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North West London Integrated Care System

Evaluation of the Early Years GP Child Health Hubs Pilots for the NHS North West London Integrated Care Board

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Mitch Blair

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Executive Summary

Background and context

GP Child Health Hubs (CHHs) based on the Connecting Care for Children (CC4C) model have been well established in Northwest London (NWL) for over a decade, and have been evaluated as being cost effective and efficient. They are popular with parents, carers, and professionals, and are now an established part of the NHS England Guidance on Neighbourhood Multidisciplinary Teams (MDTs) for Children and Young People published in January 2025.

NHS England (NHSE) funded a team to carry out a project to build on the success of General Practice (GP) CHHs to further improve health and wellbeing of infant and early years child health in the London. Three boroughs, Harrow, Brent, and Ealing, were identified as the pilot sites with a focus on establishing and sustaining a "hyper-local preventive care team" (HLPCT) around the most vulnerable families at neighbourhood level. The boroughs were selected on the basis that there was already a functioning CHH and good local authority partnership in place. The vision was to connect the existing mature CHHs to local authority family hubs and children's centres in addition to the local Voluntary Community and Faith Social Enterprise (VCSFE) organisations by making full use of all the resources available in a locality, in essence, an integrated neighbourhood team (INT) for infants, children, and young people. The project was funded for 2-years (April 2023 to March 2025), led by Professor Mitch Blair and supported by a central Integrated Care Board (ICB) Programme Manager and Project Manager together with a GP lead from each borough and their local project managers and business intelligence analysts.

The project was evaluated independently by academic researchers based in the School of Public Health at Imperial College London, by using the ICB evaluation framework and quantitative and qualitative data collection and analysis. An Early Years Toolkit was also commissioned to support staff and service users to set-up and create an early years CHH in all Primary Care Network (PCN) locations across NWL and share learning to other sites. The toolkit will be available as a link on the National Institute for Health and Care Research (NIHR) NWL Applied Research Collaboration (ARC) website from early Spring.

Each site (Harrow, Brent, and Ealing) determined their early years priority areas based on a focused interagency needs assessment and the Core 20 plus 5 themes at a neighbourhood level. Each site designed the interventions based on published national and international evidence of effectiveness, and sought the support of local borough partnerships and an external expert steering group. This report describes each intervention in more detail, the inputs and framework for evaluation, and the impact to date. It is important to note that such complex local interventions typically take between 3- 4 years to mature, and demonstrate returns on investment at 5-10 years to show early life course benefits.

We report on the status of each site two years into the pilot which were phased; Harrow started in Summer 2023, Brent in Spring 2024, and Ealing in Autumn 2024. This report describes the impact and learning to date from each site, and recommendations for further GP CHH development. Details of each set of results are provided in the body of the report and its Appendices, and is structured around 6 key areas followed by a summary of the learning from the teams and key recommendations for the Integrated Care System (ICS). The six areas are:

1. **Case-finding/population health management**
   Using practice based and public health intelligence, and the use of data dashboards to support the identification of 'at-risk' groups in need of support.
2. **Community connectors**
   Those integrated into the practices including community health and wellbeing workers, social prescribers, family link workers, community pharmacists, community maternity champions, and other volunteers.
3. **Innovation fund and co-production**
   The provision of small community grants for the co-production of local projects to support health and wellbeing of the target communities.
4. **Integrated neighbourhood teams (INTs)**
   Using the pilots to improve interprofessional collaboration and learning.
5. **Clinical case studies**
   From all three sites which demonstrated the wider role of community connectors.
6. **Specialist clinics**
   a. Patient group consultation for perinatal mental health
   b. Preschool respiratory health clinic
   c. GP based enhanced case finding for social, emotional health and wellbeing, and child development

Main findings

It takes time to co-design and establish service models, and meaningfully engage the community

At the end of two years, all three sites are operational and have started to engage families effectively with the use of "community connectors". The funded postholders are in turn working closely with maternity and community champions and with multiple voluntary sector and faith organisations. An estimated 2,300 families from the most disadvantaged areas of the three boroughs have been in contact with one or more services to date. The most mature models are in Harrow, where all three components of the model are working well together. Brent and Ealing are closely following. A similar mature system exists in Kensington, Chelsea and Westminster (Bi-Borough) where local GPs are leading a complementary infant/early years' programme through established links with local authority services, and have similarly good levels of local community engagement. A major component of this project was community led co-creation of interventions which was facilitated by small innovation grants (£7k - £25k) in the pilot sites. This allowed a deeper understanding of the community's own needs and empowered local VCFSE organisations to be more closely connected to the GP and family hubs. Thoughtful and inclusive team building is required to ensure full inclusion of these organisations into the HLPCTs. Borough wide umbrella organisations (e.g. Voluntary Action Harrow, Brent Community and Voluntary Sector, Ealing Community and Voluntary Sector) have acted as excellent facilitators.

Community connectors are key to extending primary care "listening" capability and clinical effectiveness

The detailed case studies included in this report have demonstrated the immense complexity of the lives of many families living in our localities where language, digital and health literacy, financial debt, social isolation, housing, and wider environmental stresses are impacting on parent/carer, infant, and child health and wellbeing. These case studies also highlight the importance of having trusting relationships with community connectors, often from a similar

background, who can provide the space and time to signpost, directly refer, set goals, and support families with practical issues and ensure timely early preventive care is offered. The community connectors are also bringing cases for discussion to their supervision meetings with GPs and the wider CHH MDTs, especially in relation to perinatal mental health and early child development, at a much earlier stage and therefore avoiding potential crises and suboptimal utilisation of overwhelmed statutory services.

Specialists and GPs together increase the quality of clinical decision making and care

The three clinics are innovating with fully integrated support from allied health professionals, secondary and tertiary level respiratory specialist expertise, perinatal, child and adolescent mental health, and local public health specialists. Professional feedback indicates a more "joyful "work experience based around relationships and shared knowledge and skills, and less around transactions, referral thresholds, and bureaucratic blocks. The clinic in Brent has been particularly helpful in addressing the needs of preschool children with undiagnosed asthma. There are several thousand children in the sector who are aged under five years with frequent attendance to hospital Emergency Departments (EDs) for respiratory wheeze who receive emergency treatment on multiple occasions without a definitive diagnosis. The Brent clinic, using a joint primary /specialist respiratory multidisciplinary team in the community, has carried out holistic assessments and confirmation of diagnosis with subsequent optimisation of treatment. It is a model with the potential for scaling to other areas of the ICS with high levels of cost benefit. The other clinics are continuing to collect evaluation data which will be available in late spring/early summer.

GPs are gradually increasing their awareness and knowledge of family hubs and the voluntary sector as local neighbourhood child, family and community resources

Primary care team integration with family hubs is at a very early stage of development in the three pilot sites, but local children centres are an immensely helpful resource for local parents and families. In the three boroughs, local family engagement is around 30-45% of those eligible. However, GP and primary care teams can and are, increasing the referrals of families to child centres for support with sleep, breast feeding, language stimulation, and play group activities. The local voluntary sector has welcomed the opportunity to become more integrated with primary care and collaborate to support patients. The 'health and wellbeing fairs' and outreach events for the local community were a great success and provided an opportunity for local organisations including health services, public health, housing, citizen's advice, and specialist charities to meet and learn from each other. The cost of these is minimal but the social value to all who attend is immense.

National ambitions, integrated care systems and on the ground 'translation into practice' needs to be more carefully planned and facilitated

This early year's pilot has been a complex multiagency endeavour which has taken key recommendations from national reports and guidance (Fuller, Hewitt, NHS Reports and Local government reports on Family Hubs) and attempted to translate these on the ground. Any similar projects would benefit from a strong, stable and dedicated integrated central project team with sufficient capacity to support the project planning, data analytics, governance, finances, communications, and evaluation functions required.

Capability and capacity issues in the central team has led to and continues to cause considerable delays in delivery due to unwieldly and varied standardised operating procedures. This has been compounded by ICB reorganisation processes and a national general election

with change of government. These have caused great uncertainty for staff allocated to the project. There were almost too many simultaneous moving parts in all the organisations which has impacted what could have been achieved in the time allocated. Nevertheless, the dedication of the local GP leads, and their teams have done a tremendous job in pursuing the pilot interventions, often in their own time, despite the issues.

Recommendations for ICS on Early Years Pilots

Case findings and Population Health Management

- A dedicated Babies, Children, and Young People (BCYP) team should be developed to support the development of BCYP Integrated care data packs at INT and practice levels. These should be action oriented to enable changes to be made based on the existing evidence base, e.g. improving low immunisation rates, improving uptake of child health reviews, optimising asthma management, or reviewing children with no care plans.
- Interagency/interorganisational data dashboards which are live and well validated should be produced with a view to facilitating ongoing continuous improvement on key metrics, ideally this would reflect a holistic picture including key social determinants of health. 'A Better Start' has a core outcomes framework which takes a life course approach based on routine operational data and could be adopted in NWL.
- An agreed and standardised data collection tool should be developed at each GP CHH. This can be completed at each clinic and MDT meeting to be able to support continuous improvements of the system, and ensure those most vulnerable are being served.
- MDTs:
  - A high proportion of children discussed at MDTs had suspected or diagnosed neurodiverse needs. Expertise from a range of professionals in these fields might support professional discussions further. Diagnosis and better understanding of neurodiversity disorders, parental coping mechanisms, peer support, avoidance of medication through sleep courses, therapeutic input for challenging behaviours, and linking in with children's centres for play groups, could be better utilised.
  - Services have different criteria, referral processes, and pathways with waiting times which can be challenging for both children and parents. Parent support is needed during these waiting times. More links and referrals to Family Hubs would be beneficial with their full range of services aimed a CYP aged from 1 to 25 years, including those with special educational needs and disabilities (SEND).
  - Few High Intensity Users (HIU) were discussed at the MDTs. Further work is needed to understand how proactive care for groups of children at higher risk should be conducted with a view to shifting from reactive to proactive care. Currently, fewer than 15 users and 25 users across the NWL ICB use the CYP rising risk and the Learning Analytics Dashboards (LADs) on a regular basis. A dedicated programme (task and finish group) which aims to upskill staff on population health management for BCYP is recommended.

Community connectors

- At the scoping stage of a pilot proposal, factor in recruitment processes and timescales with clear timelines.
- Map the geographical area, in terms of services and provision available.
- Factor in time (1-1½ months) to undertake a thorough new starter induction, training programme, and introduction meeting with key partners.
- Operational policy development around lone working, and health and safety and practice guidance requires 3-6 months to develop and embed into practice.
- Clinical supervision of community connectors (whichever model is favoured) requires dedicated time from the GP. This is essential and needs to be recognised in programmed activities (GP contracts).

Community engagement and co-production events

- Attention to detail is required around signposting especially for workshops and children's activities as part of community event planning.
- Evaluations of these events which involve a number of partners should be designed collaboratively in order to avoid participant overload.
- The acoustics in a large hall were difficult and therefore a fully functioning personal address system is vital. This would allow for a proper introduction for the day where all people can hear appropriately.
- The incentive of providing food vouchers (in this case Sainsbury's) in exchange of completing evaluation forms was helpful in ensuring a high return. A QR code was used for electronic data collection via a Qualtrics link, providing options of how to feedback.
- These events provide a superb opportunity to ensure appropriate filming and photographs can be taken on the day. However, this requires consent and organisation in advance with the various communication teams and should be agreed to ensure appropriate joint governance is followed.
- The return on investment in community outreach events; the cost per attendee was estimated at around £15.60 per head including all refreshments and room and equipment hire, vouchers, child entertainment, and creche facilities etc. The value to the local community was in terms of information exchange, new knowledge and referrals to services, and the building of trust. Several attendees subsequently applied for innovation grants.
- Translators are essential to the workshops to provide support parents when circulating stalls.
- ICS to share the evidence base around how to effectively incorporate the under 5s child's voice in commissioning.

