Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People Committee

Dydd Mercher, 21 Medi 2011
Wednesday, 21 September 2011

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives
Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Jocelyn Davies	Plaid Cymru The Party of Wales
Keith Davies	Llafur Labour
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur Labour
Lynne Neagle	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Fran Dale	Rheolwr Dechrau'n Deg, Dwyrain Cymru Flying Start Manager, East Wales
Stuart Geddes	Cyfarwyddwr, Cymdeithas Ddeintyddol Prydain yng Nghymru Director, British Dental Association Wales
Dr Sue Greening	Cadeirydd, Cyngor Cymru Cymdeithas Ddeintyddol Prydain Chair, British Dental Association Welsh Council
Karen Jones	Rheolwr Dechrau'n Deg, Gogledd Cymru Flying Start Manager, North Wales
Chris Koukos	Rheolwr Dechrau'n Deg, De Cymru Flying Start Manager, South Wales
Nia McIntosh	Rheolwr Dechrau'n Deg, Gorllewin Cymru Flying Start Manager, West Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Claire Morris	Clerc Clerk
Meriel Singleton	Dirprwy Glerc Deputy Clerk
Sian Thomas	Gwasanaeth Ymchwil Research Service

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Dechreuodd y cyfarfod am 9.16 a.m.
The meeting began at 9.16 a.m.

[1] **Christine Chapman:** Good morning, bore da, and welcome back to the Assembly's Children and Young People Committee. We have not had any apologies this morning. I would like to formally welcome Aled Roberts to his first meeting as a member of the committee. Welcome, Aled.

9.17 a.m.

Ymchwiliad i Iechyd y Geg mewn Plant yng Nghymru: Sesiwn Dystiolaeth
Inquiry into Children's Oral Health in Wales: Evidence Session

[2] **Christine Chapman:** The first substantive item on the agenda is the inquiry into children's oral health. We have received papers from the British Dental Association, and I would like to welcome to the meeting Dr Sue Greening, the chair of the association's Welsh council, and Stuart Geddes, its director in Wales. I thank you for your paper. All the members of the committee will have read it. I would now like to go straight into questions, because the paper was comprehensive.

[3] I will start with a broad question. The Designed to Smile programme was first introduced in 2008 and extended across Wales in late 2009 and early 2010. In terms of improved health outcomes, what contribution has the programme made to improving child dental health so far?

[4] **Mr Geddes:** It is early days; because the project has not been in place in Wales for a significant length of time, we cannot say that at this point there have been major benefits. There has been a roll-out, and the contact between children and dentistry is improving; that is probably as much as we can say in Wales. We look very much to the Scottish experience, which seems to show significant improvements in the oral health of children in the target groups. The Scottish programme has been running for considerably longer.

[5] **Dr Greening:** Within dentistry, we produce outcome evidence of decayed, missing and filled teeth, as you probably understand. We do surveys of five-year-olds every few years, and the most recent was in 2007-08. We are about to do another survey of five-year-olds next year, and that is where we would see an evidence base for any improvements. Anecdotally, though, I work in a community dental service for Aneurin Bevan Local Health Board, and we have only been running the programme for a year, but within the project itself, a number of people say that they can see that children are brushing more, and you can see the improvement in oral health. However, we obviously cannot give you the evidence for that until it is proven through an epidemiological survey. Anecdotally, it seems to be working.

[6] **Jocelyn Davies:** It is encouraging that the indications are that this works, and once we have evidence, we will know. Are there other factors in the Scottish experience that we need to take into consideration? It might not be an exact replica.

[7] **Mr Geddes:** The demographic picture in Scotland with regard to children is very similar. It has the same deprivation areas, the same population problems and the same levels of decay. Scotland used to be at the bottom of the pile, or the top of it, depending on which way you are looking at it, and, at one point, Wales was better off than Scotland. That changed about three or four years ago and we went to the bottom of the pile. There are many similarities, and our hope is that the benefits that are being seen in Scotland will be seen in Wales.

[8] **Dr Greening:** A great deal of the programme that has been developed took into account what was happening. We were lucky in a way that we already had something to look at in Scotland. The programme in Wales has developed around the same sort of principles as

the programme in Scotland, so, fingers crossed, it will be successful.

[9] **Mr Geddes:** I think we stole the programme, or at least our colleagues did. [*Laughter*.]

[10] **Dr Greening:** I would not say that, but we certainly used the experience of others, which is what you would do.

[11] **Jocelyn Davies:** You learnt from best practice. You looked for good examples and looked at other people's mistakes.

[12] **Mr Geddes:** Indeed.

[13] **Dr Greening:** Absolutely.

[14] **Suzy Davies:** I think that we all accept that it is too early to take strong evidence on the question that we have asked, but the programme began in certain areas before it was rolled out. When you are undertaking this study over the next couple of years, will you be including those pilot areas, as they will obviously have been running longer and the evidence from them will be far stronger?

[15] **Dr Greening:** The epidemiological study will be across the whole of Wales. It will be done across the whole of the UK, in fact. That is where we get our data from, so all the information we get on five-year-olds is through those studies. This will be the first time we will be able to compare the results with the last study. We had some issues about consent. I do not know whether you are aware of it, but the last study could not be compared with studies done before because of the issues around consent. This time, the study will be the same as the last one. The only difficulty with looking at the evidence from an epidemiological survey is that we have targeted groups in the population because, despite a lot more money being put into the system, there still is not enough money to target the whole population. We have therefore targeted the most deprived areas and the Communities First areas in most of Wales. So, we will be able to look at the small areas to see improvements, but that might not translate to the whole population. It might be a small improvement. We will be able to look at the small areas, such as Blaenau Gwent and Merthyr—the really high-need areas—and, with any luck, those will show a bit of improvement.

[16] **Aled Roberts:** You mention funding. On page 7 of the evidence, you point out that there were some problems with the release of funds by finance directors within certain areas. Can you expand on that? I am quite interested to know whether there were any particular problems in particular areas.

[17] **Dr Greening:** I think that that was really to do with working in large organisations. When the money was first allocated to these organisations, there was a difficulty with transferring capital. We were buying mobile units and there are difficulties with transferring capital and revenue. There were lots of issues like that. There was also the fact that, within organisations, this was quite a lot of money to be landing in the lap of community dental services, so there was always the issue of whether we were using it correctly. They were checking that we were using it correctly. We managed to spend most of it. For next year, the organisations are set up to spend the money properly and by the right date.

[18] **Aled Roberts:** So, in the worst example, what was the extent of the delay, given that we have been talking about time being of the essence in assessing success or otherwise?

[19] **Dr Greening:** I will use the example of the Aneurin Bevan Local Health Board. We were working around school years, as you obviously cannot go into schools and nurseries

during the summer holidays, so, although the money was given to us in November 2009, by the time we had appointed people, because of the processes we had to go through, the programme did not really get going until April/May 2010. It takes you that long to employ people and get people in post. That is the sort of thing that caused delays. Now that is done and set in place, we have the right people in place and we have the systems running. From now on, those problems will not arise. They were just the teething problems of developing a new service that involved employing a lot of new people, which is not as straightforward as it might seem in big organisations with big structures that you have to work through.

[20] **Mr Geddes:** To make a general point about funding, dentistry is lucky in that the previous Minister for health ring-fenced, or badged, the dental budget, and it is quite difficult to get that concept through to finance directors of health boards—formerly trusts—as they look at the pot for dentistry and try to squeeze it. They have not quite grasped the concept that if they do not use the money for dentistry, it comes back to the Assembly and gets used for something else, probably.

[21] **Dr Greening:** [*Inaudible.*]—the finances are so tight in health boards at the moment that they are looking at every single penny. Every penny has to go through a scrutiny process, which takes time. It is just the nature of the way we are at the moment, I am afraid.

[22] **Jocelyn Davies:** It was therefore probably very wise to ring-fence the funding—let us put it that way. Just to get it on the record, why is the oral health of children from very deprived families likely to be poorer than children from other families? Those children can sometimes be very hard to reach in terms of programmes like this. Are you satisfied that the programme can make a significant impact? How much is this dependant on the availability of dentists in the most deprived communities, because I noticed that you mentioned in your evidence that the number of training places has been reduced?

[23] **Dr Greening:** There is evidence in deprived areas across the UK that deprivation and poor oral health go together—it is one of those public health definites. That is why we direct the programme towards smaller populations rather than targeting everyone. We know that there might not be very many dentists in the north of Gwent, but this is a health promotion programme about getting fluoride into contact with children's teeth. So, with any luck, they will not have disease levels that need more dentists—that would be the ideal. At the moment, we are managing within the community dental service to pick up the children who are in need, but the problem, as you said, is that they are difficult to get at and bring to dentistry. What we need to do is to get at those children and families before they ever need to get to a dentist. If they are aware of oral health and the issues to do with dentistry and teeth, we would hope that they would look for a dentist themselves. We would then have to look at the issue of whether there are enough dentists. However, if we can reduce the disease levels and the amount of decay, we hope that it would not have a knock-on effect in the form of not needing the services.

[24] **Christine Chapman:** You mention the European comparisons in the paper, and say that Wales was better than countries such as Sweden and Finland, although we are used to thinking of those countries as being top of the league. What are your views on that?

[25] **Mr Geddes:** We are better at the 12-year-old level. At 12 years old, however, children are out of the mixed dentition period having lost a lot of baby teeth; they have a new set of teeth to start getting decayed. That is probably part of the reason why we have better oral health at that level.

[26] **Dr Greening:** It is an issue of diet, education and all sorts of things at that level. The main problem is to do with issues of having to have general anaesthetics. You see a little three-year-old or four-year-old come in with a big fat face because they have dental decay,

and the only way to treat it is by sending them to have their teeth out. It is not a nice thing to have to do, and that is the sort of thing that we want to reduce for children in that age group.

[27] **Lynne Neagle:** I am sorry if this is a very basic question. In deprived communities, if a parent does not have a dentist, does that mean that the child also does not have a dentist, or is there another route?

9.30 a.m.

[28] **Dr Greening:** No, the community dental service is there to pick up children, and we try to target children and send out information to families. The evidence is that it is not just dentistry—those families do not take up maternity or antenatal services, either. There is a group in the population that does not take up services.

[29] **Lynne Neagle:** When you say that information is sent out, how does that get communicated to those parents?

[30] **Dr Greening:** Through the schools. Designed to Smile is starting to work with some practices as well, through a pilot programme. Some practices are working with the Designed to Smile team, so ideally the route would be through to a general practice, if we could get to that stage, because there are not many community dentists. Ideally, if we were to find children with need, we should be able to channel them through into practices, and we are starting to do that now with the pilot practices. We would hope that, once the pilot scheme has run for a while, and evidence has been built up, we might be able to expand that in Wales.

[31] **Mr Geddes:** The knock-on effect may also be that, by introducing children to a better level of oral hygiene, and to dentistry, their parents will take it up. Historically, parents in deprived areas do not go to the dentist on a regular basis—they tend to seek treatment when they have a problem, and they adopt that approach for their children as well. That is what we are trying to stop.

