please see overleaf ➔

Your name PLEASE PRINT

Your telephone number

Today's date PLEASE PRINT

Please inform us <u>as soon as possible</u> by -

***Freephone*: 0800 092 1250**

***Fax*.: 020 7612 6880**

***E-mail*:** childnc@cls.ioe.ac.uk

***or, post first class to*:** Child of the New Century – Millennium Cohort Study,

Centre for Longitudinal Studies, Institute of Education, FREEPOST LON20095, London. WC1H OAL

2.6 Document F: Moving Family Form

Doc. F

Child of the New Century

The Millennium Cohort Study

MOVING FAMILY FORM

Please complete this form for families with a child of up to 9-months of age, with a recent, or anticipated, change of address.

Name of Ward:_____

Name of Health Visitor:_____ **Tel.:**_____

Full name of parent(s) PLEASE PRINT *(Please include title, forename and surname)*	
Is this the Mother or Father? PLEASE WRITE IN RELATIONSHIP TO BABY	
Full name of baby(ies) PLEASE PRINT *(Please give forename and surname)*	
Date of baby(ies) birth PLEASE PRINT *(Please write in day, month and year)*	
New Address & Postcode PLEASE PRINT — **Address**	
Town	
County	
Postcode	
New Telephone Number PLEASE PRINT *(if available)*	

Please see overleaf ➔

Old Address & Postcode PLEASE PRINT	**Address**	
	Town	
	County	
	Postcode	
Date moved (or likely to move) PLEASE PRINT		

Please inform us <u>as soon as possible</u> by -

***Freephone*:** 0800 092 1250

***Fax*.:** 020 7612 6880

***E-mail*:** childnc@cls.ioe.ac.uk

***or, post to*:** Child of the New Century – Millennium Cohort Study,
Centre for Longitudinal Studies, Institute of Education,
FREEPOST LON20095, London. WC1H OAL

2.7 Document G: Parents' letter

January 2002

Dear Parent,

CHILD OF THE NEW CENTURY
The Millennium Cohort Study

We are writing to invite you to take part in a new study that will follow the development of babies in the United Kingdom. It is going to be vitally important in getting good services for children growing up in the 21st century. The *Centre for Longitudinal Studies* at the *Institute of Education, London University* and the *National Centre for Social Research* are carrying out the study. The enclosed leaflet explains what it is about and why it is so important. As well as asking your Health Visitor to help us by giving you this letter, the team has also told GPs in your area about the study.

The study will start by collecting information on over 20,000 babies. This will be done through interviews with the parents. It will not involve any medical examination or tests on your baby.

You may wish to know why your own baby has been chosen for 'Child of the New Century'. Firstly, the study only includes babies born between 1st September 2000 and 30th November 2001. Secondly, you happen to live in one of the areas chosen to be part of the study.

An interviewer from the *National Centre for Social Research* will be calling on you at home some time during the next month or so. You will get a letter from them nearer the time. When the interviewer calls, he or she will explain more about the study, and confirm whether you wish to take part. If so, they will arrange a convenient time for the interview, which should normally take about an hour and a half.

Anything told to the interviewer will be treated in the **strictest confidence**. No report will ever identify you or your family.

We hope very much that you will want to help with this important study. If you have any questions please call a member of the study team free on 0800 092 1250.

Thank-you for your co-operation. We hope you will enjoy talking to the interviewer.

Yours sincerely,

PROFESSOR HEATHER JOSHI
Project Leader

Doc. G

2.8 Document H: Parents' information sheet

Child of the new Century

National Centre for Social Research

Child of the New Century
About our survey

Is your baby special?

We think so. Your baby has been picked to be in a major new national survey that could make all the difference to people's lives in the future.

What is it like for children growing up in the 21st century? How will they get on at school? What helps them and what holds them back? The answers you give us will help plan health care, education and child care services to really benefit children and their parents.

So can we come and ask all about you and your baby? The information you give us will be confidential under the law – you won't be named in the survey report, no names are made public.

Our interviewers are trained to ask everyone the same kinds of questions about

- your baby's birth and early development
- your family
- your beliefs and concerns about bringing up children today

The interview with Mum will last a little over an hour, and one with Dad, if available, about half an hour. The interviewer will not need to handle your baby, and there will be no medical tests.

To fill in the background we'll also ask you a bit about your own education and employment and about the home you live in.

Then we'll put together the answers from all the people we talk to throughout the United Kingdom. This will show what life is like right now for the Children of the New Century.

Project Leader: Professor Heather Joshi
Centre for Longitudinal Studies ■ Institute of Education ■ University of London
20 Bedford Way ■ London ■ WC1H 0AL

Do you have questions for us?