Community innovation grants

- ICS to incorporate these experiences and learning from the pilot sites (comms, templates for applicants, panel structure, dispersal of funds and monitoring) into their commissioning strategies.
- Future procurement exercises to factor in adequate timescales for organisations to partner up and consider joint bids.

Integrated Neighbourhood Teams

- Governance
  - Discussions around information governance, clinical supervision, and support need to take place as early as possible as it can take over 6 months to agree and obtain the correct approvals and documentation. An Information Governance (IG) expert from the ICB should be informed at the start of the project to advise and support applications.
  - NHS emails should be offered to all community connectors working in the HLPCT to improve security of data exchange between providers.
- Training
  - Every attempt should be made to curate and deliver both generic and specific knowledge, skills, and attitude training in early years using adult learning methods as per the recommendations of the Institute of Health Visiting (IHV) report[1]. The training should be monitored as part of the clinical supervision and appraisal processes for staff. A borough- or sector-wide approach with full workforce lead involvement is recommended so that a clear strategy and timescale is agreed.
  - Speech and language therapy led promotion of communication, is cost effective and skills up a large early year's workforce to enable early identification and support at a universal level and should be sustained.
  - Minor illness pharmacy intervention should be commenced as soon as possible as way to divert children safely from the ED and Urgent Care Centre (UCC) services in the areas. This has already been demonstrated to be effective in North East London as described in the ICB Business case (agreed in April 2024) but has been delayed during this specific pilot period.

Multidisciplinary team meetings (MDTs)

- Effective chairing of MDTs, often by the GP leads, needs to take into consideration how members of the team can be fully included; natural power dynamics that exist should ensure that all voices are heard in the most efficient and effective way to support the families discussed and encouraged to challenge decisions where appropriate. One consideration might be to place indicative timings against individual case discussions.
- It is noted that family navigators and health visitors are essential key people who have the ability to further improve the connections between family hubs and GP CHHS through the existing MDTs in both. The co-location of staff in part or whole is known to improve this connectivity.
- Consideration should be given to focused MDT meetings around High Intensity and Rising Risk Users, asthma or mental health. The ICB clinical lead for asthma (Dr Stephen Goldring) and his team are already helping to develop this initiative.
- It is recommended that a workshop should be developed to further this work stream and explore with partners the barriers and facilitators which might need to be considered.

Case studies: Professional and parent perspectives

- To use learning from professionals and parents to co-commission services together.
- ICS needs to review its strategy around co-production with parents and wider community with an emphasis on the power dynamics which can be barriers to effective and meaningful collaboration.
- ICS to use its expertise to improve communications and branding of integrated care teams and their role.

- ICS to consider how best to engage parents and VCFSE organisations in training and upskilling ICS workforce.
- Training of staff in active listening should be essential for all staff.
- Consideration should be given to use of standardised tools in all sites for ascertaining social determinants (e.g., Social Determinants of Health Questionnaire; SDH-Q) and monitoring progress against goals set (MYCaW; Appendices 3 & 4), this will allow longitudinal follow up of cohorts of parents and families and measure changes over time. It takes time for community workers to develop sufficient trust with a family to undertake these in a non-judgemental, respectful way.
- Clinical decision quality is a major factor in resource utilisation and efficiency in the system and should be better quantified.
- Future research with parents and professionals alike would benefit from researcher in residence or in situ observation of interactions in order to better understand what characterises a productive relationship and describe in more depth, the interactive and decision-making processes.

Specialist Clinics

- Specialist clinics have been set up at specific practices within a PCN. To provide equitable access to all practices either in a PCN or INT will require agreement by individual practices and the design of inclusive pathways.
- Information and clinical governance requirements need to be considered as early as possible when initiating the clinics.
- Administrative support must be designed into the operational requirements of establishing and ongoing monitoring of clinics.
- Senior trainees in paediatrics with imminent Certificate of Completion of Training (CCT), are in a good position to support clinics but must in turn have supervision from a named consultant paediatrician with the necessary expertise.

Introduction

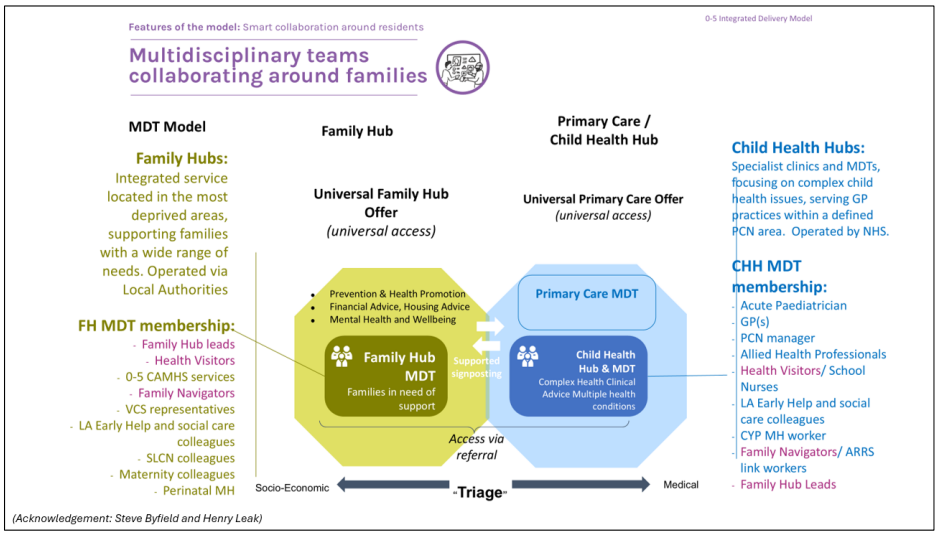
The North West London (NWL) Integrated Care Board (ICB) has encouraged the development of GP Child Health Hubs (CHHs), also referred to as Integrated Neighbourhood Teams (INTs), to provide a more holistic approach to supporting babies, children, and young people (BCYP), and their families. Through fostering inter-professional relationships to help address health inequalities, CHHs have been increasingly implemented in most parts of NWL over the past 10 years by integrating paediatric support and wider local authority services into the primary healthcare setting. Based at the primary care network (PCN) level, there are currently 24 CHHs in NWL. Most include monthly clinics where individual children are referred and seen by a consultant or senior trainee alongside the GP. Cases are also discussed through multi-disciplinary team meetings (MDTs) where a variety of professionals come together to discuss cases in a one-hour meeting. These often include teaching and learning opportunities. There is flexibility with how CHHs are implemented to ensure that services are tailored to meet the needs of the local communities.

The Early Years Pilots

A successful bid was made by the NWL ICB to the National Health Service for England (NHSE) as a direct response to the recommendation of both the Fuller[2] and Hewitt[3] Reports. The Early Years Pilots were funded for a two-year period (April 2023 – March 2025) to be tested in three London boroughs: Brent, Ealing, and Harrow. The main concept is to bring together professionals, communities, and the voluntary services working in a locality to strengthen a hyperlocal preventive care team (HLPCT) around the family and community. They aim to build upon the existing CHHs, but also to enhance the link between professionals and the local authority early years services including emerging "family hubs" in each locality. The boroughs were selected on the basis that a functioning CHH with good local authority partnership was already in place.

The overall model of collaboration is shown in the figure below which is based on the central London (Kensington, Chelsea and Westminster) Bi-Borough integrated care model (Figure 1). The staff indicated with purple colouring are important "common connectors" in the system.

Figure 1. Bi-borough integrated care model



The Early Years Pilots were developed around five key issues:

1. **Health inequalities**

Health disparities among babies, children and young people (CYP), and those from disadvantaged backgrounds have remained persistent over many years despite a changing landscape of health and local authority service provision. These lead to poorer outcomes especially for children in terms of mortality and morbidity which have been well documented nationally.

2. **Opportunity costs**

Without interventions, families already facing barriers to access healthcare will continue to face challenges. There are detrimental to their children's health such as missed opportunities for preventive care, early intervention, and timely management of health conditions. In turn, potentially leading to increased hospitalisations, higher healthcare costs, and poorer wellbeing of individuals. Young children, particularly those aged under five years, are the highest attending population group for urgent and emergency services; 59% of infant attendances of emergency and urgent care in NWL are for lowest acuity issues that do not require investigation or treatment, at a cost of £1.8m per annum. The drivers are complex but are primarily due to poor parental confidence, low health literacy, risk aversion, and system access issues.

3. **Underuse of existing resources**

CHHs were designed to make existing resources more accessible and efficient for many children. However, under-fives have been underrepresented within the existing models of care. The Early Years Pilots are designed to bring together valuable community assets, INTs, and collaborations between healthcare providers and educators to help children reach their full potential and improve their health outcomes, by primarily using existing resources in the community by working more effectively and efficiently.

4. **Missed opportunities for learning and improvement**

Valuable insights can be gained from local communities of how best to improve healthcare access and outcomes for disadvantaged populations through co-creation opportunities and developing trust between professionals and the public. The Pilot's focus on iterative learning based on evidence-based interventions and data-driven evaluation is central for promoting early preventative care and improving health outcomes of CYP.

5. **Long-term societal impact**

Individuals can face educational, social, and economic challenges due to lack of access to healthcare in the early years. Additionally, the strain on healthcare resources caused by preventable health issues contributes to the overall burden on the healthcare system. These negative impacts on health, the healthcare system, and society at large, highlights the importance of implementing evidence-based interventions as early as possible in the life course for longer-term health benefits, which in turn contribute to societal wellbeing.

Economic case

The economic rationale for early intervention is strong, especially within integrated care systems that can effectively address these changes. Recently, a systematic review that looked at the impact of Sure Start programme on disadvantaged children in the UK showed significant reduction in hospitalisations in older children, accidental injury, and obesity prevalence[4]. The findings suggest that for underprivileged children, the Sure Start programme is effective in

health generation across the domains of physical health, and neurodevelopmental disorders but with mixed findings for social development.

Sure Start was introduced in England in 1999 and rolled out over 11 years. Estimates show that hospitalisations increased during infancy but significantly reduced during childhood and adolescence. The programme's impact is strongest amongst children living in the 30% poorest areas of the country. Cost benefit analysis shows the financial benefit from reduced hospitalisations offsets approximately 20% of the provision of Sure Start. This impact is seen in the most disadvantaged neighbourhoods[5].

Evidence indicates that specific social determinants of health are crucial for reducing disparities in children's health in underserved communities[6]. However, focusing on short-term pilot programmes limits establishing a robust evidence base, as these initiatives typically require more time to become impactful.

A systematic review of interventions targeting cognitive development in children aged 0-36 months found promising outcomes[7]. These programs, which promote responsive care giving, showed modest but significant effects, underscoring their potential for improving child health and development.

Additionally, a review of early intervention systems[8] underscores the need for innovative approaches in childhood disability interventions and trauma informed care. These are crucial to support families facing social marginalisation, including racism, and to ensure equitable opportunities in children.