[32] **Dr Greening:** It is quite surprising how much influence four and five-year-olds can have; if they are brushing their teeth in nursery, they go home and ask, ‘Where is my toothbrush? I want to brush my teeth’. Once they get used to it, they know that it is part of their life. That is what we are hoping to develop.

[33] **Aled Roberts:** As a parent, picking up what Lynne said, I do not know whether there is an understanding of what the community dental service is. It is still widely called ‘the school dentist’; I am talking from my own experience. Many people have experienced difficulties with accessing NHS dentists, so most parents tend to think that they have to take their children to the non-NHS dentist. That is a barrier.

[34] I was also interested in your earlier point about oral health in 12-year-olds being better in the UK than in Sweden, but not at any other age. I could not follow that. Surely the issue about milk teeth being replaced by adult teeth would also apply to Sweden, so why are we at the bottom of the league in the early years, but, by the age of 12, it would appear that our position has improved? I would have thought that the general feeling was that diet is better in Sweden than here.

[35] **Dr Greening:** Quite possibly.

[36] **Mr Geddes:** Yes, and where families are using modern toothpastes, we have to say that there are considerable benefits. Most brands are fluoridated, so there is a topical effect from that. I am not sure about the distribution of toothpastes, but I suspect that, in the Scandinavian countries, the same brands are available. Those figures do surprise me, because

a lot of the Scandinavian countries have intense programmes of supervised fluoride rinses, and those sorts of things; they originated in Scandinavia.

[37] **Angela Burns:** As you brought up the topic of fluoride, could you explain to me this elephant in the room—the putting of fluoride into water? What are your views on that?

[38] **Mr Geddes:** There is an active anti-fluoridation group, and although it is very small, it has a disproportionate voice, in my view. It has the ability to make an awful lot of noise about an awful lot of things around fluoride. The evidence for fluoridation is quite conclusive. A review was carried out a number of years ago by the University of York that showed the benefits of fluoride. There are other issues, of course, around mass medication, but if you look at your normal diet, if you use margarine in your cooking, you will be getting supplements of vitamin D, and if you eat bread, you will be getting iron, and if you eat salt, you will getting iodides. That is mass medication; iodine and fluoride are the same chemical group, actually.

[39] **Angela Burns:** Does fluoride have any negative consequences?

[40] **Mr Geddes:** Too much of it will cause mottling of teeth. So, it is quite important, if you live in an area with fluoridated water, such as the West Midlands, that you use a toothpaste that is appropriate for your child, because you do not want them to overdose on fluoride and get white marks or, at the worst extreme, brown marks on their teeth. In fact, children's toothpastes are marketed with lower fluoride levels than adult toothpastes. That is to prevent that happening. White spots on teeth are not desperately bad, aesthetically, and they can be removed, but they should not be there in the first place.

[41] **Angela Burns:** So, is it the case that there are no other consequences of using fluoride?

[42] **Mr Geddes:** None that scientific evidence would bear out.

[43] **Christine Chapman:** I have a few people with questions on fluoride. I will take questions from Jenny and then Jocelyn, because I think that they are on the same point. If you could answer those together, we will then move on to another point.

[44] **Jenny Rathbone:** You mention in your paper that Anglesey used to have fluoridation, and the evidence that you provide on the prevention of decay there is pretty amazing. Which areas of Wales are fluoridated at the moment?

[45] **Mr Geddes:** The official answer is that nowhere is fluoridated. [*Laughter*.] Secretly, until recently, it was five houses in Llandrindod Wells. The Elan Valley reservoir is the supply for the West Midlands. The fluoridation plant is in mid Wales and, historically, there were a number of houses that were owned by Birmingham Corporation to house their workers in the reservoir area, and those houses received fluoridated water.

[46] **Jocelyn Davies:** Not big enough for a trial then.

[47] **Mr Geddes:** No. In fact, Llandrindod Wells was a bit funny. It used to come out in the surveys as always having low caries rates, so there must have been a bit of leakage of the water there.

[48] **Jenny Rathbone:** Has the Assembly never looked at legislating on this matter?

[49] **Mr Geddes:** No. There is a procedure that needs to happen before the fluoridation can be enacted, and the Assembly Government has never dealt with that first stage.

[50] **Dr Greening:** As a profession, the reason that we have moved on to applying fluoride to teeth is because we have sort of given up on the fluoridation of the water. The places that have managed to get fluoridation have gone through such processes to get it, and there is always the possibility of having it taken away. That is why we have gone down the route of getting fluoride in touch with teeth in other ways—through brushing teeth. We have to realise—and it is very difficult for us to realise this—that there a lots of families in Blaenau Gwent and Merthyr who do not have toothbrushes or toothpaste. For us, living in affluent Cardiff, it is perhaps quite difficult for us to understand that that is a fairly common thing. So, even if we can give people toothbrushes and toothpaste, that is something. We are starting to think about whether we should be delivering these to the doors of the most needy children. Those are the sort of things that we are thinking about.

[51] **Christine Chapman:** There are quite a lot of questions, so I am going to move on, if you do not mind, to Julie's question. You want to talk about children from birth to the age of three, Julie.

[52] **Julie Morgan:** Yes, but before that I want to ask about the most deprived children. Do you have any evidence on reaching ethnic minority families? Do you do anything specific to ensure that that message gets through to them?

[53] **Dr Greening:** Where there are ethnic minority groups, the community dental services generally have information in the right languages and interpretation facilities available. However, the Designed to Smile programme targets particular areas—Communities First areas mainly—and is trying to get involved with healthy schools schemes and so on. So, that is the main emphasis and they would be picked up through that mechanism.

[54] **Julie Morgan:** Do you have any evidence about the effectiveness and any variations?

[55] **Dr Greening:** Generally, their oral health is poorer, particularly in Asian families and various groups. It is not usually general evidence, but evidence of particular small groups. They will be picked up in the general programmes in deprived areas and particular areas. Each service manages the scheme differently; in Cardiff, they will be targeting different groups to those that would be targeted in north Wales, perhaps.

[56] **Julie Morgan:** I was going to ask about the scheme for those from birth to the age of three. I understand that it is being delivered differently in different places. Could you tell us how that is happening?

[57] **Dr Greening:** I do not have the detail across the whole of Wales. We are starting to look at those from birth to the age of three, and young schoolchildren will be the first to be targeted. We are now going out into nursery schools, using the Flying Start system as our entry points. All areas are providing brushing and fluoride in nursery schools; it is how they have chosen the groups and who they link up with that is slightly different. We have an all-Wales steering group for Designed to Smile, which is meeting next week, so we will probably get a little bit more information about the whole of Wales by then. It is how each area looks at the evidence for that specific area. For instance, for us, most of our effort is going into Blaenau Gwent and Torfaen. The same would be happening elsewhere; they would be putting their main effort into specific areas, because we do not have the staff to go into every school. It will be based on Flying Start areas, working with health visitors and Flying Start schemes.

[58] **Julie Morgan:** It is very good that this is happening, because the earlier that it is done, the better. What about very young children, such as in mother and baby groups, playgroups and so on?

[59] **Dr Greening:** For a long time, we have been accessing antenatal groups and going

into those sorts of areas. Sometimes it is successful and sometimes it is not. So, prior to school, we are relying on our links with health visitors and other professionals. In the Aneurin Bevan Local Health Board, we have an oral health steering group on which all those groups are represented. They will know that we are there and they are very keen to get us involved in the younger years as much as possible.

[60] **Julie Morgan:** Is there a link between breast feeding and teeth health?

[61] **Dr Greening:** Long-term breast feeding is linked to dental decay. Breast feeding, generally, is good for children when they are young, and that is as far as the evidence goes. There might well be evidence that there is a link with breast feeding, but the only evidence that I know of is that, if it is prolonged, it can cause dental decay.

[62] **Julie Morgan:** That is having breast milk rather than other milk.

[63] **Dr Greening:** At three or four years of age—once they have teeth.

[64] **Suzy Davies:** You were kind enough to touch on dental health surveys earlier. I, for one, do not know how they work and how they are processed. Will you give us a bit of background on how information is collated and then processed, and also tell us a bit about this change from negative to positive consent, and the effect of that?

[65] **Dr Greening:** There is a UK organisation called the British Association for the Study of Community Dentistry, which runs all our dental surveys. We are very lucky in the UK in that we have been doing dental surveys ever since I remember—for more than 30 years. We used to do it for five-year-olds every two years; now we are doing it about every four years, because we are looking at other groups in between. We have a group of trained staff who come from the community dental services across the UK, and a team from Wales is going for a training programme next weekend, or next week, I think. They are trained in examination and standardisation and are then given a carefully selected sample of children to look at across the whole country. They then go into schools and do a survey within a few weeks of each other, so that they can be compared. In the past, we used to be able to get consent by just sending out a letter to say ‘we are carrying out this survey in your child’s school—your child is of an age that we will be examining; please let us know if you do not want us to do it. That is a much easier way for us to get consent than getting what we call ‘positive consent’, which means that they have to have a signed form from the parent as it is now. The uptake of the survey went down. The number of children in the last survey was about 30 per cent less than before.

9.45 a.m.

[66] **Suzy Davies:** What restricts a change of emphasis?

[67] **Dr Greening:** The law. The lawyers said that we could not do it without positive consent from the parents. It would be very nice if we could get back to the stage when children went into school and their guardians could sign a form to say, ‘We agree to all these things’.

[68] **Suzy Davies:** That still happens for other interactions.

[69] **Dr Greening:** I know it does. However, sadly, I think that someone must have asked for the wrong legal opinion, although I do not know. Sometimes lawyers’ opinions vary, but the legal opinion is that we need positive consent.

[70] **Simon Thomas:** Yr ydych yn dweud **Simon Thomas:** You say in your evidence

yn eich tystiolaeth bod cael cydsyniad yn anos mewn ardaloedd difreintiedig. Ydy hyn oherwydd eich bod chi'n methu cyrraedd y rhieni, neu ydych chi'n dweud yn y dystiolaeth bod rhieni mewn ardaloedd difreintiedig yn fwy amharod i roi caniatâd? Beth yw'r rheswm dros yr anhawster hwn?

that consent is more difficult to obtain in disadvantaged areas. Is this because you cannot reach those parents, or are you saying in your evidence that parents in disadvantaged areas are more unwilling to give their consent? What is the reason behind this difficulty?

[71] **Dr Greening**: I am sorry that I cannot answer you in Welsh.

[72] It is a bit of all of those things. Some of the parents cannot read well and the forms that we send home are sometimes complex. Parents get an awful lot of correspondence when their children come home from school. If they have four or five children they might have four or five letters a day.

[73] Generally, people just do not send forms back; we all know what it is like. If parents have to sign a form and send it back, we will get less of them back than if we were able to use negative consent because, in the same way, people do not bother to say that they do not want it.

[74] So, I think that there are all sorts of difficulties. The forms go home from school, but who knows what happens between school and home? Sometimes, children are clever; they do not want to go to the dentist, so they throw the form away. So, there are all sorts of reasons for that. In deprived areas, it does seem to be worse; we are more likely to get the form back in more privileged areas.

[75] **Jenny Rathbone:** Do you have a cartoon that you could show in nurseries, primary schools and community centres, describing why it is important to brush your teeth?