What's the point of this survey?

A fair question given all the fuss we're making about your baby! It's only by getting this kind of information – now and by following the babies as they grow into adulthood – that government, parents and others can change things for the better.

We've done surveys like this before – in fact Britain is the world leader in this research. We found out, for example, that good health services for mothers and children, good housing and proper food make a lasting difference to health and success as children grow up. But this is the first new survey for over 30 years.

Will this be the only interview?

We'd like to come back in a couple of years time and find out how things are going. By the time your baby grows up we will be following up with interviews every few years. That way we get a good idea of how your child is developing. This information will give the government and other groups valuable clues about how they can give people more help.

Once I've said yes to this survey is my baby stuck with it for life?

Absolutely not. You or your child can bow out at any time, although of course we hope you stay with us. People generally seem to enjoy being part of these surveys.

Who's this 'we' you keep talking about?

We are a research centre in the Institute of Education in London. We have been chosen to carry out this survey because we have carried out other, similar surveys and can be trusted to do a professional job. The interviews are being carried out by the National Centre for Social Research who we have chosen because they are experts in this field. Child of the New Century is being funded by government and others.

If you would like more information there is a leaflet that goes into more detail.
Or you can talk to someone from the Study team on Freephone 0800 092 1250.

Other useful contacts:

Parentline - 0808 800 2222

Or contact your local Citizens Advice Bureau (the number will be in your local telephone directory).

2.9 Document I: GPs' letter

January 2002

Dear Doctor,

CHILD OF THE NEW CENTURY

The Millennium Cohort Study

The first national birth cohort study for 30 years is starting this year. It will follow many aspects of the lives of children born at the start of the new century. We are writing to inform you about it as it could involve babies registered with your practice. We are not asking busy GPs to undertake medical examinations, unlike previous birth cohort studies.

Your practice is in, or close to, one of the electoral wards across the country chosen for the study. The local health visiting service is being asked to help identify special groups including families who have recently moved into the ward, to inform them about the study and to recruit them for the interview. It is also through the health visitor that we are able to contact you. He/she should be able to confirm which of your patients are cohort members and, if you so wish, to show you some further documentation about the study.

The Department of Work and Pensions (formerly Department of Social Security) is sending out preliminary letters to the eligible families, who will be visited by a research interviewer, unless they indicate an unwillingness to take part. The interviewer will also ensure that there is informed consent to proceeding with the interview. We have discussed this and other matters with the Medical Research Ethics Committee, and approval has been obtained at national level and has been circulated to the Local Research Ethics Committees. The BMA and Royal College of General Practitioners have also been informed.

Fieldwork will run for 12-13 months from June 2001. The interview, when the baby is around 9-months, will be at a date and time convenient to the parent(s) and will take just over one and a half hours. It will be conducted by a trained interviewer from the *National Centre for Social Research*. There will be no need for a medical examination, measurements or for the baby to be disturbed in any way. Under no circumstances will names of individuals responsible be revealed. The data is kept confidential and secure. Pilot studies have already indicated the interest of parents in this study, and the acceptability of the questions asked.

Do please be in touch with us at any time if there is any further information you need, and please reassure any patient, who may ask you about the survey, of our *bona fides*.

With kindest regards,

Professor Heather Joshi
MA, Mlitt, FBA
Principal Investigator

Professor Neville Butler
MD FRCP FRCOG
Senior Medical Adviser

Enclosure: Project Summary "First Survey" *Doc. I*

2.10 Document J: GPs' information sheet

Doc. J

Child of the New Century

The Millennium Cohort Study

FIRST SURVEY

Introduction

A consortium headed by the Centre for Longitudinal Studies, is to carry out the first sweep of the new Millennium Cohort Study known as 'Child of the New Century', funded by the Economic and Social Research Council and a number of Government Departments in all four UK countries. The survey will begin in June 2001, and will gather information for a sample of over 20,000 babies born in the UK over a 12-month period.

Rationale for the study

Understanding the social conditions surrounding birth and early childhood is increasingly appreciated as fundamental to the study of the whole of the life course. This applies across the range, from the origins of social exclusion through investigation of the influence of early circumstances on health over the life course to providing evidence for major policy initiatives such as "Sure Start". The initiation of the study presents an exceptional research opportunity to investigate the all-important first year of life and potentially resolve many of the issues about its long-term impact. These include issues of central policy interest such as the foundations of social capital and cohesion.