Another systematic review[9] showed that early childhood interventions have lasting benefits across various life domains including cognition, language, socio-emotional health, education, and employment. The improvement in educational outcomes for girls and disadvantaged families involved good quality pre-school programs and supplemented feeding initiatives underscores the necessity of investing in early intervention for equitable opportunities.

A systematic review on long-term economic outcomes for interventions in early childhood[10] showed a lack of outcomes measures between sectors, representing a potential limitation in reviewing cost-effectiveness measures between sectors. The benefits of early childhood interventions may be difficult to quantify because they are intangible (e.g., resilience or self-belief) or because of extrapolation methods of predicting too far in the future (e.g., adult employment).

Evidence from trials show that large-scale system change requires time to observe a potentially positive effect, and that system integration needs to be sector-aligned[11]. However, some clinical, social, and educational improvements have been observed with economic value.

Recent proposals from central government of child health systems reviews have a multi-agency and integrated working as its core to better protect our most vulnerable children. For example, in November 2024 a paper published by central government 'Keeping Children Safe: Helping Children to Thrive'[12] aligns to the previous government's 'Stable Homes Built on Love and Child Care' Review[13]. The paper focuses on strengthening multi-agency child protection.

The Independent Review of Children's Social Care[14] identified that 'health, police, education, and other partners must all play a role in child protection to ensure the needs and risks to a child are fully understood and responded to'. A proposed legal duty for local authorities is to establish multi-agency child protection teams and require other agencies to be part of this provision.

The Best Start for Life: A vision for the first 1001 critical days' report[15] identified the urgent need for accessible and joined up support for families with babies, action to address health inequalities, and improved evidence on what helps to improve outcomes for babies, children, and their families in different contexts. This is the basis of the Family Hubs transformation program that detailed the six universal Start for Life Services: Midwifery; Health Visiting; Parent-Infant Mental Health; Infant Feeding; Special Educational Needs; and Safeguarding[16].

NHS England guidance on Neighbourhood Multidisciplinary Teams for Children and Young People[17] includes a reduced number of accident and emergency (A&E) attendances and re-attendances, an increased reduction in outpatient referrals, and improved educational outcomes.

Evidence and guidance provided through these reports and publications contributes to strengthening integrated working, developing multi-agency teams, providing opportunities to align sector outcomes, and potential joint funding opportunities.

Key components in Harrow, Brent, and Ealing

Centred on the Connecting Care for Children (CC4C) integrated care model in NWL, all three Early Years Pilots in Brent, Ealing, and Harrow, have focused on four priorities:

1. **Case-finding/population health management**: using practice based and public health intelligence and the use of data dashboards to support the identification of 'at-risk' groups in need of further support
2. **Community staff**: community health and wellbeing workers, social prescribers, community pharmacists integrated into the practices
3. **Innovation fund and co production**: the provision of small community grants for the co-production of local projects to support health and wellbeing of the target communities
4. **Integrated neighbourhood teams (INTs)**: using the pilots to improve interprofessional collaboration and learning

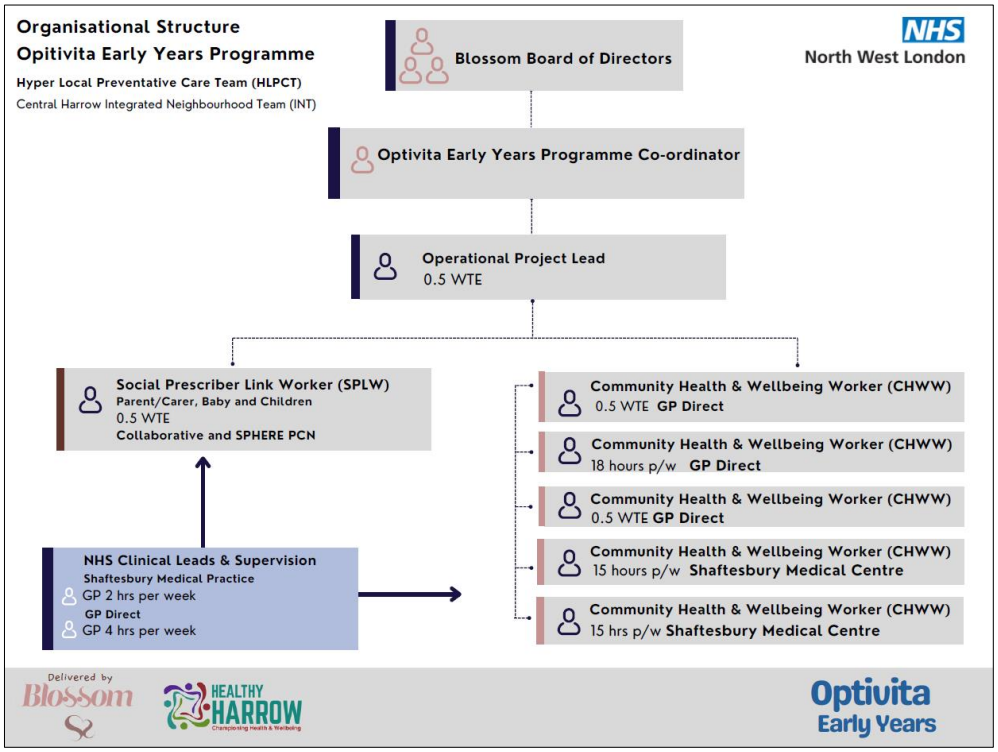
The specific clinical and social focus areas were selected by each site based on population data, public health priorities for the area, and clinical expertise. Each pilot site assigned their project a distinctive name. The models are described in brief below.

Optivita Programme, Harrow

The Optivita programme focuses on improving the health outcomes of children aged 5 years and under, living in the most deprived postcodes in Harrow. The target group is the first 1000 days of a child's life, preventative care, and embedding health promotion at the very early stages of development. Previous data on high infant mortality rates in the area had indicated a need to improve perinatal and postnatal health care especially for the Somali population living locally.

Staffing and resources

Figure 2. Optivita Organisational Structure



The expected outcomes from the Optivita programme are:

- Improved access to healthcare and wider services for children and families during pregnancy and the first 1000 days of a child's life.
- An increase in uptake of routine antenatal and postnatal health, and development reviews (i.e., Healthy Child programme) including immunisations and oral health practices.
- Improved case-finding intelligence and identification and support for families who need additional help and in integrated response, especially for those with mental health issues and frequent attendance in primary and specialist care.
- Improved parental confidence to look after their infants and avoid non urgent attendance in urgent and emergency care facilities in the hospital.

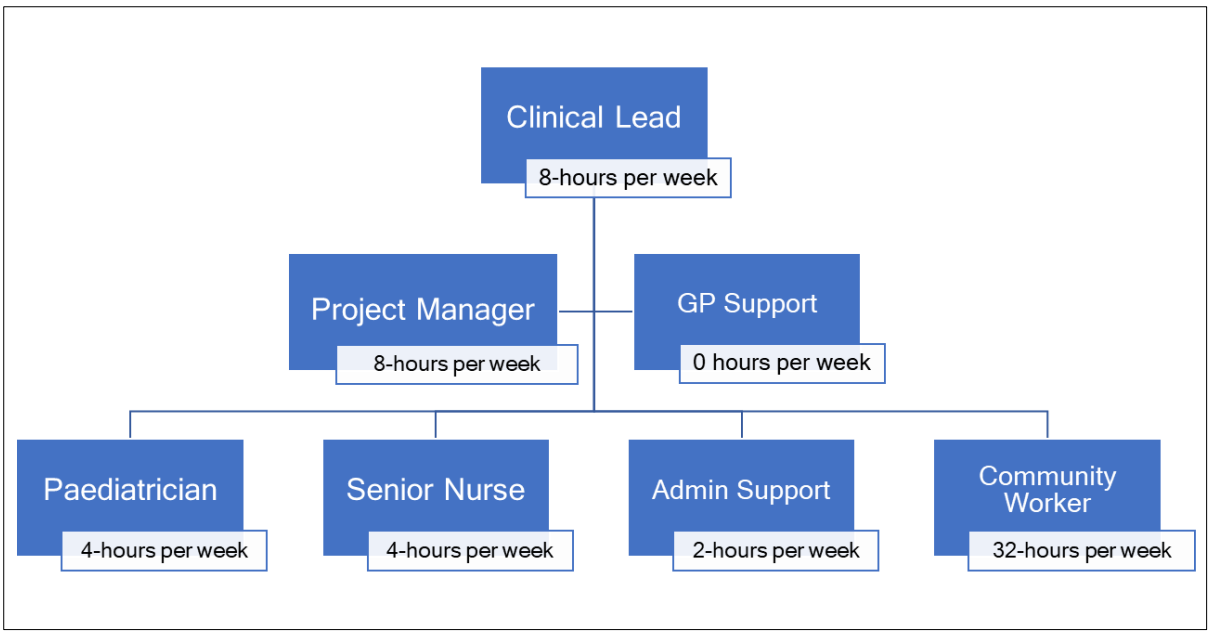
Create Model, Brent

The Create model is focused on improving under-five's respiratory health through household environmental surveillance. This includes reducing household pollution from sources such as tobacco smoke and indoor sources of pollution. Create will lead to improved identification and support for under-fives with frequent attendances to urgent and emergency care (UEC) with preschool asthma. The Create model aims to:

- Provide specialist multiprofessional preschool asthma as community clinics
- Improve early identification and support for children with developmental issues through both professional and community worker training and voluntary sector organisation support for families.

Staffing and resources

Figure 3. Create organisational structure



The expected outcomes of Create are to:

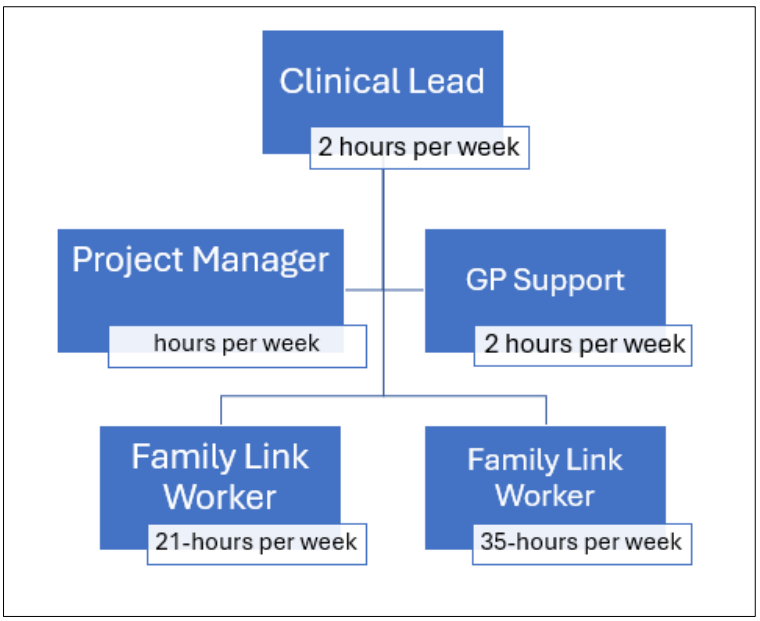
- Reduce household smoking.
- Increase parental awareness of sources of indoor and outdoor pollution and mitigating actions.
- Increased confirmed diagnoses of preschool asthma in GP and hospital records.
- Improve previously unidentified developmental delays in speech language and communication, or motor development for those children entering reception.
- Improve support for those on waiting lists with suspected neurodiversity issues awaiting full assessments.