[76] **Dr Greening:** Yes. There are all sorts of things, including puppet shows, that they will do. Do you mean resources for the parents?

[77] **Jenny Rathbone:** The television is always on in most houses. If we had DVDs, we could lend them to people and so on. Is there something that you would particularly recommend that explains in a child-focused way why it is important to brush your teeth?

[78] **Dr Greening:** There are all sorts of things targeted at children, depending on the age group. The health promotion teams are good at developing the sorts of packages that are needed to teach in the schools. There are all sorts of different things. The Designed to Smile team itself has a whole range of materials, including DVDs and visual aids, that are standardised across Wales. The children will all know Dewi the dragon, who is lovely. We have big suits for someone to wear to the schools. The kids love Dewi the dragon, who has big teeth, a big tooth brush, and that sort of thing. That is the sort of thing that we have. Dewi the dragon is the logo, which you might see on the vans, on the mobiles, and all of the paperwork. So, it is standardised. If you have young children, you might well have seen the standardised information on the scheme.

[79] **Mr Geddes:** One of the people who works on this scheme in Swansea said that the danger for the staff was that if they stood still for too long, they would get a logo slapped on them, and anything else that did not move got a logo firmly placed upon it.

[80] **Christine Chapman:** I want to bring in Keith Davies. I remind Members that you do not need to touch the microphones, because they come on automatically.

[81] **Keith Davies:** Bûm yn ffodus iawn **Keith Davies:** I was fortunate in that I was

gan imi ymweld ag ysgol a oedd mewn ardal Dechrau'n Deg pan gafodd y Cynllun Gwên ei lansio. Yr oedd y plant wrth eu boddau; yr oeddent yn canu, a chafodd pob un ohonynt frws dannedd. Credaf yr oedd y cynllun i bara tri mis neu chwe mis, ond oni ddylech newid eich brws dannedd ar ôl chwe mis? A yw'r cynllun yn sicrhau y bydd yr ysgol yn cael cefnogaeth dros flwyddyn, dwy flynedd, tair blynedd neu tra bydd y cynllun yn para? Yr oedd y plant wrth eu boddau; yr oeddent yn canu ac yn dawnsio ac yn y blaen, ac yr oedd yn fore hyfryd yno. Fodd bynnag, a fydd y cynllun yn para?

visiting a school in a Flying Start area at the time that the Designed to Smile scheme was launched. The children loved it; they were singing, and each one of them received their own toothbrush. I think that the scheme was to last three months or six months, but should you not change your toothbrush after six months? Does the scheme ensure that the school will continue to receive support for one year, two years, three years or however long the scheme will last? The children loved it; they were singing and dancing and so on, and it was a lovely morning there. However, will the scheme last?

[82] **Dr Greening:** I would hope that it will, provided that we continue to receive funding—the posts are all funded. Our staff support the schools and visit them every six weeks or so, or even more frequently. They also take new toothbrushes with them every four months. That is what some of the staff are there for. We have health improvement practitioners who are qualified dental nurses who have been trained further to carry out some of the health promotion work. We have therapists who do some of the clinical work, who are linked to the programme. We also have support workers, who have come from all walks of life, who support the health improvement practitioners, and who go to the schools all the time; they are always delivering stuff. We have toothpaste and toothbrushes coming out of our ears in most of the health boards, and they are stored in very large buildings. They are delivering those constantly. So, it is not just a one-off; the whole idea is to continue to support the children through the scheme, not just during the first year, but in their second, third and fourth years at school as well.

[83] **Keith Davies:** Yr oedd fan yn yr ysgol y bore hwnnw hefyd, ynghyd â chadair i ddeintydd ac yn y blaen. A yw'r fan yn mynd i'r ysgolion neu i gymunedau? Sut yr ydych yn defnyddio'r fan a oedd yno?

Keith Davies: There was a van at the school that morning, as well as a dentist's chair and so on. Does the van go to the schools or to communities? How do you use the van that was there?

[84] **Dr Greening:** The van goes to the school. All community dental services have one of those. Did the van have the Designed to Smile logo all over it? I presume that it did it.

[85] **Keith Davies:** Yes.

[86] **Dr Greening:** Those vans go there in order for fissure sealant to be applied, which is a preventive plastic coating that is applied to the back teeth as part of the programme, which helps to prevent decay in the second teeth that come through. They also have little vans that go around with all the equipment. They are very visual, so all the children see them. In most areas of Wales, mobile services will be taken to schools where the decay levels are high, or to special schools. We go to special schools regularly to provide dental care in a mobile dental surgery, so that the children do not have to go anywhere else. That breaks down one of the barriers to taking children to a dentist. That is done in targeted areas.

[87] **Mr Geddes:** This is a relatively new scheme in Wales, which is funded by the Welsh Government. It is new money, and it is important that that money continues and, hopefully, increases.

[88] **Simon Thomas:** Yn dilyn yr hyn a ddywedodd Keith, a oes cysylltiad rhwng y

Simon Thomas: Following on from what Keith said, is there any link between the

cynlluniau yr ydych wedi'u disgrifio y bore yma a nawdd masnachol, neu gwmni sy'n cynhyrchu past dannedd neu frwsiau dannedd? A ydynt yn noddi'r cynlluniau, neu a oes a wnelont rywbeth â hwy?

schemes that you have described this morning and commercial sponsorship, or any company that produces toothpaste or toothbrushes? Do they sponsor the schemes, or are they involved with them in any way?

[89] **Dr Greening:** No. They are not directly involved. Obviously, we have links with companies that provide goods on payment, but they are not linked in at the moment.

[90] **Simon Thomas:** Diolch; yr oeddwn eisiau bod yn glir ynglŷn â hynny.

Simon Thomas: Thank you; I just wanted to be clear about that.

[91] Darllenais yn eich tystiolaeth bod nifer y dannedd sy'n cael eu tynnu o gegau plant yng Nghymru yn eithaf uchel. Soniasoch am hyd at 9,000 o lawdriniaethau'n cael eu gwneud gan ddefnyddio anaesthetig cyffredinol. Mae peryglon—ac mae digon o straeon yn y wasg am hyn—ynglŷn â defnyddio anaesthetig ar gyfer triniaeth ddeintyddol ar gyfer plant a phobl ifanc. Felly, byddai dod â'r ffigur i lawr o fudd i bawb. Pa gamau sy'n cael eu cymryd i leihau'r defnydd o anaesthetig ac a oes tystiolaeth bod y Cynllun Gwên yn helpu yn y broses honno?

I read in your evidence that the number of teeth that are extracted from children's mouths is quite high in Wales. You mentioned up to 9,000 of those extractions being carried out with the use of general anaesthetic. There are dangers—and there are plenty of stories in the media on this—in relation to the use of anaesthetic for dental procedures for children and young people. Therefore, bringing that figure down would be of benefit to us all. What steps are being taken to reduce the use of anaesthetic and is there any evidence that the Designed to Smile programme is helping in that process?

[92] **Mr Geddes:** The ideal is to reduce the number of general anaesthetics administered to children. As you say, there are always dangers, and luckily there have not been any nasty fatalities, particularly in the past few years. General anaesthetics are now delivered in very specialist units. The spin-off from this campaign will be that the number of teeth with active decay will reduce, which we hope will eliminate the risk of infection from those particular bad teeth, which, in turn, will reduce general anaesthetic usage. There is a movement towards sedation rather than general anaesthesia, and that is very valuable in the more apprehensive patient—adult or child—and gets them into restorative dentistry.

[93] **Dr Greening:** Part of the problem is that a lot of the general anaesthetics are for very young children who are unable to co-operate with any sort of treatment. So, if we can target those young children with the Designed to Smile programme and lessen the decay there, we will reduce the use of anaesthetics. There is often not a lot we can do by the time we see children with a lot of decay, pain or swelling and the only option is to go for a general anaesthetic. If we can reduce the decay at a young age, even if they get decay later on, we might be able to manage it without resorting to general anaesthetic, which we prefer not to use.

[94] **Simon Thomas:** Fodd bynnag, mae'n wir dweud, hyd yma, nad oes tystiolaeth bod y Cynllun Gwên wedi achosi gostyngiad yn y defnydd o anaesthetig cyffredinol. Yr ydych yn gobeithio bydd gostyngiad, ond nid oes tystiolaeth o hynny eto. Ai dyna'r sefyllfa?

Simon Thomas: However, it is true to say that, to date, there is no evidence that the Designed to Smile scheme has achieved a reduction in the use of general anaesthetics. You hope for that reduction, but there is no evidence to prove that yet. Is that the situation?

[95] **Dr Greening:** Yes, because it has not been around long enough yet. The scheme needs to be in operation for three or four years to see any practical change in the young

population.

[96] **Simon Thomas:** Hoffwn droi yn awr at gwestiwn mwy cyffredinol, yn dilyn rhywbeth y gofynnodd Julie Morgan. Mae'r Cynllun Gwên wedi'i dargedu, fel yr ydych wedi'i amlinellu, ar ardaloedd Dechrau'n Deg a Chymunedau yn Gyntaf ac ati. Fodd bynnag, mae un corff wedi dod ataf i ddweud ei fod eisiau bod yn rhan o'r cynllun, ond ei fod yn cael anhawster gwneud hynny oherwydd ei fod yn gweithredu nid yn unig mewn ardaloedd Cymunedau yn Gyntaf ond ar draws ardal wledig eang. Felly, a oes posibiliadau a chyfle i fudiadau eraill i ddod yn rhan o'r cynllun hwn, neu a yw'r cynllun ei hun yn eithaf caeedig ar hyn o bryd oherwydd y ffocws ar ardaloedd difreintiedig?

Simon Thomas: I would like to turn to a more general question, following something that was asked by Julie Morgan. The Designed to Smile scheme is targeted, as you have outlined, at Flying Start and Communities First areas and so on. However, one organisation has approached me and said that it wants to be part of the scheme but it is finding it very difficult to do so because it works not only in Communities First areas, but across a broad rural area. So, are there possibilities or opportunities for other organisations to become part of this scheme, or is the scheme itself relatively narrow at the moment because of the focus on disadvantaged areas?

[97] **Mr Geddes:** It is a matter of funding.

[98] **Dr Greening:** Yes, it is a matter of funding and resources. We would ideally like to spread it across everywhere. When people come to talk to us, and we have a number of schools in our area that would love to be involved in it, we try to explain to them that we do not have the staff to be able to spread into those areas. There is certainly room for dialogue between the services that are providing it and anyone who wants to be involved. They would need to explain their own circumstances, because each area has different funding and priorities.

[99] **Simon Thomas:** A oes tystiolaeth—storïol neu fel arall—ein bod yn colli rhai pocedi o bobl ddifreintiedig, yn enwedig yng nghefn gwlad ac efallai mewn dinasoedd a threfi hefyd, drwy dargedu ardaloedd difreintiedig yn unig? Gall ardal sy'n ymddangos yn weddol gefnog gynnwys pocedi difreintiedig, ac efallai nad yw'r cynllun hwn yn medru cyrraedd y bobl hynny. A oes gennych unrhyw dystiolaeth bod hynny'n broblem neu ei fod yn mynd i fod yn anhawster yn y dyfodol?