Major questions about the prospects for children born in 2000-1 concern poverty and wealth, the quality of family life and its support by public policy and the broader community. The health and wellbeing of parents and infants will be located in the context of the rich socio-economic data to be collected in the study. Issues to emerge for future sweeps of the cohort will include: advantage and disadvantage in education, health, employment and the parenting of the next generation. Besides changing family forms, there are social and economic changes in the labour market, technology, social polarisation, gender roles, and the ideology of individualism. These will make the unfolding lives of the new cohort different from those of their predecessors. Will such changes also be reflected in variation in behaviour, attitudes and expectations among parents? Which of the intricate links between the social and biological aspects of human development can be illuminated?

The Sample

The sample population for the study will be drawn from all live births in the UK over a 12-month period, beginning 1st September 2000 in England and Wales, and 1st December 2000 in Scotland and Northern Ireland.

The sample will be selected from a random sample of electoral wards, disproportionately stratified to ensure adequate representation of all four UK countries, disadvantaged areas and those with high concentrations of Black and Asian families.

The Survey

Identification and recruitment of the sample will be achieved in two ways - through the DSS (now the Department of Work and Pensions) who keep child benefit records and also from health visitors employed in Community Health Trusts and attached to general practices where the baby is registered.

A home interview lasting approx. 1 ¾ hours will be carried out with the mother and (where resident) father or father figure when the cohort baby is 9-months of age. No medical examination or tests will be involved. The actual procedure will be conducted by a trained interviewer from the National Centre for Social Research. The techniques include Computer Assisted Personal Interview (CAPI) and Computer Aided Self-completion Interview (CASI).

Requisite ethical clearance has been obtained at national level. Strict precautions are taken to ensure confidentiality.

J

Some of the subjects covered in the interview are shown in the following table:

Respondent	Element	Content
Mother or Father	Interview	Household & family
Mother	Interview	Ethnicity & language Baby's father Lone parenthood Pregnancy, labour & delivery Baby's health & development Childcare Grandparents, friends & social support Parental health Education & training Employment & earnings Housing, local community & services Time with & without the baby Interests
	Self-completion	Baby's temperament & behaviour Partnership relations Domestic tasks Previous pregnancies & partnerships Mental health Attitudes to relationships, parenting, work, etc.
Father (where available)	Interview	Ethnicity & language Father's involvement with baby Lone parenthood Baby's mother (if not resident) Grandparents & friends Parental health Education & training Employment & earnings Time with & without the baby Interests
	Self-completion	Baby's temperament & behaviour Partnership relations Previous children Mental health Attitudes to marriage, parenting, work, etc.

Disposal and publication of results

This first survey will produce a multi-purpose, multi-disciplinary dataset covering family and baby during the first year of life. Results will be made available to professionals and practitioners. The data will be also available to the research community via the ESRC Data Archive. The results also aim to lay the foundation for future follow-ups of the same cohort. Thank you for your interest.

Contact

For further details e-mail: ***childnc@cls.ioe.ac.uk*** or call: **0800 029 1250** or visit our website at **www.cls.ioe.ac.uk**.

The Research Team comprises the following:

The partner institutions
Centre for Longitudinal Studies (CLS), Institute of Education:
Professor John Bynner

International Centre for Health and Society, University College:
Professor Sir Michael Marmot

Institute of Child Health, University College:
Professor Catherine Peckham

Department of Psychology, City University:
Dr. Dermot Bowler

The Millennium Cohort Study Management Team (CLS)
Professor Heather Joshi (Project Director)
Kate Smith
Ian Plewis
Peter Shepherd
Dr Elsa Ferri
Professor Neville Butler
Mahmood Sadigh
Kevin Dodwell
Denise Brown

Other Members of Research Coordinating Team (including Scientific Consultants)
Professor Mel Bartley -International Centre for Health and Safety (ICHS)
Dr. Helen Bedford – Institute of Child Health (ICH)
Dr. Leslie Davidson - University of Oxford
Professor Peter Dolton (CLS)
Professor Harvey Goldstein – Institute of Education (IoE)
Dr. Yvonne Kelly (ICHS)
Dr. Kathleen Kiernan – London School of Economics (LSE)
Professor Alison Macfarlane (City University)
Professor Christine Power (ICH)
Dr. Ingrid Schoon (City University)
Dr. Dick Wiggins (City University)

Child of the New Century – Millennium Cohort Study

Area Characteristics : Health Visitors' Questionnaire

CONFIDENTIAL

The letter on the following page gives full details about the purpose of this questionnaire and the manner in which it is to be completed. Please read this carefully before you begin to complete it.