StartWell Model, Ealing

The Ealing model will focus on improving emotional and behavioural health in the early years, and similarly to Brent, will also focus on early identification of developmental delays in speech, language, communication, and motor development. The main intervention is a systematic screening process of all families at the GP 6–8 week Healthy Child Programme infant review, including a family link worker detailed assessment for wider determinants of parental/family health, and family link worker support for children aged 0-3 months seen opportunistically in the two GP practices.

Staffing and Resources

Figure 4. StartWell organisational structure



The expected outcomes of StartWell are:

- Improved parent confidence in managing behavioural and emotional issues.
- Reduce the numbers of children attending at school entry with significant emotional and behavioural issues not previously identified.

Pilot Site Costings

The NHS England grant was awarded in proportions across all three pilot sites to cover project management, case finding, community champions, co-production, innovation and integrated neighbourhood teams (Table 1).

Table 1. Costings for all pilot sites

	Year	
Site Allocation	**23/24**	**24/25**
Project Management	**£9,225.92**	**£0.00**
Harrow	£4,612.96	£0.00
Brent	£4,612.96	£0.00
Ealing	£0.00	£0.00
Case finding[1]	**£38,814.29**	**£52,698.36**
Harrow	£35,635.60	£17,566.12
Brent	£1,589.35	£17,566.12
Ealing	£1,589.35	£17,566.12
Community Champions	**£30,091.05**	**£120,502.80**
Harrow	£14,493.42	£40,167.60
Brent	£7,798.82	£40,167.60
Ealing	£7,798.82	£40,167.60
Co-Production & Innovation	**£24,008.89**	**£144,053.33**
Harrow	£16,005.93	£48,017.78
Brent	£4,001.48	£48,017.78
Ealing	£4,001.48	£48,017.78
Integrated Neighbourhood team	**£31,611.43**	**£100,295.58**
Harrow	£16,999.33	£33,431.86
Brent	£7,306.05	£33,431.86
Ealing	£7,306.05	£33,431.86
Training Costs	**£39,600.00**	**£0.00**
Harrow	£13,200.00	£0.00
Brent	£13,200.00	£0.00
Ealing	£13,200.00	£0.00
Total Site Allocation	**£124,525.66**	**£417,550.07**
Harrow	£100,947.23	£139,183.36
Brent	£38,508.66	£139,183.36
Ealing	£33,895.70	£139,183.36

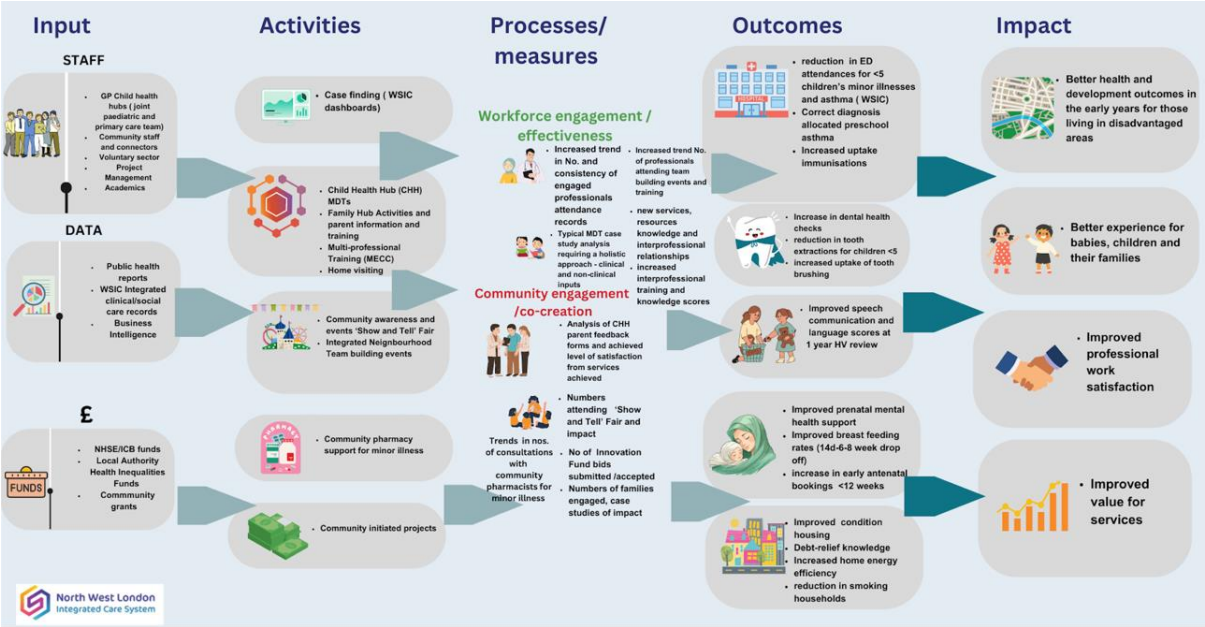
[1]*Harrow based on 7 months in the first year; Brent & Ealing based on 3.9 months*

Evaluation framework for the pilot sites

To prepare for the evaluation of the Early Years Pilots evaluation, the team created a logic model comprising of five processes (Figure 5). These include 'input' (staff, data, costs), 'activities' (case findings, MDTs, community awareness), 'processes and measures' (workforce engagement, community engagement), 'outcomes' (improved health and wellbeing), and 'impact (improved healthcare/community relationships, service availability awareness).

Essentially the model follows a typical "Donabedian" Structure, Process, and Outcome format[18] to describe the different pilot sites together with the learning gathered in each of the four domains of interest: case finding and population health management; community staff; innovation fund and co-production; and INTs.

Figure 5. North West London Early Years Pilots Logic Model



A summary table of the three pilot sites in the form of a PICO (Population, Intervention, Comparator, Outcome) table is shown in Appendix 2.

The data that has been used for this evaluation comes from several sources and uses a mixed methods approach as recommended by the ICB in its own evaluation toolkit[19].

This section of the report describes each of the four main components of the model (case finding and population health management; community staff; innovation fund and co-production; and INTs), and its evaluation, and follows on with separate detailed reports of the qualitative interviews conducted with professionals, and parent interviews and feedback.

Case finding and Population Health Management

In each site, data was analysed from a variety of sources in order to establish the epidemiological needs of the local populations. Much of this was available from existing datasets, e.g., Public Health England (PHE; now Office for Health Improvement and Disparities (OHID)) Fingertips profiles, Whole System Integrated Care (WSIC) data dashboards (including LADs, Children and Young People Rising Risk (CYPRR) dashboard, and additional support from analysts and those working with Business Intelligence (BI) team members at the NWL ICB. Additional data analysis was carried out using hospital maternity data collected routinely at London North West University Healthcare (LNWUH) NHS Trust to identify antenatal risk factors including mental health, late booking, and low birthweight.

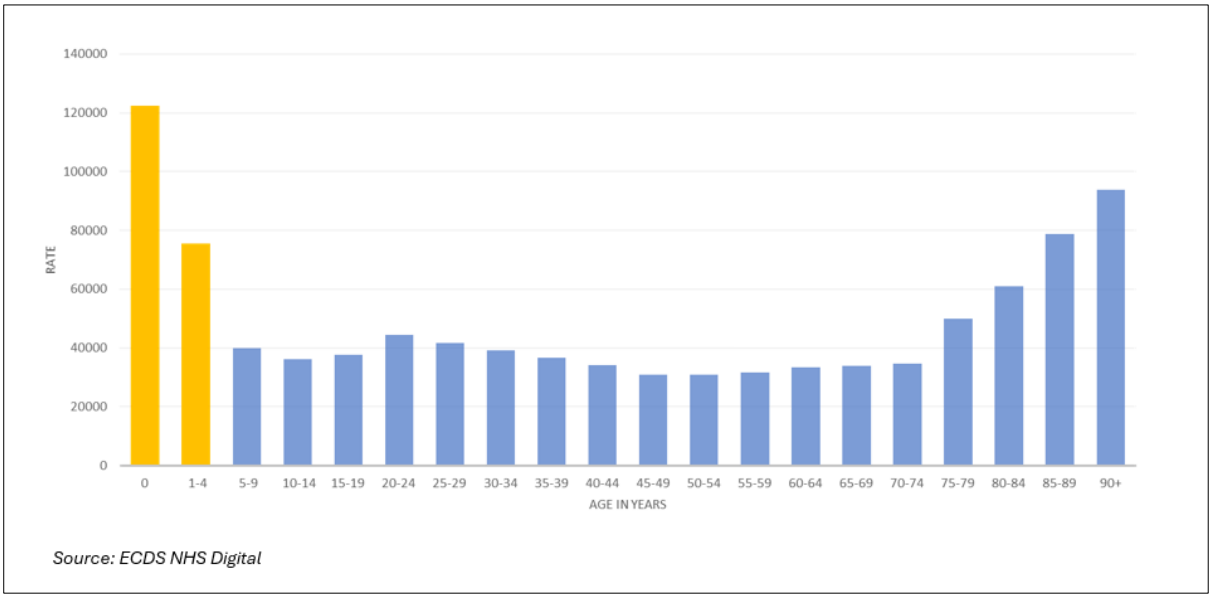
The other main route for case finding was through the monthly MDT meetings in the GP CHHs. This has been described in detail previously.

Harrow

ED attendances of infants and young children

Children under five are amongst the highest users of ED services both nationally and locally of any age group in the population (Figure 6).

Figure 6. England ED attendance by age rate per 100,000 population 2022-23



- Compared with all other ethnic groups, babies (<1 years) from 'other White' (Romanian and other Eastern European communities) ethnic groups had lower health visitor developmental review coverage rates and higher A&E attendances that did not require further investigation or treatment.
- There is a social gradient in the uptake of health review for the 2-year review; uptake is lower in areas with high levels of deprivation.

- In 2022/23, about 1 in 4 (27%) of A&E attendances did not require a further investigation or treatment was a repeated attendance (more than 2 attendances).
- Repeat attenders 6% of children attending 4 or more times in a year make up 25% of the workload in ED. Two thirds of these are for primary care sensitive issues and one third complex care needs such as prematurity and those with congenital malformations or metabolic disease.
- Trends in A&E attendances that do not require investigation has been rising since 2020.

The top 10 A&E usage with no further investigation and treatment (low medical acuity) for children aged under 5 years (Table 2).