Simon Thomas: Is there any evidence—anecdotal or otherwise—that we are missing some pockets of disadvantage, particularly in rural areas and perhaps in cities and towns as well, by targeting disadvantaged areas only? An area could appear to be relatively affluent but could contain pockets of disadvantage, and perhaps this scheme cannot reach those people. Do you have any evidence that that might be a problem or that it will cause difficulties in the future

?

[100] **Dr Greening:** That is the benefit of the community dental service knowing its local patch. The community service is the public dental service in each area and it should know its local patch. We have certainly expanded the scheme in our area to schools outside the Communities First area, because we know that they have been missed out just because of geography or how the boundaries were set up originally. That is an issue and people are aware of that. I can raise that with the other areas when we have our meeting next week and see what they are doing about that.

10.00 a.m.

[101] **Mr Geddes:** There is also the general problem of access to dentistry in rural areas. Unless they are branch practices, it is often difficult to establish a practice in a very rural area.

[102] **Simon Thomas:** Chair, if any information comes back, perhaps we could see it as a committee. It would be useful.

[103] **Christine Chapman:** This has been an interesting evidence session. I have a final supplementary question from Keith Davies. We have a few more questions, but, because of the time constraints, I suggest that we write to you with those, if you are happy to send a written reply, and with any additional questions that Members want to ask.

[104] **Keith Davies:** Bwriad y Llywodraeth yw ymestyn Cymunedau yn Gyntaf. Mae hynny yn ein maniffesto. A fyddwch yn gallu darparu eich gwasanaeth gyda'r staff sydd gennych yn awr os yw Cymunedau yn Gyntaf yn cael ei ymestyn neu a fyddwch yn ymladd i gael mwy o bobl i weithio ichi?

Keith Davies: The aim of the Government is to extend Communities First. That is in our manifesto. Will you be able to provide your service with the staff that you have at present if Communities First is extended or will you be fighting to have more people working for you?

[105] **Dr Greening:** We will always be fighting to have more staff to work for us. [*Laughter.*] We have already, in some areas, looked at our most deprived communities. If there is an opportunity to expand, we would always want to take it. However, with the present amount of funding, we would be able only to spread people more thinly and perhaps not go and support them as often as we do by going into other schools. So, it is a question of funding. We would look at how we would manage that if more Communities First areas came on board.

[106] **Christine Chapman:** I thank both of you, Dr Greening and Mr Geddes, for attending this morning and sharing with us your views on this important inquiry.

[107] **Dr Greening:** Thank you for having us.

10.03 a.m.

Rhwydwaith Dechrau'n Deg—Trafod y Prif Faterion
Flying Start Network—Discussion of Key Issues

[108] **Christine Chapman:** You will remember that, at the meeting on 14 July, we discussed undertaking an inquiry into the Flying Start programme. You will know that the Welsh Government is currently undertaking an evaluation of the impact of the programme. The evaluation comprises two waves of surveys and we are expecting the results of the first wave towards the end of the autumn, while the second wave is scheduled for 2012. In this session, we will talk to the Flying Start co-ordinators who are delivering the programme—I welcome them here today—to identify any issues that they have and to help us with particular areas of inquiry that we could look at if we decide to take this forward in the near future. Thank you all for coming here today. I welcome Karen Jones, who is representing the north Wales Flying Start managers; Nia McIntosh, who is representing west Wales; Fran Dale, who is representing east Wales; and Chris Koukos, who is representing south Wales. Thank you for your paper. We will go straight into questions, if you are happy to do that. I will ask the first question. The Flying Start interim evaluation, which was published in 2010, found that significant achievements had been made and that

[109] 'over half of the Partnerships are close to having established a full service programme over the four main entitlements in the space of just 2-3 years.'

[110] Which factors helped you to achieve this level of progress?

[111] **Ms McIntosh:** That is a very wide question. We had a quick discussion about this previously. The Flying Start programme is very complex. As you are aware, it involves intensive health visiting, free childcare, basic skills programmes and parenting programmes. If you look at the infrastructure that we have put in place in order to be able to deliver services in those areas, you will see that there has been vast commitment from the staff. There has also been a huge recruitment drive, because each local authority has had to recruit specialist staff in a number of posts. We have taken a multidisciplinary approach to the delivery of services to families, with the families—parents and children—being the focus of the programme. The multidisciplinary approach provides a team around the family, almost.

[112] Even though there are more formal moves towards adopting that approach now, Flying Start has been doing that for several years. If you look at the specialist staff within local authority teams, we have, for example, intensive health visiting being delivered by professional health visitors, support officers supporting health visiting work; parenting officers and basic skills officers and teachers. Other specialist staff include midwives, speech and language therapists, domestic abuse workers, counsellors and dieticians. There are a whole host of specialist staff to provide intensive services for children between birth and the age of three. So, one of the key factors is the success of the multidisciplinary approach and of all of these services being targeted towards meeting the needs of children.

[113] Behind that, there are many factors to be considered when implementing a new programme. Co-location has been vital and the services that have been co-located have seen real benefits from having open communication in a shared office with professional staff, discussing children on a daily basis. The logistics of being at the end of a phone or in another office at the other end of the community mean that, although people are still accessible, it is not as easy to discuss a family's needs immediately and make an immediate referral. It is far easier to do this when staff are co-located, and therefore that has been really beneficial. I know that not every local authority has benefited from the ability to do that, but those who have say that that is one of the significant factors as well as the multidisciplinary approach.

[114] Another factor is the drive of senior managers—me and those above me—and their commitment to and belief in the programme. That will make a difference. The commitment from staff and managers has been huge. The recruitment drive needed to put the infrastructure in place took a good 18 months. In Carmarthenshire alone, we have a team of just under 30 staff. There are brand new posts with brand new job descriptions and people need to be recruited to fill those posts. So, there has been a considerable effort to put all of those things in place.

[115] **Christine Chapman:** Thank you, that is interesting. Jocelyn, would you like to ask a question?

[116] **Jocelyn Davies:** The interim evaluation also found that there was variation in delivery in some aspects of the Flying Start entitlement. Can you explain the variations and do you think that they will be significant?

[117] **Ms Dale:** It is clear from the meetings that we have held over the last four years that the variations add to the wealth and depth of Flying Start. Delivery needs to meet the needs of each locality. Therefore, some team deliveries, whether health and social care or even the chilcare elements, have needed to be diverse so that the delivery can reach all of the families that they need to at the point of need. However, the method of delivery needs to vary and therefore diversity in relation to who is in the team and how it is done—whether it is co-located or based with the childcare settings; whether those childcare settings are beside or near a school—need to be led by the children and young people's partnerships.

[118] **Christine Chapman:** Jenny, do you want to ask a question on the hardest-to-reach

children?

[119] **Jenny Rathbone:** Can you tell us what the reach is in each of your areas?

[120] **Ms Koukos:** Can you explain what you mean?

[121] **Jenny Rathbone:** The reach—you will have a population of children in each Flying Start. How many of them are you working with or in contact with?

[122] **Ms Koukos:** Each area has a cap, which has been set by—

[123] **Jenny Rathbone:** I am not talking about the cap. You have a population of children from birth to the age of five, so how many of them, within the targeted area, do you reach?

[124] **Ms Koukos:** In relation to targeting the children and the hard-to-reach children, the door to those children's lives is their parents and it is about how we engage with them. We know who these children are, because we have their details and addresses. Obviously, the health visitor is the first port of call because they come into contact with all children who are aged from birth to 5. However, actually engaging in a meaningful way with the family is very different. What Flying Start does that is different from generic services is, because we have a team approach, and because we work very much together, our channels of communication within our data protection guidance are such that we talk to each other as professionals a lot more probably than we would in normal life because of the co-location that we have. For example, in a Flying Start setting, you would have the health visitor base there, as opposed to being in the primary healthcare team. You would have the childcare staff, the parenting workers, and whoever else is involved with those children, so you actually have much more opportunity to work on strategies to engage. You share the issues and the problems that are affecting these families.

[125] For example, most of the families take up the childcare, so if the parents are coming to bring their child to the childcare setting, then, if the health visitor is on site, she can see those parents who might not have responded to her visiting at home. They are soft strategies, I suppose, to break down the barriers to organisations and authority where people feel threatened and judged. It is about looking at not necessarily the parenting programmes that you can advertise to which people will come because they want to, but at what happens before, in the home, and at the barriers to them coming out and engaging with the professionals. Flying Start has had great success in relation to that because of the multi-agency approach.

[126] **Jenny Rathbone:** You mentioned that people tend to take up the childcare offer, so your reach among two-year-olds in the cohort is—?

[127] **Ms Koukos:** There is a difference between taking it up and maintaining attendance; it is an ongoing thing. Most families—

[128] **Jenny Rathbone:** I was looking for statistics, such as 10 per cent or 90 per cent.

[129] **Ms Koukos:** In our area, for example, we may have more than 90 per cent taking up their place, but when it comes down to bringing the child five days a week for their two and a half hours, that is a very different thing, depending whether their session is in the morning or the afternoon. We started off with attendance of possibly 40 or 50 per cent, and strategies have been put into place to look at the reasons why that might be. We have instances of improving that to over 70 per cent, because you do not just wait and see; as soon as the child does not attend, that very same day you would ring the parent, as you would if a child does not attend school, and you would ask them why the child was not there and whether they

needed support. We have other examples of attendance from elsewhere—

[130] **Jenny Rathbone:** If we stick with south Wales for now, what is your reach within the birth to one-year-old cohort?

[131] **Ms Koukos:** With those from birth to the age of one, because we have—

[132] **Jenny Rathbone:** Or birth to the age of two, if you want.

10.15 a.m.

[133] **Ms Koukos:** That would be 100 per cent in relation to the contact from the Flying Start family health visitor. The generic health visiting service has a core health visiting programme, under which we have a number of visits. In the Flying Start health visiting programme, we have an additional nine visits and contacts with the family. Initially, for the birth visit, which is undertaken between 10 and 14 days after the birth, the take-up is 100 per cent. Again, that is because we provide an intensive health visiting service and work in a slightly different way to generic health visitors. Instead of going to the GP surgery to have routine advice and information about feeding or weighing their child, parents can do that in the Flying Start setting, where it is friendly and non-threatening. So, the take-up is very good in the beginning.

[134] The evidence from health visitors is that there has been a considerable reduction in the number of families they would normally have problems engaging with during home visits that would result in no access. For example, the speech and language therapist in Flying Start carries out home assessments, and we recently received information from her that, following 35 referrals, only two individuals were not in when she visited their homes, and one of those had let her know that she would not be there. This particular speech and language therapist also works in generic speech and language therapy, where that is unheard of. She is quite used to families not attending an appointment in the main clinic. They would be given another appointment, but then there would be nothing else, because there is no follow-up. However, in Flying Start, you are in the home. Only one individual had told her that she would not be in—everybody else was in. That is one example of a different way of working with families, because you are meeting them on their territory, and you are building bridges then. They then think, 'This isn't so bad, actually. They work together in Flying Start, and she was all right, so let's see what else is on offer'. There are families you will not find so easy to engage with, and they are problematic. That can then escalate to become a child protection issue or a safeguarding issue.