✯ This questionnaire should be completed in relation to the electoral ward area depicted on the attached map. ✯

If you have any queries about this survey or would like any help with the questions, please contact:

Angela Brassett-Grundy, Child of the New Century – Millennium Cohort Study

Tel. *: 020 7612 6764* ***E-mail:*** *abg@cls.ioe.ac.uk* ***Fax.*** *: 020 7612 6880*

Please return this form, by 26th July 2002

using the FREEPOST envelope provided, or by fax. or e-mail:

Fax.: 020 7612 6880

E-mail: childnc@cls.ioe.ac.uk

(**Freephone:** 0800 092 1250)

Child of the new Century

June 2002

Dear Health Visitor,

Millennium Cohort Study – Health Visitor Questionnaire

We would be very grateful for your further help with the Millennium Cohort Study (also known as 'Child of the New Century').

Given your role in Needs Assessment, we hope that you will be able to provide us with an expert overview of the sorts of services available to families living in the electoral wards from which the survey has drawn its sample, so that we might be better able to explain health inequalities and improve the services dealing with them. For this reason we have developed a short questionnaire for completion by health visitors who are working in Trusts that cover each of the selected wards. A copy of the questionnaire is contained in this booklet, and we have also enclosed a map of the area to which the questionnaire relates. We would be most grateful if you could take ten minutes to complete and return it in the enclosed FREEPOST envelope, to reach us by **26th July 2002**. We would also like to stress that your co-operation is entirely voluntary, yet very much appreciated.

You will notice from the questions that we are interested in the availability of a range of services which might be provided within the area itself or in adjacent areas which people in the survey area could use. We are also especially interested in the availability of these services to mothers and fathers with babies who do not have access to a car, and this should be borne in mind when completing the questionnaire. If you know that a service is provided in the area outlined on the attached map (in whole or in part) you should tick the "*Yes, provided within this area*" box; if you know that the service is accessible from this area but are not sure of its exact location, then please tick the "*Yes, provided in adjacent area*" box. If you feel that you are unable to complete this questionnaire, do feel free to enlist the help of a colleague(s) who also has knowledge of the area outlined in the attached map.

We would like to point out that all of your responses will be treated in the utmost confidence. In addition, all those who participate will receive a summary of the results as soon as they are available.

May we take this opportunity to thank you for your co-operation in the study to date; it is only with your help that we can make this study a real success.

Yours sincerely,

Professor Heather Joshi
Principal Investigator
Millennium Cohort Research Team

Angela Brassett-Grundy
Research Officer
Millennium Cohort Research Team

How to answer these questions

Please follow the instructions given for each question. You may be asked to give your answers in a number of ways; for some questions you will be asked to tick a box, while for others we would like you to write in your answer. For example:

Please **tick one box only**, on questions like this:

Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
☐	☐	☐	☐

Please **write in your answer**, on questions like this:

Other (please specify):
……

Questionnaire begins here:

1. Childcare: Are any of the following available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Registered Childminders	☐	☐	☐	☐
2. Employer provided Childcare	☐	☐	☐	☐
3. LA provided Nurseries	☐	☐	☐	☐
4. Private Nurseries	☐	☐	☐	☐
5. Neighbourhood Nurseries	☐	☐	☐	☐
6. Social Services Sponsored Childminding Schemes	☐	☐	☐	☐
7. Early Excellence Centre	☐	☐	☐	☐
8. Pre-school Learning Alliance	☐	☐	☐	☐
9. Private Nursery School	☐	☐	☐	☐
10. L.A. Nursery School	☐	☐	☐	☐
11. Nursery Classes in Primary/Infants Schools	☐	☐	☐	☐
12. Playlink Scheme	☐	☐	☐	☐
13. Breakfast Clubs	☐	☐	☐	☐
14. After-school Clubs	☐	☐	☐	☐
15. Summer Play Schemes	☐	☐	☐	☐
16. Story-telling sessions	☐	☐	☐	☐
17. Other childcare (please specify): …… ……	☐	☐	☐	☐

2. <u>Health:</u> (a) Are any of the following services available, on NHS through GP referral, to people living in this area? ***(<u>If you answer 'Yes', please indicate waiting times where known</u>.)***

					Waiting times			
	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**	1 month or less	1-6-months	6-12-months	more than 1 year
1. Specialists: (a) Clinical Psychologist	☐	☐	☐	☐	☐	☐	☐	☐
(b) Speech Therapist	☐	☐	☐	☐	☐	☐	☐	☐
(c) Physiotherapist	☐	☐	☐	☐	☐	☐	☐	☐
(d) Occupational Therapist	☐	☐	☐	☐	☐	☐	☐	☐
(e) Ear, Nose & Throat Specialist	☐	☐	☐	☐	☐	☐	☐	☐
(f) Other specialist (please specify) ……	☐	☐	☐	☐	☐	☐	☐	☐
2. Child and Adolescent Mental Health Services	☐	☐	☐	☐	☐	☐	☐	☐
3. Counselling Services, including Family Therapy	☐	☐	☐	☐	☐	☐	☐	☐