Table 2. Top ten reasons for A&E attendances that do not require further investigation

Top reasons for A&E attendances with no further investigation (under 5)		A&E with no further investigation or treatment	Overall A&E	Percentage of A&E with no further investigation or treatment out of all A&E
		Number	Number	Percentage
TOTALS		**1,374**	**5,148**	**27%**
1	Fever	393	1,471	27%
2	Vomiting +/ - nausea	150	393	38%
3	Difficulty breathing	123	677	18%
4	Rash	89	233	38%
5	Head injury	73	185	39%
6	Crying infant	53	171	31%
7	Localised swelling/redness/lumps/bumps	49	155	32%
8	Diarrhoea	40	98	41%
9	Noisy breathing	37	211	18%
10	Abdominal pain	36	119	30%
114	Puncture	Less than 5		

Source: North West London ERNI – SUS dataset as for July 2024

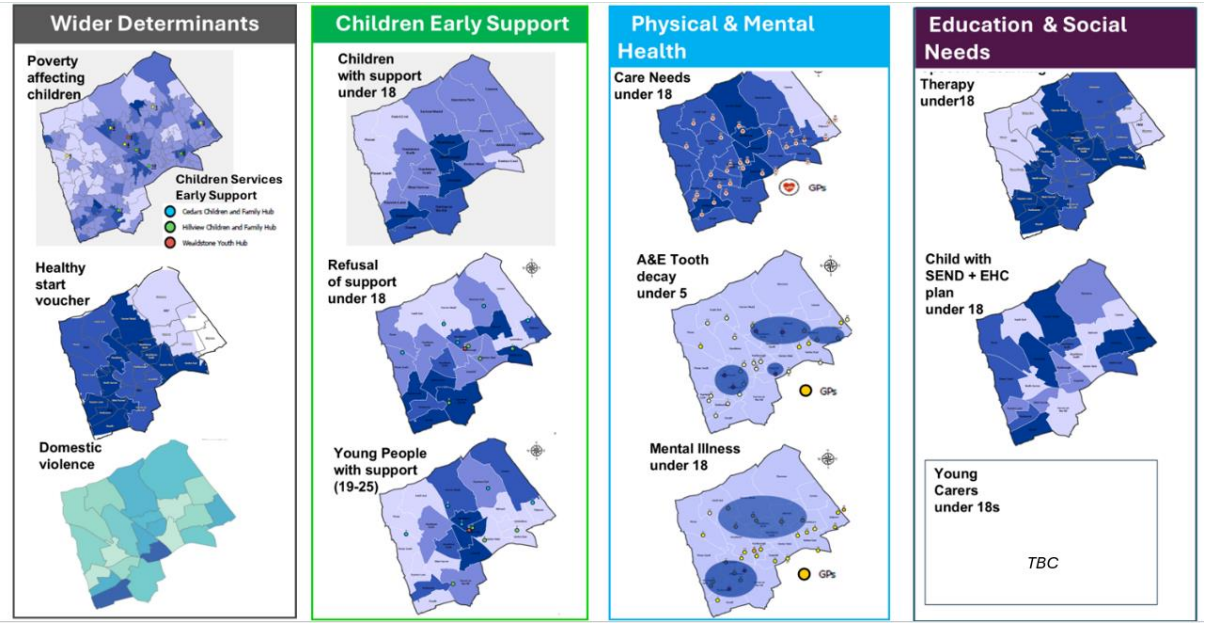
- Children aged 5 years are twice as likely to have tooth decay related admission compared with children aged 3 years or 11 years (691 per 100,000 vs 342 per 100,000 and 258 per 100,000 respectively).
- One third (24%) of all tooth decay related admissions for children aged 5 years during 2021-2023 were from other ethnic groups.
- More support/advice for parents at an earlier stage is needed to reduce A&E attendances related to frequently occurring conditions that can be managed by local services (e.g., health visitor checks, raising awareness of local pharmacies and community centres, leaflets at GP centres, etc.)

A video was produced by our team (in association with the IHV) to highlight the issues and to raise the profile of preventive care in supporting parents who might have concerns about whether to take their child to the ED: **https://vimeo.com/manage/videos/891112201**

Geographical clustering of risk

Below is a set of graphs which highlight high needs particularly in the central and south geographical localities in the borough of Harrow.

Figure 7. Cross-cutting inequalities across key areas (darker colours)



Optivita was sighted in South West Harrow in what is now the Central INT and centred around two GP practices GP Direct and Shaftesbury Medical Centre belonging to Sphere and Harrow Collaborative PCNs respectively with a high percentage of children and high levels of deprivation; a Core 20 plus 5[20] area (Figures 8 & 9).

Figure 8. Three populations neighbourhood based

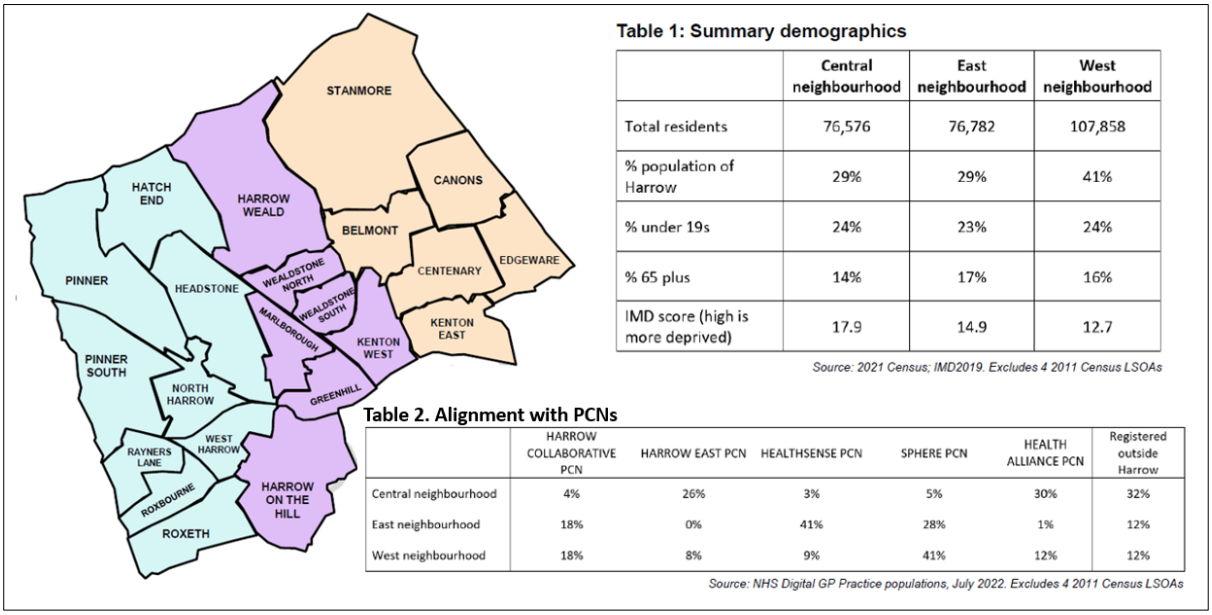


Table 1: Summary demographics

	Central neighbourhood	East neighbourhood	West neighbourhood
Total residents	76,576	76,782	107,858
% population of Harrow	29%	29%	41%
% under 19s	24%	23%	24%
% 65 plus	14%	17%	16%
IMD score (high is more deprived)	17.9	14.9	12.7

Source: 2021 Census; IMD2019. Excludes 4 2011 Census LSOAs

Table 2. Alignment with PCNs

	HARROW COLLABORATIVE PCN	HARROW EAST PCN	HEALTHSENSE PCN	SPHERE PCN	HEALTH ALLIANCE PCN	Registered outside Harrow
Central neighbourhood	4%	26%	3%	5%	30%	32%
East neighbourhood	18%	0%	41%	28%	1%	12%
West neighbourhood	18%	8%	9%	41%	12%	12%

Source: NHS Digital GP Practice populations, July 2022. Excludes 4 2011 Census LSOAs

Cohort of interest

A total of 870 children aged 0-4 years registered with these practices and living in the Harrow postcode areas of 'HA2 0' and 'HA2 8' (Figure 9).

Figure 9. Harrow population cohort of interest

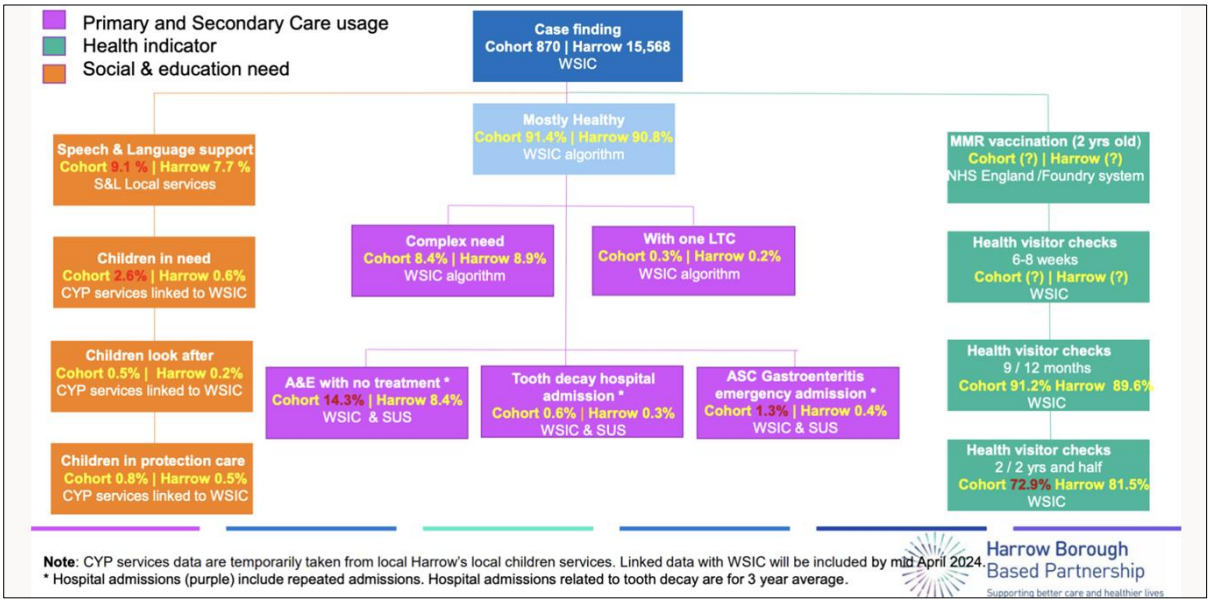
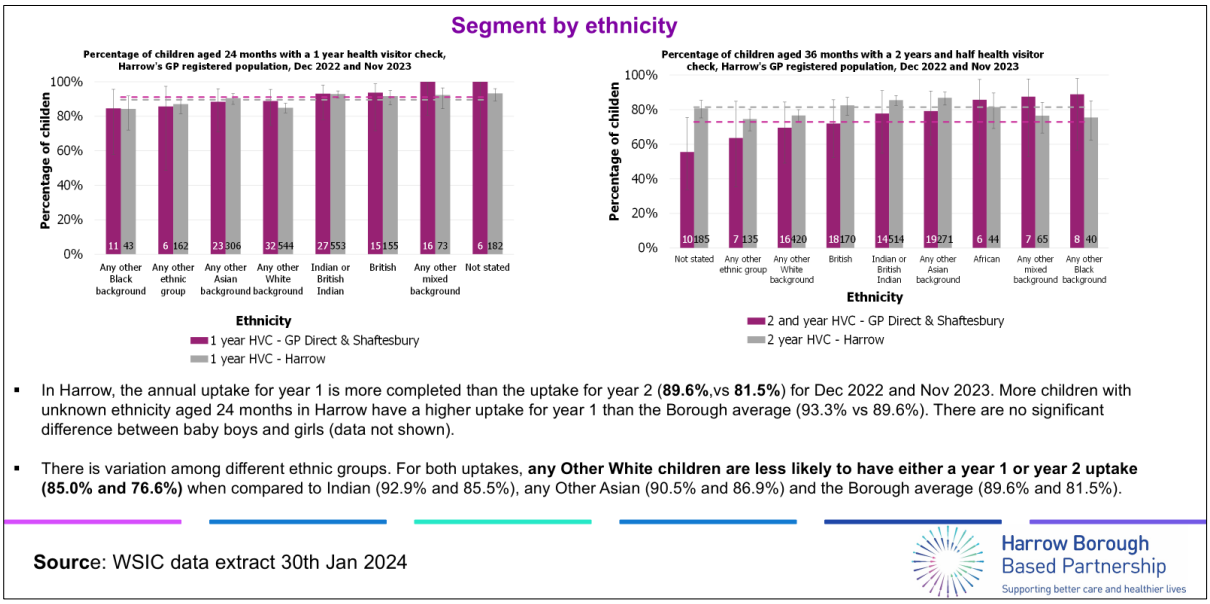


Figure 10 shows the uptake of the 1 and 2-year Health Visitor (HV) Healthy Child Programme (HCP) reviews. Currently, approximately 10-20% of children are not receiving these reviews.