[135] **Jenny Rathbone:** Did you wish to talk about other areas, Nia?

[136] **Ms McIntosh:** The thing to remember about the uptake and reach is the nature of the families we deal with and their complexity. We expect a vacancy rate with the childcare, for instance. In dealing with the most vulnerable families in our communities, we will be delivering services that have been targeted to identify those in the most deprived communities. We are all working people, and are probably used to getting up in the morning and getting the children ready for school and so on. Many families have never had that routine. So, it is a case of trying to put that in place for families where there may be substance misuse in the home, or domestic abuse, or there may be special needs. There are also housing issues, such as poor conditions, or there may be child protection issues and so on. Getting the families that we deal with to take up childcare five days a week and to ensure that the children are washed and out of bed in time for 9 a.m. is an achievement. We expect to have to work constantly to fill the places completely. Carmarthenshire has seen similar results to those in Swansea, where the take-up and registration for childcare is very good: about 96 per cent of children are registered to attend. However, the regular attendance rate is probably just under

70 per cent. We expect there to be some vacancies, but we work with the childcare workers, and the health visitors are informed if the children do not attend. We all put strategies in place, and we continually work with the parents to try to find out what the issues are—that is, to find out whether something has happened in the home, a crisis perhaps, to stop the child from attending childcare. For example, the mum might be moving. Many in that population are transient, moving in and out of our communities. So, there is a host of complex issues in relation to the vulnerable families that we deal with. Over the years, in Carmarthenshire in particular, we have seen a steady increase from an attendance rate of about 62 per cent in the first year to a rate of around 68 per cent or 69 per cent. It is going in the right direction, because we have put in place the relationships and services—it is a multidisciplinary approach.

[137] **Jenny Rathbone:** You mentioned that some of the vulnerable children you deal with live in homes where there is drug abuse or domestic violence. Could you explain how you track who is having contact with that family?

[138] **Ms McIntosh:** Our health visitors are the key workers. As Chris mentioned, we know every single child born within our community, because the child health system of the NHS notifies us straight away. So, they are known to us straight away. Our health visitor then carries out an assessment using the family assessment tool—Carmarthenshire and a couple of other areas, such as Wrexham, use it as well. So, we go into the home early on after the baby is born to assess the family's needs, using the assessment triangle. We look at the environment, the housing and at parental capacity, and we make an assessment of the family's needs. The health visitor will then put a care plan in place. For example, we could have a teenage mum living in a flat on her own in the middle of Llanelli town who has a lack of support or family around her. So, we could put in a support officer to help her with things—and they could be simple things—so that she can cope with a newborn baby in the home.

[139] So, the health visitor remains the key worker. A care plan is put in place and a decision will be made whether a person needs a support officer. That support will continue in the form of weekly visits over a period of time, after which there will be a review with the health visitor, and then they will continuously review any additional needs that the family may have. What we are finding is that by building these regular relationships, we have more information and more is disclosed about what goes on within the home. So, the health visitor may not know that domestic abuse is going on in the home, but after three months of visiting, the support officer will find out.

[140] **Jocelyn Davies:** Listening to you today, I have heard 'vulnerable families' and 'vulnerable children' mentioned several times. How do you avoid stigma being attached to families that are identified as needing Flying Start support, which might put off some people from accessing it?

[141] **Ms Jones:** In north wales, given that Flying Start is viewed as a programme that people want to be involved in, we have not found it being stigmatised in any shape or form. That is because we have made the effort not to advertise broadly what Flying Start is, because, obviously, we do not want to dangle carrots in front of people and then say, 'No, you can't have it'. So, going back to the point about the reach, with the four entitlements to Flying Start, it is very difficult to give you an overall view of that, because we use various engagement methods. For example, we may have a family that has historically never come out of a house, so we would send in one of our workers. We have various professionals in teams up in north Wales; some are social workers and some are parent support workers. We are therefore able to send various people into the home and, as Nia was saying, assess the level of support that the family needs. Because we are all co-located, we are able to come back to the office and have an informal team meeting about the family, pass on the information that we have gleaned and then look at what the best plan of campaign is for that

family. Our work is constantly updated, and there is no need to make a formal referral because we are all on site, which cuts down the time and the paperwork. The families are getting the service that they need immediately—there is no delay whatsoever. So, I do not think that there is a stigma attached, because we have made a conscious effort not to broadcast the scheme.

[142] **Jocelyn Davies:** I am not suggesting that there is stigma; I was just asking how to avoid it.

[143] **Ms Jones:** It has been the fact that we have kept it quite closely within the boundaries.

[144] **Christine Chapman:** Angela is next before we move on to another area.

[145] **Angela Burns:** I just want to follow on from the comments that you made about the multi-agency approach and how, as soon as babies are born, you send in a health visitor. I was shocked to read in the Children in Wales report that you report difficulty in getting a Flying Start child on to the child protection register if you decide that, despite all your support and intervention, there are still issues there. I do not know an awful lot about the child protection register, but I am interested to know what other people are notified, apart from all the people who are already involved—and I assume that the police might be included. Could you enlighten us on that and give us a steer as to how you think we should plug that hole, because that is, without a doubt, a hole?

[146] **Ms McIntosh:** I am sure that a few of us will want to answer this question. That is just the case in a few authorities, not in every authority. We are also quite shocked to find that they will not necessarily accept a Flying Start referral. In Carmarthenshire, our assessment teams in social services know as soon as they get an inter-agency call from a Flying Start health visitor that they must intervene, because we have already put in the support services. Our health visitors across Wales will be holding a weighty caseload for children in need who are just below the threshold of needing social services intervention. So, not every authority has that problem.

[147] **Ms Dale:** Several of the teams have now increased their multidisciplinary nature by including social workers. In the early days, there may have been some misunderstanding about the role that a social worker might play within Flying Start, but, in reality, the Flying Start social worker does not hold any families already known to the social services in his or her caseload. However, in the early days, there was an expectation that Flying Start could hold some high-end, quite risky families, which would then reduce the number of child in need or child protection referrals. Most of those misunderstandings have now been cleared up and the role of the Flying Start social worker is much clearer. Social services departments are also clearer about where their threshold lies and that we do not manage child in need or child protection families on their behalf.

[148] **Ms McIntosh:** We know that we are a preventative service and it is about getting the message through. Social services are under pressure to deliver services and they have such heavy caseloads that they perhaps saw a means of lightening the load in that we would be able to take on some of their work, early on, but, as we have said, that is not true of every authority. Work is ongoing to try to address that and to be clear that we do not hold cases; we are a preventative service. If our preventative services decide that a child is still at risk, then social services need to intervene.

[149] **Aled Roberts:** A fyddech yn dweud bod eto awdurdodau sydd yn gwrthod rhoi plant o deuluoedd Dechrau'n Deg ar y

Aled Roberts: Would you say that there are still authorities that refuse to place children in Flying Start families on the child protection

gofrestr amddiffyn plant? register?

[150] **Ms Dale:** What was being asked was whether it is true that certain social service areas are not accepting children from Flying Start on to the child protection register. As we all said earlier, we were surprised to read what was written in that way there. The information that has been collected over the last few weeks has come from all 22 local authorities, and although we represent all of Wales, we do not necessarily know which particular local authorities may have submitted that piece of information. It is more complex than that. It certainly does not happen in the area of north-east Wales where I operate. We have never had any difficulty in getting the social services department to accept a referral for assessment prior to the case conference, planning meeting or whatever is required for that family.

[151] **Aled Roberts:** Mae'n bwysig, yn sgîl datganiad y Dirprwy Weinidog ddoe ynglŷn ag un sir, ein bod ni fel pwyllgor yn gofyn beth yn union yw'r sefyllfa.

Aled Roberts: It is important, following the Deputy Minister's statement yesterday regarding one county, that we as a committee should ask what, exactly, the situation is.

[152] **Jocelyn Davies:** We should acknowledge that placing a child on the child protection register is a statutory process and no single organisation can decide that. There is a process that involves a considerable number of steps. It is the referral that is not being taken up.

[153] **Aled Roberts:** The implication is that there are authorities with policies that make it more difficult for children from Flying Start families to go through that process.

[154] **Angela Burns:** Perhaps we could ask for an expansion on this, if possible, from whoever submitted this. I guess that it was Children in Wales.

[155] **Jenny Rathbone:** We need to go back to Children in Wales and get a list of the local authorities where this is an issue.

[156] **Angela Burns:** We should also contact the Flying Start Network of Wales co-ordinators.

[157] **Christine Chapman:** So, there is work to be done there. Angela, do you want to come in now?

[158] **Angela Burns:** Yes, on geography. I have one quick other question, which is probably silly, but does a teacher in a school or nursery setting know whether a child is a Flying Start child? You are all saying 'yes'. Quite a lot of us would like to ask you questions on the geography of Flying Start.

10.30 a.m.

[159] It is a truism that families that are disadvantaged do not necessarily live in deprived communities, and I think that this is especially true in rural areas. There might be a long lane where one family living there might be in trouble, but those next door might not be. Therefore, I would like your general comments on how you think the geography works. I will try to fire off all of my questions because I know that everyone else wants to come in.

[160] Do you think that basing the programme around a school is appropriate? If we did not base it around a school, but on the individual child who could then go to any school, would that impact on your delivery of the service? The reason that I ask that is that, in some areas, there might be a number of primary schools on the edge of a Flying Start area, more and more nurseries are now attached to primary schools, and if you have a Flying Start school and children go to that nursery, they will inevitably go to that primary school, which means that

other primary schools face a drop in pupil numbers, while the school with the Flying Start children will be oversubscribed. More importantly, and this is something that people do not look at, you end up with the social consequence of having a non-mixed school, where children who have those issues do not have the opportunity to mix with ordinary kids and affluent kids. I worry about the—and forgive me for using this word; please do not misinterpret it—ghettoization that could happen if you designate a school as a Flying Start school and everyone else goes somewhere else. I hope all of those questions make sense; I can repeat them if you could not follow my train of thought, but I just wanted to get them out.

[161] **Ms McIntosh:** There are a few questions there, so we will all chip in. I understand what you have said about the schools, but we are finding the opposite to be true. The links that we are making with the schools are raising standards in those schools. In one of our flagship areas in Morfa in Llanelli, we feel that Flying Start is potentially leaving a legacy for future generations, because we have put childcare in place in a deprived area. It is based in an integrated children's centre in Maes y Morfa School. However, we have been running the scheme there for three or four years and the headteacher and the nursery teachers will tell you that there is a vast difference in the behaviour and development of the children who have received Flying Start childcare compared with those who have not. So, the opposite is true: we are raising the standards and are giving these children far more opportunities. They attend the childcare setting, where there is an opportunity for them to learn simple routines—to listen, to sit down and to have meals around the table. It is not just about their language development or their physical milestone development, but about many other things. We are able to raise standards.