2. <u>Health:</u> (b) Are any of these other health services available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Screening for postnatal depression using relevant instrument	☐	☐	☐	☐
2. Identification of parents with episodic psychotic mental illness	☐	☐	☐	☐
3. Specialist provision for disabled children	☐	☐	☐	☐
4. Portage Services *(home-visiting for preschool children with special needs)*	☐	☐	☐	☐
5. Child Health Clinic	☐	☐	☐	☐
6. Lay Mothers' Breast-feeding Group	☐	☐	☐	☐
7. Community Mothers' Scheme	☐	☐	☐	☐
8. Family Planning Service	☐	☐	☐	☐
9. Youth family planning advisory service, e.g. Sexcare	☐	☐	☐	☐
10. Well Woman Clinic	☐	☐	☐	☐
11. Self-help groups	☐	☐	☐	☐
12. Other health services (please specify): …… ……	☐	☐	☐	☐

3. Family support: Are any of the following available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. National Childbirth Trust Groups	☐	☐	☐	☐
2. Family Welfare Association	☐	☐	☐	☐
3. Family Centre (voluntary or statutory sector), e.g. Barnardos	☐	☐	☐	☐
4. Family Befriending Services	☐	☐	☐	☐
5. Home Start (provides family support through home visiting)	☐	☐	☐	☐
6. Ormiston Trust (provides support for families and children)	☐	☐	☐	☐
7. Link workers/Interpreters	☐	☐	☐	☐
8. Family Service Units (provides services for disadvantaged families and communities)	☐	☐	☐	☐
9. Welcare (provides information, advice and counselling for families)	☐	☐	☐	☐
10. Newpin (works to protect and preserve mental health in parents and children, and to prevent child abuse)	☐	☐	☐	☐
11. Women's Aid (works to end domestic violence)	☐	☐	☐	☐
12. KIDS (provides help for children with disabilities and their families)	☐	☐	☐	☐
13. BREAK (provides residential and day care services for families with special needs)	☐	☐	☐	☐
14. Children's Society	☐	☐	☐	☐
15. NCH Action for Children	☐	☐	☐	☐
16. Kids Club Network	☐	☐	☐	☐
17. Minority ethnically specific, e.g. Bangladeshi Welfare Association, Society of Asian Disabled	☐	☐	☐	☐
18. Religion specific, e.g. Catholic Child Welfare, Muslim Welfare Association	☐	☐	☐	☐
19. Parent Craft classes	☐	☐	☐	☐
20. Parenting Programmes	☐	☐	☐	☐
21. Pippin (Parents In Partnership Parent Infant Network)	☐	☐	☐	☐
22. Father Groups/Projects	☐	☐	☐	☐
23. Grandparents' Group	☐	☐	☐	☐
24. Swap-shop for children's clothes	☐	☐	☐	☐
25. Equipment Loan Service	☐	☐	☐	☐
26. Credit Unions	☐	☐	☐	☐
27. Other family support (please specify): …… ……	☐	☐	☐	☐

4. Leisure: Are any of the following available to people living in this area?

(Please exclude those which are provided by schools.)	**Yes**, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Open spaces with safe play areas	☐	☐	☐	☐
2. Adventure playground, skateboarding/roller-skating area	☐	☐	☐	☐
3. Private Leisure Centre (members-only)	☐	☐	☐	☐
4. Public Leisure Centre	☐	☐	☐	☐
5. Public Swimming Pool	☐	☐	☐	☐
6. Bowling Alley	☐	☐	☐	☐
7. Junior sports schemes, e.g. gymnastics	☐	☐	☐	☐
8. Activity centre, e.g. Whacky Warehouse, Jungle Gym	☐	☐	☐	☐
9. Parent and Toddler Group	☐	☐	☐	☐
10. Tumble Tots Groups/Baby Gym/Crescendo	☐	☐	☐	☐
11. Playbus	☐	☐	☐	☐
12. Toy Library	☐	☐	☐	☐
13. Mobile Library	☐	☐	☐	☐
14. Book Start Schemes	☐	☐	☐	☐
15. Music-making groups	☐	☐	☐	☐
16. Cinema	☐	☐	☐	☐
17. Museum	☐	☐	☐	☐
18. Zoo/City Farm	☐	☐	☐	☐
19. Other leisure facilities/services (please specify): …….	☐	☐	☐	☐

5. Statutory initiatives: Are any of the following, or their equivalents, operating specifically in this area (i.e. anywhere in the area outlined on the attached map)?