Figure 10. Health Visitor Reviews for the Healthy Child Programme



- In Harrow, the annual uptake for year 1 is more completed than the uptake for year 2 (**89.6%**,vs **81.5%**) for Dec 2022 and Nov 2023. More children with unknown ethnicity aged 24 months in Harrow have a higher uptake for year 1 than the Borough average (93.3% vs 89.6%). There are no significant difference between baby boys and girls (data not shown).
- There is variation among different ethnic groups. For both uptakes, **any Other White children are less likely to have either a year 1 or year 2 uptake (85.0% and 76.6%)** when compared to Indian (92.9% and 85.5%), any Other Asian (90.5% and 86.9%) and the Borough average (89.6% and 81.5%).

Source: WSIC data extract 30th Jan 2024

Harrow Borough Based Partnership
Supporting better care and healthier lives

Examples of under-fives cases discussed at MDTs Harrow

Cases brought to MDT Harrow

- 9 cases, for children 5 years and under between February and November 2024. These included issues such as sleep disorders, queried asthma diagnosis, autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), attachment problems, eye concerns, and constipation.
- Impact of MDT discussions led to referrals to occupational therapy (OT), Multi-agency Safeguarding Hub (MASH), Speech and Language Therapy (SALT), Children's Centre's, sleep courses, therapist for social stories work, and medication reviews following on from professional discussions.
- Prevention included one child from developing a megacolon and needing possible surgery.

Perinatal mental health patient group consultation

A new MDT was set up as a result of local needs assessment to identify pregnant women with mild to moderate mental health issues identified by the local primary care and community midwifery teams.

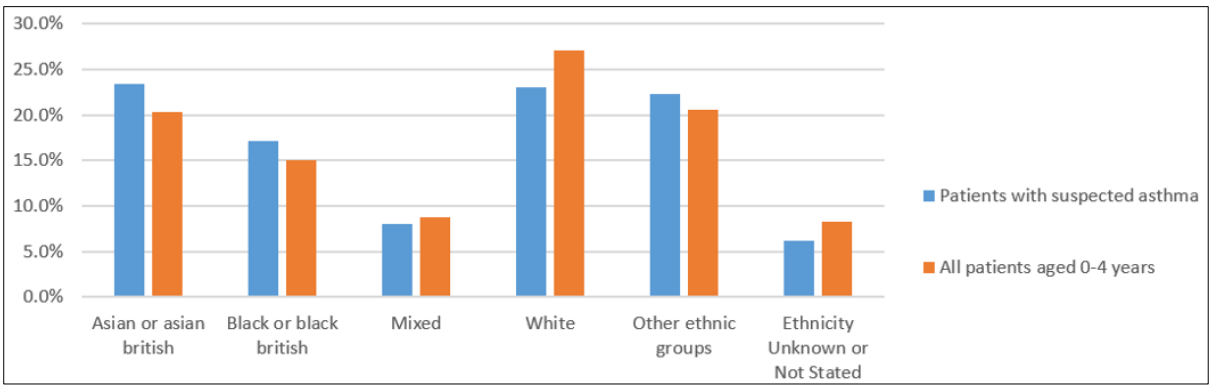
This is part of a wider intervention in Harrow which consists of patient group consultations for such women and is described later in the report in the section on *specialised clinics*.

Brent

Population Health Management (PHM)

The baseline patient cohort was identified through BI / WSIC data led searches and through the 12 GP Practices within the neighbourhood.

Figure 11. Willesden residents: percentage of patients aged 0-4 years with suspected asthma who are in each ethnic group compared with Willesden residents overall



Household Smoking

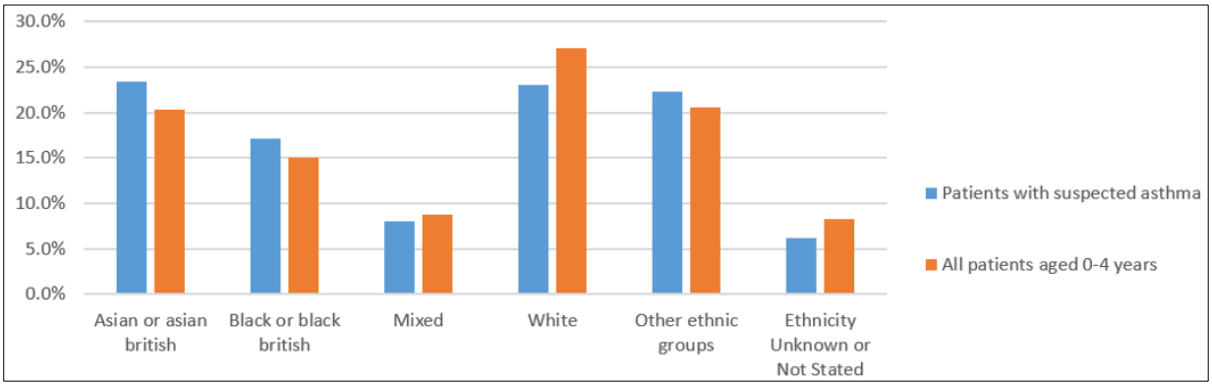
As coded by GP practices, the Egton Medical Information System (EMIS) searches show that 45 children aged under 5-years residing in Willesden are living in households where there is a smoker. However, practices are not coding children suffering from passive smoking.

An innovative solution is the use of new Unique Property Reference Number (UPRN) included in the WSIC data.

WSIC data shows that 1,437 children aged 1-4 years residing in Willesden are registered with a NWL GP practice and live in a property with 5 or less residents. Of these, 356 (25%) children live with a current smoker.

Children in the most deprived parts of Willesden (deciles 1-3) are more likely to live in a household with a smoker, compared with children in less deprived Willesden areas (deciles 4-10) (Figure 12).

Figure 12. Willesden residents: percentage of patients aged 0-4 years with a current smoker who are in each deprivation decile compared with Willesden residents overall



Undiagnosed respiratory disease

There are 2,319 under 5-year-olds registered with a Willesden GP Practice who live in the Willesden neighbourhood. Of these, 214 (9%) have suspected asthma with no diagnosis (Table 3).

Table 3. Number of patients aged 0-4 years with no diagnosis of asthma but coded with suspected asthmas or have asthma medicine prescribed

GP Practice Name	Number of patients aged 0-4 years who have NO asthma diagnosis but who have EITHER a code for suspected asthma OR any asthma medication prescribed in the last 12 months	Total number of Patients aged 0-4 years
Jai Medical Centre	14	93
Chichele Road Surgery	11	84
Willesden Green Surgery	48	378
Oxgate Gardens Surgery	36	333
St. Georges Medical Centre	7	80
Mapesbury Medical Practice	14	166
Gladstone Medical Centre	22	261
The Willesden Medical Centre	34	418
Walm Lane Surgery	11	184
Hazeldene Medical Centre	11	190
Neasden Medical Centre	6	132
Willesden Practices Overall	**214**	**2319**

The data also shows that the Black, Asian, and other ethnic groups have a disproportionately higher percent of children with undiagnosed asthma. The other, is thought to be the Arab ethnic group as Arabic is the most common language spoken in the area.

Undiagnosed autism

Twenty-three children who live in the Willesden neighbourhood have been identified with suspected autism which represents approximately 1.5% of the child population; those with autistic spectrum disorder in the UK is estimated to be around 1%.

Table 4. Number of patients with autism: confirmed, suspected, or any code suggestive of autism

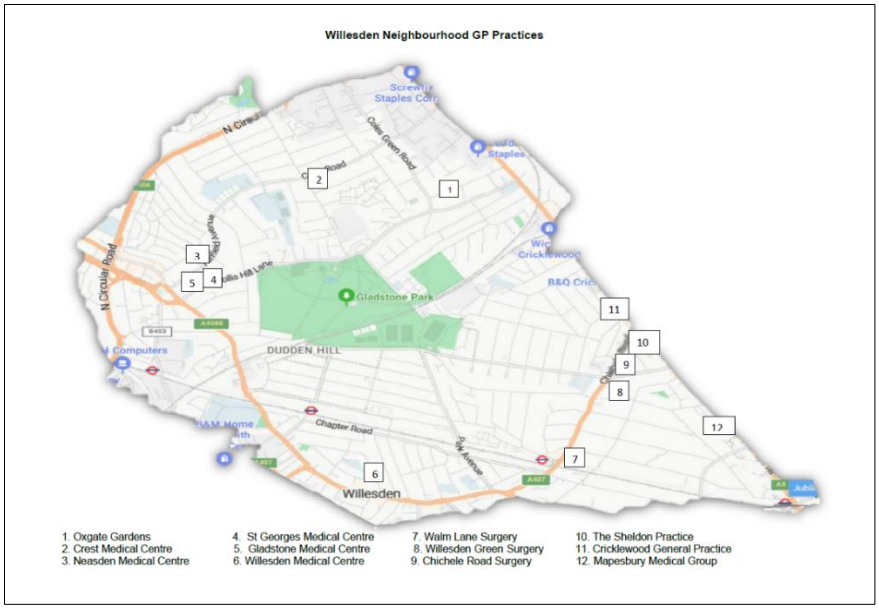
Category	Number of patients	% of all patients
Number of Patients with Confirmed Autism	19	0.62%
Number of Patients with Suspected Autism	7	0.23%
Number of Patients with Any Code suggestive of Autism	23	0.76%
Total Number of Patients Aged 0-4 years	**3042**	**100.00%**

High Intensity Users

K&W South PCN in Willesden has the second highest rate of babies aged under 1 as HIUs in NWL. There are 67 HIUs aged under 5 years. Work is being done to identify all HIUs aged under 5 years across all PCNs in the Willesden neighbourhood.

Figure 13 shows the GP practices in the Willesden neighbourhood where the Create team are focusing their efforts (Figure 13).