[162] **Ms Dale:** It has also improved relationships between home and school. Given that children now expect to come into a Flying Start childcare setting, parents consequently expect to find a nursery place. We have certainly found increased pressure on those nursery places and a great number of parents taking them up. In the past, some of these areas would have had poor levels of take-up, but it has significantly increased, and because the attendance rate has increased, school-age children are more likely to be in school. The feedback from teachers is that they are seeing fewer behavioural problems in the early intakes of the children who have gone right the way through Flying Start in comparison with previous years. That means that there is much less pressure on some of their special educational needs co-ordinators.

[163] **Ms McIntosh:** Childcare facilities have been set up in refurbished classrooms in some schools and schools have reported an increase in take-up. Historically, local parents had chosen not to send their children there, but the schools are now thanking us because, since we have placed childcare there, their intake is increasing and children want to go there now. As you said, once they start there, they are likely to continue in the school.

[164] **Ms Koukos:** From a childcare perspective, in Swansea, we have loved having the Flying Start settings in the primary schools. We have refurbished underused space and it has had a positive effect because everyone is co-located. However, we had not realised that the health visiting team are also co-located. In Swansea, we have 35 GP practices, 29 of which have Flying Start children. So, we could have a health visitor based in a Flying Start setting who has children from 12 different GP surgeries. With regard to communication processes, you have to be spot on with transferring information backwards and forwards, and you have to get the protocols right for sharing information. It is something that we probably had not realised in the beginning and I do not know what the answer is, because GPs work in a different geographical way to other professionals. We have faced a big challenge with the communication channels and we are trying to get it right, but we have learned a lot of lessons from it. That is why it is quite handy for parents to be able to visit their local Flying Start health visitor in the childcare setting for routine advice, weighing of the baby, baby massaging and things like that, as opposed to trekking to their GP who could be miles away, and getting two or three buses and having that problem. So, it is a mixed benefits approach to

the geographical area.

[165] **Angela Burns:** If we develop your argument, which I buy into totally, how could we roll Flying Start out in more rural settings? You might have a disadvantaged family over here in a rural area in desperate need of Flying Start, but there is no way that their child could get to the Flying Start school because another school that is not in the programme is just around the corner. A lot of people in rural areas will not have easy access to transportation.

[166] **Ms McIntosh:** We recognise that that is a challenge. We looked at a range of criteria regarding how we would assess where we would potentially target our areas for the next time around. It could be a whole host of criteria. For example, if you use the Wales index of multiple deprivation, it does not necessarily help rural areas because you will not have the population numbers to prove that there is a huge pocket of deprivation there, as there may be only a small number of individuals in deprivation. That is a challenge and we will have to consider how to do that. There has been talk internally about whether we should consider hubs of offices, so that even though we would keep a main central business, the question would be whether we could have an outreach office that could be used to tap into the smaller pockets of deprivation. Those are ideas, but it is difficult to pin down exactly how we would want to tackle those. However, we all recognise that those areas are a challenge when it comes to ensuring that services are universally available for those people.

[167] **Angela Burns:** One of the things worth considering would be a Flying Start-lite. If you have time to put together a separate note, I would be interested to see whether you could identify, among the enormous bag of services that you provide for people, if you had to do a Flying Start-lite that could be delivered not by the core team, but by people you had trained up in a local doctor's surgery or wherever, what the key things would be that you would take into Flying Start-lite. What links would have to come out of it, if you had to deliver the full service as a second wave? Does that make sense? What I am interested in specifically is how we roll out what is a successful programme, because if we do not catch them now, they are lost; I have a very bleak view on that. So, I am interested to know how we could roll this out throughout Wales to capture more families that are in chaos and in need of that kind of help.

[168] **Julie Morgan:** My first question is very much along the same lines. I represent an urban area in Cardiff, but there is no Flying Start provision there. However, there are families in the area that need what seems to be a wonderful service. How can we address that in an urban area? The Government has also made a commitment to double the number of children who will benefit from this programme. Are there any areas where that would present a problem in the number of professionals available, such as health visitors?

[169] **Ms Dale:** We have also been looking at how expansion could work, taking into account the lessons that we have learnt in the last few years. We would probably all agree that three of the four elements—basic skills, intensive health visiting and parenting—would work whatever model we used. The difficulty arises in that if you target individual families in particular areas based only on need, how can you include the fourth key element, namely quality childcare, because that would be done on a much more ad hoc basis? At the moment, it is done as part of the four elements—it is arranged, planned and offered as part of the integral embedded package from pregnancy onwards. That is a difficulty that we will all have to look at in greater detail.

[170] **Ms McIntosh:** The difficulty we would have with that is that we all have early years teachers as members of our staff, and the early years teacher's role is to work with our childcare settings and that would make it difficult for her. We commission childcare from a range of different childcare settings—mixed economies, family centres, bilingual playgroups, Welsh-medium playgroups and integrated children's centres—and the early years teacher has to work with all of those sectors to ensure that their quality standards are adequate in terms of

what we aspire to. It becomes difficult if you place individual children in individual nurseries because she has to try to work with a private nursery that has one Flying Start child to potentially raise the standards at that nursery. Those are challenges. We tend to buy block spaces of 10 or 20 en masse—it could be at a local-authority-run setting—and the early years teacher has much more influence when working with childcare leaders to arrange suitable activities, the curriculum and learning opportunities when there is a larger number in the cohort and she can influence on a larger scale. So, the reality is about capacity as well.

[171] **Julie Morgan:** What about the professionals? Are there going to be enough health visitors?

[172] **Ms McIntosh:** No. It is a challenge.

[173] **Ms Koukos:** It is a huge challenge because of the nature of the health visiting workforce now. Another factor is the review of health visiting and possibly the restructuring of the way in which health visitors are trained. If we were to use the same model and we doubled in size, in Swansea, for example, we would need another 12 health visitors. That is just the maths, if you divide the number of children by 110. Also, when you have a health visitor with a caseload of 110 and 20 per cent of those cases are children in need, safeguarding or child protection, that is a very heavy workload and 110 may be too many. So, we honestly do not know the answer to recruiting more health visitors; maybe you have the answer to that.

[174] **Keith Davies:** Rai blynyddoedd yn ôl, es i a chadeirydd y cyngor ysgolion i ymweld â dosbarth derbyn mewn ysgol yng nghwm Rhymni. Gofynnodd y cadeirydd i'r athrawes beth oedd y peth mwyaf anodd oedd yn ei hwynebu pan oedd y plant yn dod mewn i'r dosbarth. Atebodd yr athrawes mai'r peth mwyaf anodd oedd cael y plant i wrando am eu bod o flaen y teledu o hyd pan fyddant yn eu cartrefi. Mae'n bwysig felly gwneud y cysylltiadau hyn gyda'r ysgolion oherwydd bydd y plant yn gwella a bydd yn llawer haws i'r ysgolion i ddelio â'r plant sy'n dod o'r cartrefi hyn. Yr wyf innau'n cynrychioli tref ac mae ardal y Morfa yn rhan o'm hetholaeth. Pa gysylltiadau sydd rhyngoch chi â'r ysgolion? Gwn bod cysylltiadau agos rhyngoch a phennaeth Ysgol Maes y Morfa oherwydd yr oedd yn y cyfarfod a fynychais yn Llanelli, ond beth am yr ysgolion eraill yn yr ardal, fel yr ysgol Babyddol a'r ysgol Gymraeg? Bydd rhai rhieni yn dewis yr ysgolion eraill, nid yr ysgol leol. Sut ydych chi'n magu cysylltiadau gyda'r ysgolion eraill?

Keith Davies: Some years ago, I, along with the chair of the schools council, visited a reception class in a school in the Rhymney valley. The chair asked the teacher to describe the most difficult task facing her when the children came into the class. She answered that the most difficult thing was to get the children to listen because they are constantly in front of the television when they are at home. It is important therefore to make these links with the schools because the children will improve and it will be much easier for the schools to deal with the children who come from these homes. I represent a town and the Morfa area is part of my constituency. What links do you have with the schools? I know that you have close links with the headteacher of Maes y Morfa School as he was in a meeting that I went to in Llanelli, but what about the other schools in the area, such as the Catholic school and the Welsh school? Some parents will choose to send their children to other schools rather than the local one. How do you foster links with the other schools?

[175] **Ms Jones:** In my county, we commission childcare in a range of settings. We have voluntary sector playgroups, Welsh-medium playgroups, private day nurseries and childminders. We also have the five key schools within our catchment area and, on top of that, we utilise the Welsh-medium school and the faith school in the area. We have built very strong links with all of the schools. My early years teacher goes in and supports all the childcare settings and she is trying to increase the contact time that our staff have with the

children in the setting. The speech and language therapists go in and there is a whole range of activities that go into the setting. So, with them not being only Flying Start settings, there is a knock-on effect on all those children that are attending the setting. The childcare is benefiting a broader number of children than just the specific Flying Start children.

10.45 a.m.

[176] We are upskilling the staff in those schools. They receive professional development, and we hold practitioner forums where they are given resources that we have made—giant puppets—so that they know how to use engagement methods with the children. We give them the resources so that they can take them back and use them. We have a very good relationship with all of the schools. We did not want to exclude any.

[177] Initially, we were worried about setting up Flying Start because we were looking at developing childcare, but there were existing settings. So, the question was whether to set up our own, which would be free childcare, thereby compromising the settings already operating and causing job losses and so on. Therefore, we made a very conscious decision about that, and I think that that is true for the majority of the north Wales counties. I think that it was only Anglesey that had to set up its own centre. That has been the focus up in north Wales.

[178] **Ms McIntosh:** We have also put in place transition meetings between the early years teachers and the nursery or reception class teachers so that, as children leave childcare, the teachers know them. I cannot honestly say that they go to every school because, if we have only one child going to a school, again because of the capacity, we have to be realistic about what one teacher can do. However, if we have a largish cohort of children going to a range of schools, the health visitor will be able to hand over transition folders to the schools, providing information about the child and their development. So, we are conscious that the schools are vital in the process of our handing over the children. The feedback from the schools is that they have seen a huge difference in the children who have benefited from Flying Start childcare.

[179] **Ms Koukos:** Sometimes, as some children are identified as having additional needs while they are in childcare, they are already known to the educational psychology department, which will therefore have plans in place much earlier, anticipating the statementing of these children and meeting their needs. Schools have fed back to us that where, in year 2, they would normally be identifying children with problems and referring them for assessment, that has already been done because the child has come from Flying Start and is already on the radar of a multi-agency approach. Therefore, they are not having to start doing that themselves at that stage.

[180] **Christine Chapman:** Jenny has a brief supplementary question on the previous point, and then I want to move back to Angela.

[181] **Jenny Rathbone:** One of the challenges is how quickly we can mainstream the good practice that you describe. That is key to how we are going to double the number of children involved. The other issue is the skills mix. We may not be able to suddenly produce these very experienced health visitors. What about healthcare assistants with the appropriate NVQ? How common are those qualifications in your teams?

[182] **Ms Dale:** As we said before, the health and social care teams are very diverse across the whole of Wales. I think that we have all recognised in the past three or four years the necessity to look at the skills mix and to increase it. Most of us have family workers. We have parenting leads and basic skills co-ordinators, community psychiatric or primary healthcare workers, social workers and specialist midwives. We would all welcome a review within the guidance of what the core skills mix is for health and social care teams, because it is so

diverse. It would be helpful to us all if we had a wider menu of skills we could use for planning.