	Yes	**No**	**Don't Know**
1. Health Action Zone (HAZ)	☐	☐	☐
2. Healthy Living Centre	☐	☐	☐
3. Health Improvement Programme	☐	☐	☐
4. Sure Start local programmes	☐	☐	☐
5. Healthy Schools Initiative/Programme	☐	☐	☐
6. Education Action Zone	☐	☐	☐
7. Employment Zone	☐	☐	☐
8. Housing Action Zone/Trust	☐	☐	☐
9. Single Regeneration Budget	☐	☐	☐
10. New Deal for Communities	☐	☐	☐
11. Local Government Associations' New Commitment to Regeneration	☐	☐	☐
12. Neighbourhood Renewal Fund	☐	☐	☐
13. Local Agenda 21 *(promotes sustainable development and improves urban environ'ts)*	☐	☐	☐
14. Crime Reduction Programme	☐	☐	☐
15. Drug Action Team	☐	☐	☐
16. Other statutory initiatives (please specify): …….	☐	☐	☐

6. What do you think are the <u>bad</u> things about living in this area, for families with young children?

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7. What do you think are the <u>good</u> things about living in this area, for families with young children?

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8. Please use this space for any other comments:

……..……..
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So that we can get back to you with the results, please tell us who you are!
(Please* PRINT *your details.)

Your Name:	
Your Trust:	
Your Address:	
Your Postcode:	
Your Tel. No.:	
Your E-mail Address:	

Thank-you so much for the time and trouble you have taken to answer our questions. Your help is greatly appreciated.

✯ A summary of the results from this research will be sent to all those who participate. ✯

Please return this form, by <u>26th July 2002</u>
using the FREEPOST envelope provided, or by fax. or e-mail:

Fax.: 020 7612 6880

E-mail: childnc@cls.ioe.ac.uk

(**Freephone:** 0800 092 1250)

Child of the New Century – Millennium Cohort Study

Area Characteristics : Health Visitors' Questionnaire

CONFIDENTIAL

The letter on the following page gives full details about the purpose of this questionnaire and the manner in which it is to be completed. Please read this carefully before you begin to complete it.

✯ **This questionnaire should be completed in relation to the electoral ward area depicted on the attached map, pertaining to the enclosed postcodes.** ✯

If you have any queries about this survey or would like any help with the questions, please contact:

Angela Brassett-Grundy, Child of the New Century – Millennium Cohort Study

Tel. *: 020 7612 6764* ***E-mail:*** *abg@cls.ioe.ac.uk* ***Fax.*** *: 020 7612 6880*

Please return this form, by 12th August 2002
using the FREEPOST envelope provided, or by fax. or e-mail:

Fax.: 020 7612 6880

E-mail: childnc@cls.ioe.ac.uk

(**Freephone:** 0800 092 1250)

Child of the new Century

July 2002

Dear Health Visitor,

Millennium Cohort Study – Health Visitor Questionnaire

We would be very grateful for your further help with the Millennium Cohort Study (also known as 'Child of the New Century').

Given your role in Needs Assessment, we hope that you will be able to provide us with an expert overview of the sorts of services available to families living in the electoral wards from which the survey has drawn its sample, so that we might be better able to explain health inequalities and improve the services dealing with them. For this reason we have developed a short questionnaire for completion by health visitors who are working in Trusts that cover each of the selected wards. A copy of the questionnaire is contained in this booklet, and we have also enclosed the postcodes and a map of the area to which the questionnaire relates. We would be most grateful if you could take ten minutes to complete and return it in the enclosed FREEPOST envelope, to reach us by **12th August 2002**. We would also like to stress that your co-operation is entirely voluntary, yet very much appreciated.

You will notice from the questions that we are interested in the availability of a range of services which might be provided within the area itself or in adjacent areas which people in the survey area could use. We are also especially interested in the availability of these services to mothers and fathers with babies who do not have access to a car, and this should be borne in mind when completing the questionnaire. If you know that a service is provided in the area outlined on the attached map (in whole or in part) you should tick the "*Yes, provided within this area*" box; if you know that the service is accessible from this area but are not sure of its exact location, then please tick the "*Yes, provided in adjacent area*" box. If you feel that you are unable to complete this questionnaire, do feel free to enlist the help of a colleague(s) who also has knowledge of the area outlined in the attached map.

We would like to point out that all of your responses will be treated in the utmost confidence. In addition, all those who participate will receive a summary of the results as soon as they are available.

May we take this opportunity to thank you for your co-operation in the study to date; it is only with your help that we can make this study a real success.