Figure 13. Map of the Willesden neighbourhood where GP Practices are implementing Create



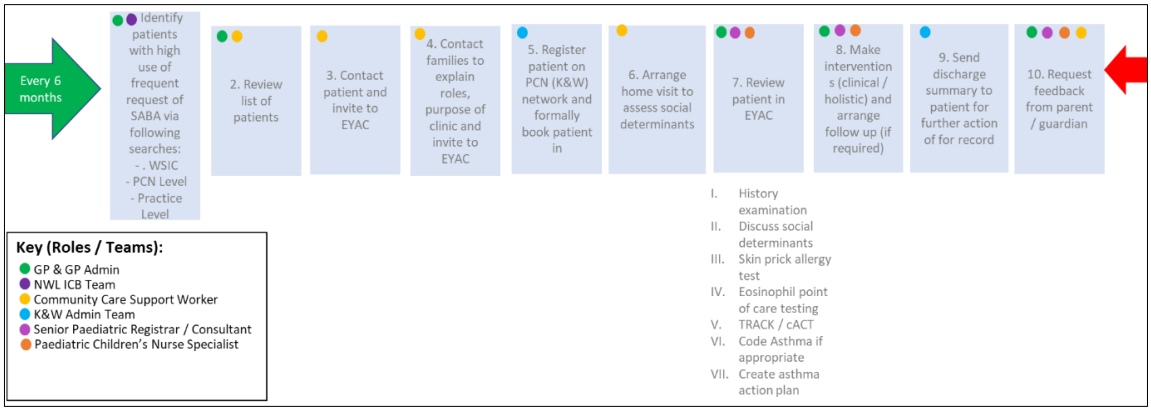
Cases brought to MDT Brent

Two under-fives' cases reviewed with ADHD, global developmental delay, and autism. The cases were discussed with the Child and Adolescent Mental Health Services (CAMHS), and the paediatrics team. Medication and behavioural strategies were considered, and management for both discussed of referral criteria and need for further information. Parents were also advised with strategies.

Pathways for the integrated care asthma clinic

Following discussions with specialists and as part of the response to the PHM data, a pathway for the integrated care asthma clinic was developed (Figure 14).

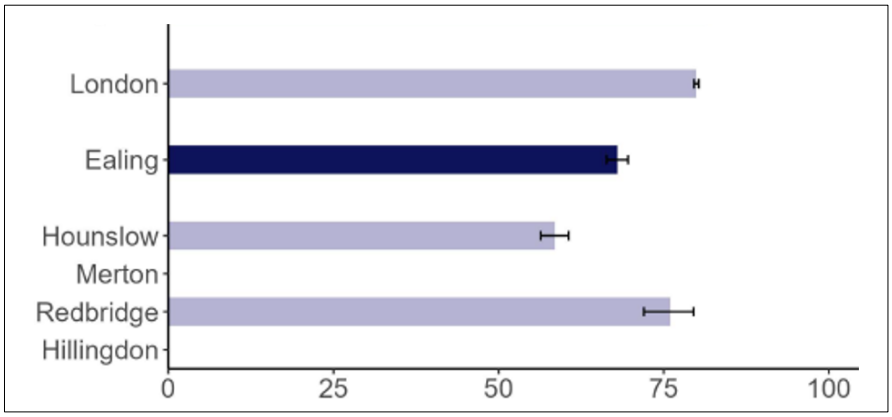
Figure 14. Integrated care asthma clinic pathway



Ealing

The Ealing StartWell team decided to focus on early childhood development. This decision was based on the findings from OHID public health local authority profiles, and the 'Learning from Lived Experience: Opportunities to Strengthen Early Child Development in Ealing', 2024 Report[21]. Taken directly from the report:

Figure 15. Child at or above expected level of development in all five areas at 2 to 2½ years in the financial year ending 2022 (percentage of children reviewed)



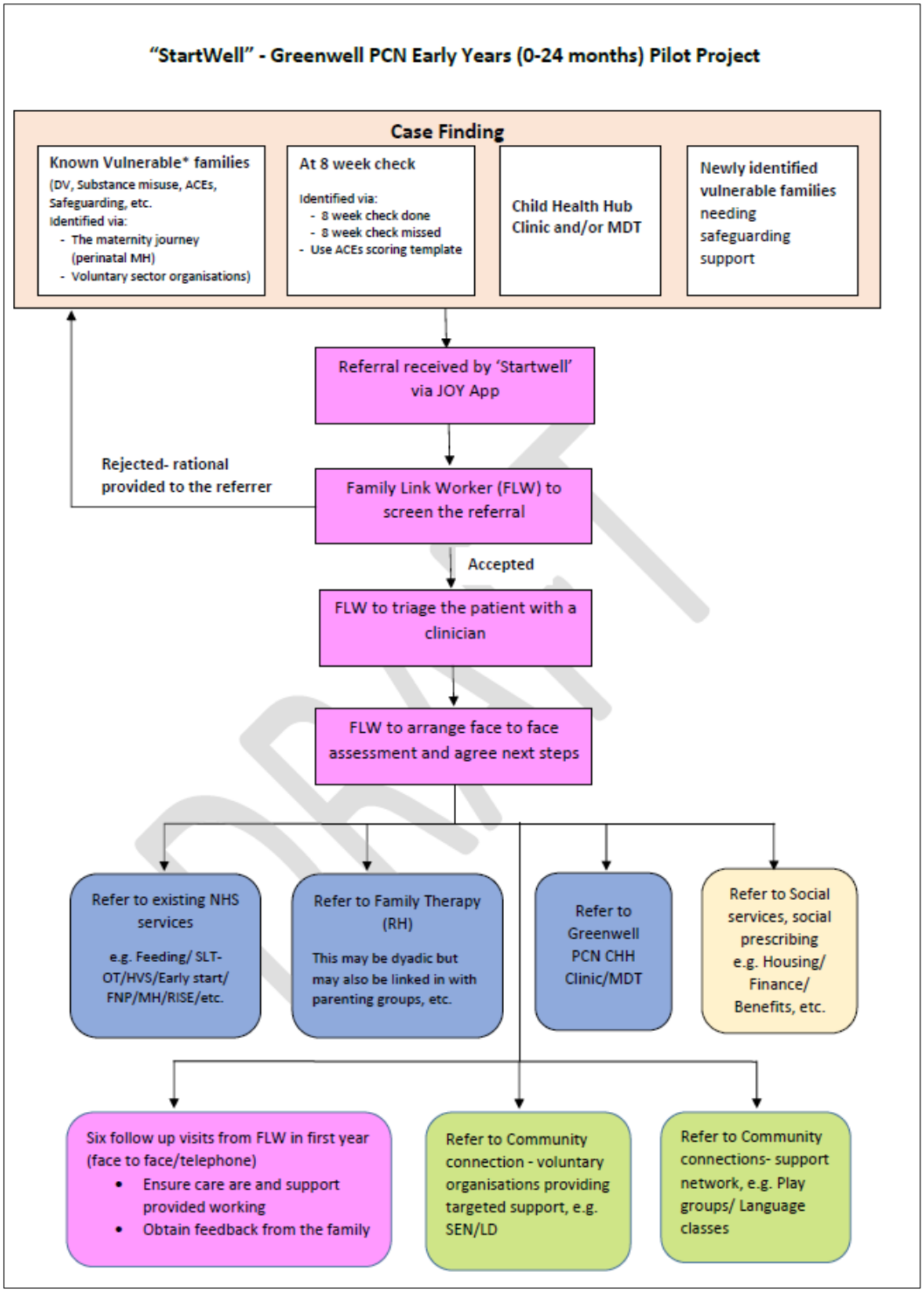
"68.0% of children aged 2 to 2½ years were at or above the expected level of developnent in all five areas of developent (communication, gross motor, fine motor, problem-solving, and personal-social skills) in the financial year ending 2022. This is lower than the England average. A lower proportion of children were at or above the expected level of development for communication skills (71.8%) and a lower proportion for personal-social skills (87.0%) when compared with England (86.5% for communcation and 91.2% for personal-social skills)."

Figure 16. Opportunities to imporve early years suppprt in Ealing

Collaborative Working

The team developed a collaboration with the local SALT teams to work in the Greenwell PCN which includes two GP practices (Oldfield and Eastmead Avenue), and their cohort of children (563 children aged under 5yrs).

Figure 17. The pathway for identification of the infants and the referral processes



WSIC: Population health management

The various WSIC dashboards provide person specific clinical data at aggregated level from which cohorts of patients can be selected for more targeted interventions.

Using the 'Watch list' function for all under-fives in all three sites at the time of writing this report revealed:

- 24 children with newly diagnosed (in the last two months) long-term conditions
- 927 non-electives in patient episodes
- 2,619 episodes of children not being brought to appointments
- 4,876 frequent ED attenders
- 1,954 with no recorded care plan

One typical patient aged 11 months with complex care needs, and who was on all 4 watchlists, spent 34 days in hospital. The cost to the health care system was £82,313. The patient was noted to have frequent unexplained non-attendances.

The paediatricians had sent each GP lead a list of similar patients for consideration of validating the records and to consider proactive action. Attempts at using the current monthly MDT meetings to discuss the high intensity or high cost patients were made throughout the pilot period. However, due to the reactive nature of the MDTs in terms of the existing demands on GPs for cases seen in the practice already, the lack of dedicated time to search these databases, and few financial incentives, resulted in this type of proactive case review being underutilised. This is a common finding across other central sites.

Lessons learned

- Data analysis at neighbourhood / INT level is in its infancy and requires sufficient analyst time to obtain the raw data for the relevant cohorts of children. Appendix 1 shows a detailed analysis from one data analyst.
- GP time was used alongside practice manager time to delve into practice-based records in order to identify proactive case finding such as high intensity users. There is little incentive to do this for children and adults where Quality of Outcomes Framework (QOF) payments and completed and accurate records are maintained.
- Despite WSIC producing relevant dashboards, these are underused due to lack of time for practices to be proactive when there is already a huge demand on reactive services, i.e., patients already coming into contact with practice staff, often in crisis.
- A different approach could have been taken to find common priorities between the three sites on which to focus. Potentially one or two clinical areas might have simplified the PHM data collection and evaluation process. This was the approach taken in some of the other national pilot sites (e.g., focusing on oral health or sleep safety only).
- Live up-to-date data is important to capture via a dashboard which is maintained over time to allow continuous improvement around the key process measures.

Recommendations for ICB

1. A dedicated BCYP team is required to support the development of BCYP Integrated care data packs at INT and practice levels. These should be action oriented to enable changes to be made based on the existing evidence base e.g., improving low immunisation rates, improving uptake of child health reviews, optimising asthma management, or reviewing children with no care plans.
2. Interagency / interorganisational data dashboards which are live and well validated should be produced with a view to facilitating ongoing continuous improvement on key metrics. Ideally this would reflect a holistic picture including key social determinants of health. 'A Better Start' has a core outcomes framework[22] which takes a life course approach based on routine operational data and could be adopted in NWL.

3. An agreed and standardised data collection tool should be developed at each GP CHH which can be completed at each clinic and MDT meeting to be able to support continuous improvements of the system and ensure those most vulnerable are being served
4. A high proportion of children discussed at MDTs had suspected or diagnosed neurodiverse needs. Further expertise from a range of professionals in these fields might support professional discussions further. Diagnosis and better understanding of neurodiversity disorders, parental coping mechanisms, peer support, avoidance of medication through sleep courses, therapeutic input for behaviours that challenge and linking in with children's centres for play groups could be better utilised
5. Services have different criteria and referral processes and pathways with waiting times which can be challenging for both children and parents. Parent support is needed during these waiting times and more links and referrals to Family Hubs could provide beneficial with their full range of services for 1-19 and 25 SEND.
6. Few High Intensity Users (HIU) were discussed at the MDTs to our knowledge. Further work is required to understand how proactive care for groups of children at higher risk should be conducted with a view to shifting from reactive to more proactive care. Currently fewer than 15 users and 25 users across the NWL ICB using the CYP rising risk and LADS dashboards on a regular basis. A dedicated programme (task and finish group) which aims to upskill staff on population health management for BCYP is recommended

Community staff (“connectors”)

There are multiple roles which might be considered as “community connectors, i.e., staff whom interface with the GP CHHs, family hubs, voluntary sector, and community members. These include community champions, community health and wellbeing workers, family link workers, family navigators, social prescribers, health, and wellbeing coaches, etc.