[183] **Jenny Rathbone:** Excellent. Thank you.

[184] **Ms McIntosh:** There is a concern for us that we could become too diverse and involve too many other professionals. There is a balance to be struck with the skills mix.

[185] **Jenny Rathbone:** I am not talking so much about people's backgrounds—

[186] **Ms McIntosh:** Yes, sorry, I am talking about the skills mix.

[187] **Jenny Rathbone:** We are talking about people who are less qualified being supervised by those who have those qualifications.

[188] **Ms McIntosh:** I think that we are conscious that we do not want to go too far in one direction and have too many other non-professional posts. Our health visitors remain key workers, so they could potentially end up with larger cases where they are not directly involved, and the pressure could be quite considerable if health visitors were not available. We would potentially be asking health visitors to oversee more cases with other support staff in place. That is a considerable ask and puts pressure on the professional person.

[189] **Angela Burns:** I have a final question about the cap system, which I do not really get. Perhaps you can explain it. How do you differentiate? You have a geographical area, which is your Flying Start area, but you are allowed only a certain number of children within that. How do you decide which family to take in if many of them have a similar level of need? How would you manage the situation where you had a Flying Start child who, obviously, grows another year and then has a sibling? Does that child automatically become a Flying Start child as well? When the first sibling leaves the Flying Start programme but then another sibling comes along, do you end up having elongated families as well? Does that gobble up more of your cap for completely separate families that might be in need?

[190] **Ms Koukos:** From our experience, we have not gone over our cap in Swansea. Although I was not involved in the original planning, I am aware that there was an anticipated or a predicted number of children in an area. That was taken into consideration in the initial bid and the setting of the postcodes. We have kept within it. What we did not understand at the time was that, while the programme targets children from birth to their fourth birthday, the nature of the work and the families means that, technically, we would be handing those children back to a generic health visitor for another year. We have made a decision that we cannot do that, because they are part of the family and the plan and, for consistency, they need to keep to the same professionals. So, that is what has bumped the numbers up in most areas, more than we had anticipated.

[191] **Angela Burns:** So, are you suggesting that it would be more beneficial to extend Flying Start to official school age, when children are five years old?

[192] **Ms Koukos:** Health visitors have a duty to keep children on the case load until they are five years of age. The majority of children in generic case loads are not kept on until that point. However, in having the cut off at the age of three, what do we do with these children when, technically, we are not funded for them but we have to keep them on because of consistency? I would say that that would be necessary in the guidance.

[193] **Ms Dale:** In addition, I am not convinced that the generic health visiting teams have got capacity to take these children back. For families, to have two health visitors would not be of any benefit. Sometimes, these children require additional support over that age. To ask

another agency or organisation to meet that family's needs when we know the family and possibly have the workers within the multi-agency skills mix to meet those needs, would not seem sensible.

[194] **Ms Mcintosh:** There has been an issue in some areas with the lack of school nursing—there has been a shortage of school nurses. If we were to retain case loads, our health visitors would hand children over to school nurses when the children started school. There has been a bit of a time lapse. If there has been a lack of school nurses, who do you hand them over to? You cannot have a situation where no-one takes care of the children. That is one issue.

[195] To pick up your other point on siblings, if a child is born to a Flying Start mum and she still lives in the same area, she would automatically be entitled to the service again. As the other siblings become older and move outside the age range, what we have done locally—I am sure that other authorities have done the same—is work with projects previously funded by Cymorth and with Sure Start projects, where the support services are in place locally for children from birth to the age of 14. So, we would hand the children over. Home Start is another example. If the family still had needs when some of the children were outside our age range, we would hand over to organisations that could offer continued support. We work in partnership. We would not just leave when that child was too old. We would provide a service and work with our partners to ensure that there is continued support for those children and continue to offer interventions from birth to the age of four.

[196] **Angela Burns:** Given your point that trust is such a difficult thing to build up and that, once you have gained it, you want to keep it, is there any merit in considering the concept of making it a Flying Start family, rather than a Flying Start child? Once the family is on the programme, we would build a programme to nurture that family, with continuity of people, right through to the child leaving primary school. We keep talking about how we lose children—we lose them in transition—but when someone they love and trust drops out of their life, they go straight back to base. Is there any merit in even starting to entertain that thought? Forget the fact that it is going to cost a packet—that is another issue—but what about the philosophy of making it a Flying Start family?

[197] **Ms Koukos:** We already provide the service for the whole family. As has been mentioned, we dovetail with generic services, funded by other means—Genesis Cymru Wales 2, Welsh Sure Start and Families First—and are starting to do that with the voluntary sector. As the definition of a child sometimes includes those up to the age of 18 or 25, we are working with children at an early age, and the family is supported all along. If there are families where there is drug or alcohol abuse, or if there are housing issues or looked-after children and so on, you cannot just say that you are there for the child; it is definitely a family programme as it stands. We have always seen it in that way.

[198] **Angela Burns:** However, you do not necessarily have control over those agencies.

[199] **Ms Koukos:** No.

[200] **Ms McIntosh:** We are relying on partners. As you said, the money would be an issue, as would be staff capacity. There are other services that we work closely with. Just because a child reaches the age of four or five does not mean that the family issues stop, or that the complexity of the problems changes. So, the support continues, and that is when we rely on partners, which is vital for handing children on.

[201] **Ms Dale:** The growing use of the approach involving the team around the child or the team around the family throughout Wales means that we are routinely integrating our services much more closely with those for the rest of the family.

[202] **Christine Chapman:** I apologise to Members and witnesses, because we now need to move on, as there are many other areas that we need to cover. However, if there are particular issues that we want to raise, I am sure that we can write to the witnesses on those.

[203] **Suzy Davies:** You have been kind enough to touch on your dealings with the childcare entitlement, and I have a few supplementary questions on that. You mention that, despite the level of attendance rising to around 70 per cent among those who were not attending consistently, there are still gaps. Does that have implications with regard to resources? In addition, what sort of flexibility do you have to combine those periods of 2.5 hours a day for individual parents into longer periods in order to meet once a week, say? That might help those women who want to go back to work.

[204] **Ms Jones:** The whole childcare entitlement is hugely complex, and it is difficult to say that one thing will suit everyone, because it will not. There are changing thought processes about the benefit of the childcare entitlement. Is the childcare entitlement there for the benefit of parents or for the benefit of the child? Possibly, the benefits will not be the same. Flying Start views things from the perspective of the benefit to the child, and sees the purpose as being to integrate the child into a childcare setting and to get them ready for school and for the foundation phase, so that they can socialise, build up social skills, learn how to converse and so on. In addition, parents learn how to set a routine: getting up in the morning, getting children to the childcare setting on time, and remembering to go to collect them. We have had parents forget to collect their child. They may have been having a coffee, and then say 'Sorry I'm late, I forgot the child'. However, some families have never had to experience that routine, and have never had to follow that process.

[205] So, it will be difficult to put sessions together for parents to go to work, because that will not necessarily benefit the child. We would probably need more guidance on the thinking on that, and would perhaps need to employ childcare experts. Initially, there were five sessions a week: once a day, every week for 42 weeks. We were told emphatically that we had to pay for all five sessions so that the children could build up their entitlement. If they started with only one session, we would still pay for five so that they had the opportunity to build up their entitlement. The children may have just had their second birthday and would then start. Parents are not necessarily happy with leaving their children in a childcare setting when they are two years old. They do not know the staff, and they have to build up a relationship, because they are new people. Some children are not ready for that, because they have never left their parent before. We need to be mindful of the benefits to the child and not push the childcare element towards employment and training for parents.

[206] **Suzy Davies:** I want to turn that on its head, if I may. Going back to the previous question about the geographical limit that you face, in a school catchment area in a deprived area where you operate, there will be families who are not so needy but who see Flying Start as being so attractive that they would like to buy into it and take advantage of it, which may be for their own convenience. Is that weeded out at the family assessment stage or do you have other mechanisms in place to ensure that this is not just something that is lovely but not absolutely necessary for a particular family?

11.00 a.m.

[207] **Ms Jones:** I think so. The counties that employ midwives in Flying Start are working with those families before the baby is even born. So, you have two to two and a half years of input with that family to build up a relationship and trust, to assess needs and to see what is best for the family. So I think that you can winkle out those people who do not want any other contact with Flying Start apart from childcare.

[208] I did a little bit of research, because I was shocked that the interim report was quite scathing about the take-up of childcare, so I went back with my pen and started to work it out, and, out of 127 children who were entitled to the childcare element that year, three did not take up that entitlement. One child was from a family that was experiencing huge trauma and the grandmother had stepped in and wanted to keep the child with her, which was the best thing for the child. The second child came from a family where both parents worked outside of the catchment area. The child was in full time day care, and the family was receiving working families tax credit and did not want to confuse issues so they did not take up their entitlement. The third child had a disability. We had put a whole care package in place and were ready to implement it, and then mum said that she did not want to leave the child anymore. So, we worked with that family and we managed to get that child in for one day a week, which was a huge step in a positive direction.

[209] There is also an added complication when you look at take-up and the number of places attended. You have authorised and unauthorised attendance in schools, but the figures we report are the take-up of attendance places. We do not take into account unauthorised and authorised absences. So, again, I did some work and worked out that, if you took the number of children going to the childcare setting or not, the figure was 79 per cent. However, when you factor in issues such as parental choice, with, say, parents only wanting the children to attend for two days, as granny has them for one day and they only work two days, and sickness—for example, if you get one bout of chicken pox in a day nursery then no-one will be in for a month—the attendance was 97 per cent rather than 79 per cent. So, I think that the attendance is very good and the difference in those children when they start the foundation phase is marked. The teachers and the headteacher come out of the school to find our early years teacher to congratulate her and the voluntary settings on the support that they have given to the school. So I think that the data that the interim report use may be a little crude and that perhaps the people who wrote the report did not understand fully the complexity of childcare.

[210] **Christine Chapman:** I will move on to Lynne Neagle. We have touched on health visiting, but I am not sure whether you wanted to ask anything else about that, Lynne.

[211] **Lynne Neagle:** Jenny has already asked the question, and it has been answered.

[212] **Christine Chapman:** Right, thank you. I think that Julie Morgan wants to ask about parenting.

[213] **Julie Morgan:** Yes. Obviously, you have already covered some of this. The support for parents seems to be varied across the country. Do you have any comments on that? Do you feel that everyone has a minimum level of support or that more could be given?

[214] **Ms McIntosh:** The guidance issued by the Welsh Government at the time stated that we were allowed to deliver category a, b or c courses and it gave us a list of certain courses. So, certain authorities will deliver the recognised courses that are allowed, which are mainly the Webster-Stratton courses, the incredible years and getting to know your baby courses. On top of that, historically, there are support services that have been in place for many years. Different authorities have found that different parenting courses have had some benefit for parents. Some of the variation may therefore be down to the fact that there are locally recognised courses, known to be of benefit, that people would still like to continue to deliver, which then supplement the courses that we must deliver. So, the variation may be to do with that, as well as staffing structures. We had quite considerable freedom at the outset of the programme to develop our own staffing structure. I am not aware that there are huge variations, because we must stick to delivering the category a, b or c courses, as directed by our guidance, but there will be slight variations according to local needs.