Yours sincerely,

Professor Heather Joshi
Principal Investigator
Millennium Cohort Research Team

Angela Brassett-Grundy
Research Officer
Millennium Cohort Research Team

For help with this questionnaire, please contact Angela Brassett-Grundy, Child of the New Century – Millennium Cohort Study,
Tel.: 020 7612 6764 **E-mail:** abg@cls.ioe.ac.uk **Fax.:** 020 7612 6880

How to answer these questions

Please follow the instructions given for each question. You may be asked to give your answers in a number of ways; for some questions you will be asked to tick a box, while for others we would like you to write in your answer. For example:

Please **tick one box only**, on questions like this:

Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
☐	☐	☐	☐

Please **write in your answer**, on questions like this:

Other (please specify):
……

Questionnaire begins here:

1. Childcare: Are any of the following available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Registered Childminders	☐	☐	☐	☐
2. Employer provided Childcare	☐	☐	☐	☐
3. LA provided Nurseries	☐	☐	☐	☐
4. Private Nurseries	☐	☐	☐	☐
5. Neighbourhood Nurseries	☐	☐	☐	☐
6. Social Services Sponsored Childminding Schemes	☐	☐	☐	☐
7. Early Excellence Centre	☐	☐	☐	☐
8. Pre-school Learning Alliance	☐	☐	☐	☐
9. Private Nursery School	☐	☐	☐	☐
10. L.A. Nursery School	☐	☐	☐	☐
11. Nursery Classes in Primary/Infants Schools	☐	☐	☐	☐
12. Playlink Scheme	☐	☐	☐	☐
13. Breakfast Clubs	☐	☐	☐	☐
14. After-school Clubs	☐	☐	☐	☐
15. Summer Play Schemes	☐	☐	☐	☐
16. Story-telling sessions	☐	☐	☐	☐
17. Other childcare (please specify): …… ……	☐	☐	☐	☐

2. <u>Health:</u> (a) Are any of the following services available, on NHS through GP referral, to people living in this area? ***(<u>If you answer 'Yes', please indicate waiting times where known</u>.)***

					Waiting times			
	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**	1 month or less	1-6-months	6-12-months	more than 1 year
1. Specialists: (a) Clinical Psychologist	☐	☐	☐	☐	☐	☐	☐	☐
(c) Speech Therapist	☐	☐	☐	☐	☐	☐	☐	☐
(c) Physiotherapist	☐	☐	☐	☐	☐	☐	☐	☐
(d) Occupational Therapist	☐	☐	☐	☐	☐	☐	☐	☐
(e) Ear, Nose & Throat Specialist	☐	☐	☐	☐	☐	☐	☐	☐
(g) Other specialist (please specify) ……	☐	☐	☐	☐	☐	☐	☐	☐
2. Child and Adolescent Mental Health Services	☐	☐	☐	☐	☐	☐	☐	☐
3. Counselling Services, including Family Therapy	☐	☐	☐	☐	☐	☐	☐	☐

2. <u>Health:</u> (b) Are any of these other health services available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Screening for postnatal depression using relevant instrument	☐	☐	☐	☐
2. Identification of parents with episodic psychotic mental illness	☐	☐	☐	☐
3. Specialist provision for disabled children	☐	☐	☐	☐
4. Portage Services *(home-visiting for preschool children with special needs)*	☐	☐	☐	☐
5. Child Health Clinic	☐	☐	☐	☐
6.				
7. Lay Mothers' Breast-feeding Group	☐	☐	☐	☐
8. Community Mothers' Scheme	☐	☐	☐	☐
9. Family Planning Service	☐	☐	☐	☐
10. Youth family planning advisory service, e.g. Sexcare	☐	☐	☐	☐
11. Well Woman Clinic	☐	☐	☐	☐
12. Self-help groups	☐	☐	☐	☐
13. Other health services (please specify): …… ……	☐	☐	☐	☐