[215] **Ms Koukos:** The courses are obviously one part of it, but I do not know what the definition of parenting entitlement is, because it is not just about the courses, it is about the one-to-one work that is done in the home when the baby is born and giving the parents the skills to look after that child, to set up routines and various things such as that. So, that goes on as well, and I am not quite sure that is being captured when the numbers are counted, because a lot of parenting goes on in the home with the families, including the grandparents and whoever is caring for the child, that is not technically a group in another building, which is what is classified as a course. So, it is hard to unpick it. Some families might have all of it, some might have one-to-one work in the home and never require further referral, and some will attend one course after the other, because research shows us that sometimes you need two or three courses to perfect any change in a pattern of behaviour. It is a pick and mix; one thing does not suit every family. It is about what is identified as the need of a particular family. It is not just about the courses.

[216] **Julie Morgan:** Are men as fully engaged as women?

[217] **Ms Koukos:** In Swansea, we have specific dads workers as part of the parenting team. They are not specifically part of Flying Start, but they dove-tail into it. So, we have dads workers who work with just fathers, who can bring their children if they want to, and we provide childcare for them. It often revolves around some sport or cooking—it is common for them to like that—but covers issues around their role within the family and their responsibilities as a father. In relation to domestic abuse and the freedom programme and working with perpetrators, we also have dads workers who work with fathers in that regard. So, we have a dedicated dads programme to address their needs specifically and that is quite successful. Some men come with their partners to generic parenting programmes, but they are fewer in number. We try to engage with teenaged parents. We try to engage the partners, who are not necessarily the father of the child, along with the girls when they have their babies.

[218] **Simon Thomas:** That was my question.

[219] **Christine Chapman:** It became your question, Julie. [*Laughter.*] Simon Thomas has questions on language and play.

[220] **Simon Thomas:** Yr oeddwn eisiau gofyn ynglŷn â'r cynllun iaith a chwarae sydd hefyd, yn ôl yr hyn yr wyf yn ei ddeall, yn un o'r hawliau tu fewn i Dechrau'n Deg. Pa dystiolaeth sydd gennych o effaith ac effeithiolrwydd y cynlluniau hyn ar wella sgiliau yn arbennig? A oes gennych unrhyw dystiolaeth i'r pwyllgor ynglŷn â'r ffordd y dylid datblygu'r cynlluniau hyn ac unrhyw broblemau sydd wedi deillio ohono?

Simon Thomas: I wanted to ask a question about the language and play scheme, which is also, as I understand it, one of the entitlements within Flying Start. What evidence do you have of the impact and effectiveness of these schemes on improving skills, in particular? Do you have any evidence for the committee on how these schemes should be developed and can you identify any problems that have arisen from it?

[221] **Ms Dale:** I would like to see language and play knitted in with the previous question about the parenting entitlement, because we have been focusing a great deal on attachment and the relationship of the parent or parent-carer with their child. In the main, we see language and play as one of the steps towards increasing that relationship between the parent and child. Many parents do not realise that their child is learning all the time and that the medium by which they learn is day-to-day activities, from the initial stages, when they are a babe in arms or even antenatally, with the parent-carer in the home. We see that language and play can be delivered and maintained on a much more varied basis. It does not have to be a set six-week programme that a group of people does away from the home, but it can be implemented or embedded into practice in one-to-one work by any of the health and social

care team members when they see a family within the home, in addition to a more formal setting within groups or parenting sessions. That work can then be integrated with the work of whatever learning and play/number and play or parenting teams are already available within the local authorities.

[222] **Simon Thomas:** I ddilyn hynny, yr oeddech yn sôn gynnau am y cysylltiad rhwng y cyfnod sylfaen a'r sgiliau cynnar yn yr ysgol. A oes gennych unrhyw dystiolaeth i ddangos bod y plant sy'n mynd drwy'r cynlluniau hyn yn cael eu paratoi yn well ar gyfer y cyfnod sylfaen? A oes hefyd dystiolaeth ynglŷn â'r effaith ar sgiliau darllen ac ysgrifennu'r plant sydd wedi mynd drwy'r cynlluniau hyn?

Simon Thomas: To follow that up, you mentioned earlier the link between the foundation phase and the early skills in schools. Do you have any evidence to show that the children who go through these schemes are better prepared for the foundation phase? Is there also evidence regarding the effect on the reading and writing skills of the children who go through these schemes?

[223] **Ms McIntosh:** I would not say that we have direct evidence that language and play alone would be the reason why we have seen improvements, but we certainly use a developmental screening tool with all Flying Start children, which is a schedule of growing skills assessment. We carry it out when the children are aged two and again at the age of three. One of the successes of the Welsh Government has been its introduction of this assessment for every Flying Start child. Previously, a generic health visitor would have carried out a SOGS assessment on a child if there were concerns about the child's development. However, the Welsh Government decided that it wanted every single Flying Start child to have this assessment. So, every two-year-old and three-year-old will be assessed by a health visitor or teacher. All of the staff have been trained in how to use this developmental screening tool. There is a scoring matrix, which will look at the child's development in areas of social skills, language development, hearing skills, cognitive and manipulation skills—that is, whether they can hold a pencil, climb one or two steps unaided, whether they are potty trained, and whether they can string two words together. It is about development at that basic level and there is a tick-box assessment of what is the highest level that the child can achieve.

[224] So, we assess the children at the age of two and at the age of three. By the age of three, the potential interventions for these children may have included attendance at language and play courses, their parents may have attended a parenting group or received one-to-one attention in the home, they will have had intensive health visiting and a year's worth of free childcare. So, the developmental tool will give us potential evidence of the combined effect of all that. It is not a scientific tool, but it is a tool that recognises the developmental improvements that children have made.

[225] I have asked my colleagues whether they were happy for me to share a story from Carmarthenshire, and they were happy for me to do so. We have tracked a cohort of 44 children aged two and three—so the same children have had the same assessment, bearing in mind that they have benefited from childcare, parenting classes, intensive health visiting and potentially a whole host of other specialist services, and some may also have had speech therapy. I do not have the exact figures with me, but I think that I remember them correctly. Around 60 per cent of children at the age of two will reach the development level for their chronological age. That means that, if they are aged two, they will do the activities that a two-year-old should be doing. If they are one band above or below the level of their chronological age, that is an acceptable range. When we reassessed them at the age of three, we saw a 23 or 24 per cent improvement in the children's ability, which is potentially a result of their receiving all of these intensive services. So, we feel that, as a tool, the SOGS assessment gives us a good indication of the positive steps and changes that these children are making as a result of the intervention.

[226] That does not directly answer your question about language and play alone, but language and play is certainly a very valuable service within the four strands because it is seen as an engagement tool and it is potentially the main activity that a parent does with a child. We do parenting with parents in groups or on a one-to-one basis at home, but language and play is shown to the parent and they are encouraged to interact with their child. In many cases, these parents do not know how to do that.

[227] One point that I would like to add in relation to the expansion is that, if that goes ahead, we should continue to have the ability to use a developmental screening tool to add weight to the evidence regarding development.

[228] **Ms Dale:** Language and play is also used in many of the childcare settings, and parents are encouraged to come in and work with the childcare settings and take activities back into the home. So, it is not just about what happens at home and in the groups, but the thread running through all four elements.

[229] **Simon Thomas:** Hoffwn ofyn cwestiwn mwy eang am iaith yn gyffredinol, nid iaith a chwarae yn benodol. Mae gennym ddwy iaith yng Nghymru, Cymraeg a Saesneg, yn ogystal ag ieithoedd lleiafrifol. Yr ydych wedi sôn eisoes am weithio gyda Mudiad Meithrin ac ati, ond a allwch ddweud mwy ynglŷn â sut mae dewisiadau iaith rhieni yn cael eu parchu? Os mae plentyn yn mynd i un lle, mae'r plentyn yn debygol o aros yna, felly mae'n bwysig bod hynny'n cael ei adlewyrchu yn gynnar yn y broses o ddewis iaith.

Simon Thomas: I would like to ask a broader question about language in general, not specifically about language and play. We have two languages in Wales, Welsh and English, as well as other minority languages. You have already talked about working with Mudiad Meithrin and so on, but can you say more about how the language preferences of parents are respected? If a child goes to one place, that child is likely to remain there, therefore it is important that it is reflected early on in the process of choosing a language.

11.15 a.m.

[230] **Ms Koukos:** In Swansea, we have a large minority ethnic community. In one of our Flying Start settings, 53 per cent of the children at once school are predominantly from the Bangladeshi community. So, within the health visiting team, we have a link worker who supports the health visitor in working with families, and who also works with the parenting officers. We have evidence that, after years of working and trying to engage with parents to join the groups, we now have a good attendance of parents. That is quite a turnaround. Within the childcare setting, we also have staff who speak a particular language. It is about adapting, because we also have asylum seekers in other settings, and language is becoming a bigger problem. It means having protocols in place with interpreters, and it means recognising cultural differences, raising awareness among staff and being mindful of the needs of the child and the family in relation to their language and understanding.

[231] **Christine Chapman:** I will move on to the final question. I know that there were other questions that Members wanted to ask, so we may write to you for your responses. However, we have one important question before we finish this session on funding.

[232] **Lynne Neagle:** With the forthcoming expansion of Flying Start, how do you feel the money should be spent?

[233] **Ms McIntosh:** We all agree that we have learnt considerable lessons since the beginning of the first Flying Start—I presume that there will be a second. It took considerable time to put the infrastructure in place to be able to utilise all of the funding. Staff recruitment

alone took around 18 months. Most of the funding will go towards salaries, of course. There is a view—correct me if I am wrong—that we would not be able to deliver services immediately without having the infrastructure in place. Without it, we cannot fully utilise the funding. There is a sense of caution in case there is any possibility of staggering the funding to be able to utilise it effectively. Nobody wants to be in a position of having to return grant funding to the Assembly; we want to utilise it fully. We have learnt lessons from the first time around, and that was one of the biggest lessons.

[234] **Ms Dale:** It was to do with capital funding, was it not?

[235] **Ms Koukos:** We received capital funding for one year and then another, and then another, but we are still not able to say that we have completed the capital programme. Instead of having an equation to allocate capital funding, it would be better if it were needs-led and asked what the requirements would be to establish a Flying Start setting or what would be needed to refurbish whatever is to be used in the schools in the area. It would be better to have the money to start it with the possibility of carrying on the following year without having to start again, bidding for more money and doing a bit more work. It is about being a bit more joined up with the capital allocation. Then, you would not need all of your revenue until the capital work is under way. It is about being mindful of both budgets and giving us some local discretion in how we think we could manage them.

[236] **Christine Chapman:** Thank you, co-ordinators, for such comprehensive evidence. As a committee, we will decide how to take this inquiry forward, and your evidence has been very useful. Thank you for attending.

11.19 a.m.

Cynnig Gweithdrefnol
Procedural Motion

[237] **Christine Chapman:** To allow the committee to discuss matters relating to possible future inquiries, I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(ix).

[238] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.19 a.m.
The public part of the meeting ended at 11.19 a.m.