3. Family support: Are any of the following available to people living in this area?

	Yes, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. National Childbirth Trust Groups	☐	☐	☐	☐
2. Family Welfare Association	☐	☐	☐	☐
3. Family Centre (voluntary or statutory sector), e.g. Barnardos	☐	☐	☐	☐
4. Family Befriending Services	☐	☐	☐	☐
5. Home Start (provides family support through home visiting)	☐	☐	☐	☐
6. Ormiston Trust (provides support for families and children)	☐	☐	☐	☐
7. Link workers/Interpreters	☐	☐	☐	☐
8. Family Service Units (provides services for disadvantaged families and communities)	☐	☐	☐	☐
9. Welcare (provides information, advice and counselling for families)	☐	☐	☐	☐
10. Newpin (works to protect and preserve mental health in parents and children, and to prevent child abuse)	☐	☐	☐	☐
11. Women's Aid (works to end domestic violence)	☐	☐	☐	☐
12. KIDS (provides help for children with disabilities and their families)	☐	☐	☐	☐
13. BREAK (provides residential and day care services for families with special needs)	☐	☐	☐	☐
14. Children's Society	☐	☐	☐	☐
15. NCH Action for Children	☐	☐	☐	☐
16. Kids Club Network	☐	☐	☐	☐
17. Minority ethnically specific, e.g. Bangladeshi Welfare Association, Society of Asian Disabled	☐	☐	☐	☐
18. Religion specific, e.g. Catholic Child Welfare, Muslim Welfare Association	☐	☐	☐	☐
19. Parent Craft classes	☐	☐	☐	☐
20. Parenting Programmes	☐	☐	☐	☐
21. Pippin (Parents In Partnership Parent Infant Network)	☐	☐	☐	☐
22. Father Groups/Projects	☐	☐	☐	☐
23. Grandparents' Group	☐	☐	☐	☐
24. Swap-shop for children's clothes	☐	☐	☐	☐
25. Equipment Loan Service	☐	☐	☐	☐
26. Credit Unions	☐	☐	☐	☐
27. Other family support (please specify): …… ……	☐	☐	☐	☐

4. Leisure: Are any of the following available to people living in this area?

(Please exclude those which are provided by schools.)	**Yes**, provided in **this** area	**Yes**, provided in **adjacent** area	**No**, not available	**Don't know**
1. Open spaces with safe play areas	☐	☐	☐	☐
2. Adventure playground, skateboarding/roller-skating area	☐	☐	☐	☐
3. Private Leisure Centre (members-only)	☐	☐	☐	☐
4. Public Leisure Centre	☐	☐	☐	☐
5. Public Swimming Pool	☐	☐	☐	☐
6. Bowling Alley	☐	☐	☐	☐
7. Junior sports schemes, e.g. gymnastics	☐	☐	☐	☐
8. Activity centre, e.g. Whacky Warehouse, Jungle Gym	☐	☐	☐	☐
9. Parent and Toddler Group	☐	☐	☐	☐
10. Tumble Tots Groups/Baby Gym/Crescendo	☐	☐	☐	☐
11. Playbus	☐	☐	☐	☐
12. Toy Library	☐	☐	☐	☐
13. Mobile Library	☐	☐	☐	☐
14. Book Start Schemes	☐	☐	☐	☐
15. Music-making groups	☐	☐	☐	☐
16. Cinema	☐	☐	☐	☐
17. Museum	☐	☐	☐	☐
18. Zoo/City Farm	☐	☐	☐	☐
19. Other leisure facilities/services (please specify):	☐	☐	☐	☐

5. Statutory initiatives: Are any of the following, or their equivalents, operating specifically in this area (i.e. anywhere in the area outlined on the attached map)?

	Yes	**No**	**Don't Know**
1. Health Action Zone (HAZ)	☐	☐	☐
2. Healthy Living Centre	☐	☐	☐
3. Health Improvement Programme	☐	☐	☐
4. Sure Start local programmes	☐	☐	☐
5. Healthy Schools Initiative/Programme	☐	☐	☐
6. Education Action Zone	☐	☐	☐
7. Employment Zone	☐	☐	☐
8. Housing Action Zone/Trust	☐	☐	☐
9. Single Regeneration Budget	☐	☐	☐
10. New Deal for Communities	☐	☐	☐
11. Local Government Associations' New Commitment to Regeneration	☐	☐	☐
12. Neighbourhood Renewal Fund	☐	☐	☐
13. Local Agenda 21 *(promotes sustainable development and improves urban environ'ts)*	☐	☐	☐
14. Crime Reduction Programme	☐	☐	☐
15. Drug Action Team	☐	☐	☐
16. Other statutory initiatives (please specify):	☐	☐	☐

6. What do you think are the <u>bad</u> things about living in this area, for families with young children?

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7. What do you think are the <u>good</u> things about living in this area, for families with young children?

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8. Please use this space for any other comments:

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So that we can get back to you with the results, please tell us who you are!
(Please* PRINT *your details.)

Your Name:	
Your Trust:	
Your Address:	
Your Postcode:	
Your Tel. No.:	
Your E-mail Address:	

Thank-you so much for the time and trouble you have taken to answer our questions. Your help is greatly appreciated.

✯ A summary of the results from this research will be sent to all those who participate. ✯

Please return this form, by <u>12th August 2002</u>
using the FREEPOST envelope provided, or by fax. or e-mail:

Fax.: 020 7612 6880

E-mail: childnc@cls.ioe.ac.uk

(**Freephone:** 0800 092 1250)