There are different models of employment: volunteers, PCN employed, local authority employed, voluntary sector employed. All of which have their challenges in terms of data accessibility and sharing, joint governance arrangements, recruitment, terms, and conditions of service, etc.

Local people know the local community best and there are many who wish to take on this type of role. The key skills required are being able to listen respectively and to have sufficient social, emotional, and cultural intelligence to be able to best support such families, and in turn support themselves in this work.

Clinical supervision cannot be underestimated as an important means of integration and team development. We have seen from our experiences of the vulnerability of many of the families contacted who have issues of trust with statutory services and who are struggling with the most pressing domestic issues around cost of living, housing, and food poverty.

It takes time for the team to “form and norm” and there are opportunities to improve connections between the parts of the system through better information exchange as we have seen in the health and wellbeing fairs and from local learning opportunities (see section on integrated neighbourhood teams).

Each site decided on the specific model of service which they wished to implement.

Harrow selected the ‘Community Health and Wellbeing’ model which has been tested in several sites in England including in Westminster, London. The model consists of an individual from the local community who visits each household in a defined geographical area on a monthly basis to befriend and offer support to local families. They usually cover around 120 households each whole time equivalent. The offer is usually all age, comprehensive, hyperlocal, and fully integrated with local primary care services.

Brent decided to employ a family link worker to specifically work with families with under-fives who have preschool asthma and wheeze, identified by the general practices.

Ealing employed two individuals who are also family link workers and work closely with the GPs who have identified families at the 6–8-week GP review.

Recruitment

Each of the pilot sites had to recruit community workers. This included writing job descriptions, placing job adverts, interviewing candidates, designing and delivering suitable inductions, and suitable compliance checks. These activities all take time.

Induction and Training

Induction and training are essential for new community workers to understand the wider community and make connections. Each pilot site provided tailored training for their specialism and geographical area. Training and development also take time to implement.

Operational policies and guidance were developed that were adapted to the smooth operations of the specific pilot site and geographical area, and met the legal requirements set out in employment law.

Ealing case study - Family Link Worker

The benefits of holistic support: *"no one thinks I can do this"*

Pre-referral to Family Link Support
A family was referred by the CHH to family link workers due to concerns about feeding and development. The mother described to the team how no one thought she could be a mother to the child because she (the mother) had schizophrenia. The mother had been diagnosed with schizophrenia and was known to the perinatal team. The family consists of both parents and an 8-month-old baby girl. The mother had advised that she wanted to participate in child friendly groups and meet other parents as a form of socialisation for her and her daughter. Both parents are from Afghanistan.

Identified concerns
At the first home visit, the mother declared that she was very anxious about caring for her baby and did not feel capable of doing this correctly. The mother stated that she was very overwhelmed and needed support from her parents and husband at all times.

The mother was very hesitant about leaving the baby to crawl on the floor and held her on her lap during the entire visit. She had not introduced meat into the baby's diet as yet as she was very anxious about the baby choking.

The mother became very anxious with any noise (including crying) which the baby made. She felt that she was always getting things wrong, and she was making so many mistakes. Her mother and aunt were always correcting her parental choices, and this was affecting confidence and judgement.

The family link workers raised safety concerns during the home visit, the most prominent being the need of a stairgate as the flat is an upstairs maisonette and it limits the play area for the baby.

Interventions offered
The mother was initially very eager and positive about attending lots of play groups and fun activities with her daughter. The family link worker immediately made these arrangements.

The mother did not attend on the arranged date and messaged the family link worker that she had slept in with the baby and had forgotten the details. This continued to happen for the next few contacts that were attempted. Plans were made for engagement, but the mother would forget and not arrive or be out when a home visit was arranged.

It was 2.5 months before the family link worker was able to have an in-person meet up at the home. The family link worker visited the mother who was very anxious and upset. Her main concern at this time was financial issues as they were tied into a private contract for their flat and they felt they could no longer afford this as her partner was the only working parent.
The mother also stated that she was struggling with the stairs at her property and was too frightened to carry her daughter down the stairs as she felt it was very unsafe. This meant she was staying inside unless a family member was there and able to help.

The family link worker offered to visit and take the mother and baby outside for a walk to the local park or to a playgroup. Help with financial assistance was also offered and a food bank referral was made. A Baby Bank referral was also offered but it was advised that an Early Start Worker was already doing this.

Professional Engagement
Contact was made early on by the family link worker to the early start worker who was working closely with the family but was unable to do home visits frequently. Contact was also made with the Consultant Perinatal Psychiatrist who was working with mother and adjusting medication when it was deemed necessary. After every contact with mother, an email was sent to the perinatal team and to her HV so that everyone was aware of the latest update.

When the family link worker home visit took place, they noticed that there might be some developmental delays with the baby. The baby did not appear to be sitting up fully independently and concerns that the baby was not displaying core strength. This was affecting the baby's sitting technique and neck strength. There were also concerns about lack of space and play for the baby who was very confined to one living room area where the mother was standing over the baby and not allowing for any physical learning. The mother was too concerned about possible injury. The family link worker also noted that there was no highchair for the baby who was not in the habit of sitting down to eat food so there were concerns about little food intake and growth.

All concerns were sent to the team working with this family and it was requested that a HV should make contact for a developmental , and to reiterate safety issues in the flat so that the baby would have a bigger space to explore.
The early start worker completed a home visit and provided a stairgate and highchair for the family, and checked the impact of having more space available to the baby who was increasing confidence and mobility.

The family was referred family to HomeStart with their consent.

Present Impact/Evidence
The family link worker has developed a trusted relationship with this vulnerable mother from whom they have received a few very distressed phone calls. The family link worker has been able to follow up and make visits, often with very little notice.

The continued visits and communication resulted in knowing when the mother's mental health was declining. This was immediately communicated to the GP, and the mother's anti-psychotic medication was increased. The family link worker has been able to promote more confidence in the mother in a safe way. The mother is never left alone with her baby but having a family link worker present means she can still get out and her family get more of a break.

The family link worker has encouraged the mother and baby out of the house and going for a walk to a local park in all weathers. The mother was shown how to use the pram and the highchair, and all safety issues were discussed and that it is a matter of repeated practice.

The mother had asked for her family link worker to accompany her to her local GP and wait with her when she has been feeling overwhelmed. The family link worker has been able to offer this help.

The mother has agreed to attend the family wellbeing 10-week workshop. While mother feels she cannot tackle the stairs down to ground level, it has been organised with HomeStart help that a volunteer will call at the home address to help the mother and baby leave the flat.

Because of the stair gate and mother's confidence, her baby has started cruising around furniture, has more strength, and has put on weight and eating a more varied diet. The mother is also talking more to her baby, copying our modelling, and subsequently the baby is babbling back a lot more.

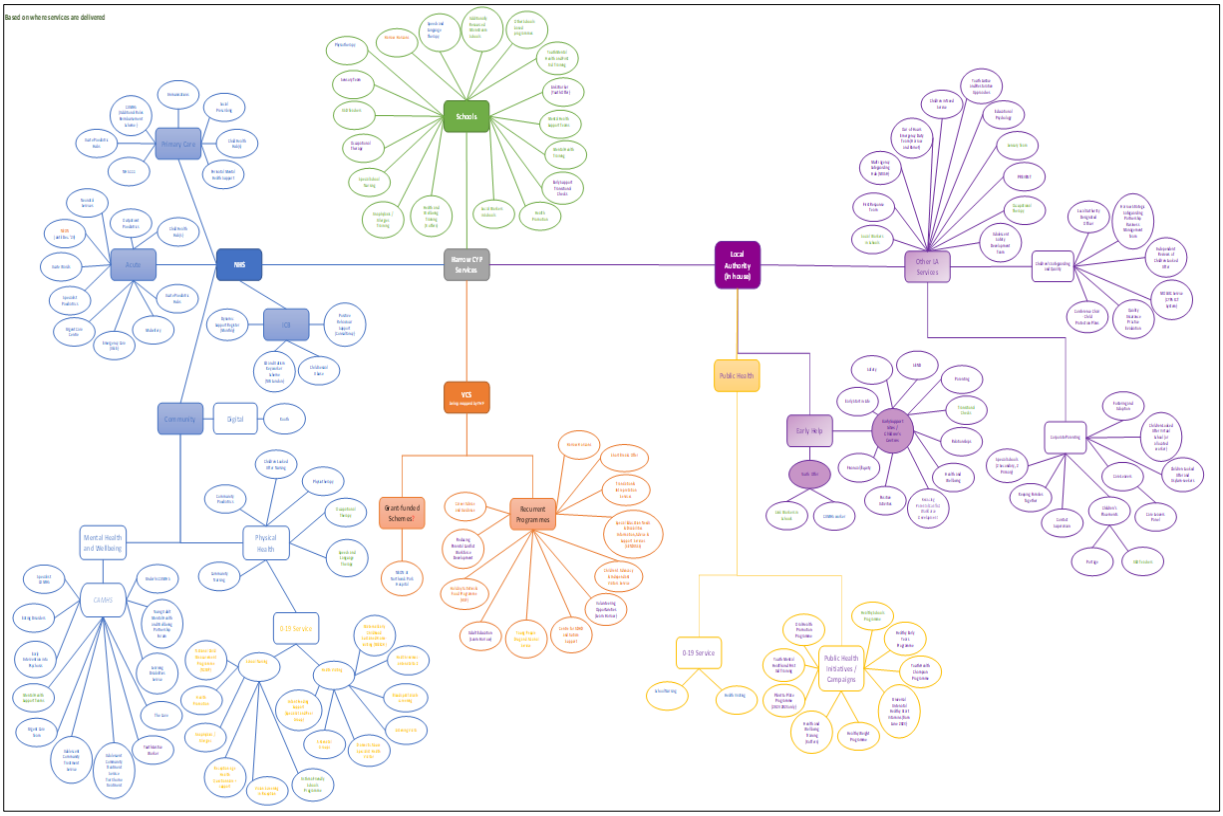
Community connecting – a mapping exercise

Community connections are a key aspect of meeting the aims of each pilot site, and community workers took time to get to know their local connection and establish strong professional relationships. In Harrow, a full range of partners and services were mapped out, in Ealing, professional relationships with health partners was developed, and in Brent, strong links with housing services as part of the asthma and mould interventions offered by Community Workers was developed.

A typical map (Figure 18) of services highlights both the number of agencies working in an area and the potential to connect *existing* resources to support the most vulnerable families.

Figure 18. Mapping the potential to connect resources and agencies in an area

Key: NHS, Local Authority incl. Public Health, Schools, VCS (to be completed)



Acknowledgements: Ayo Adekoya

Lessons learned

- Recruitment takes time which must be incorporated realistically within the scope and plan of the project.
- Decide which resources are required for recruitment and who has the best skills set to support the process.
- Utilise online government tools and templates that are readily available.
- Utilise the templates, tools, and learning from other successful pilots and services within the local geographical area. The Optivita pilot utilised the resources from the Bi-Borough Family Hubs which were invaluable.

- The need to be clear about the roles and type of tasks, and knowledge and skills required when developing the job description. Undertake market research and understand what other companies offer.
- Think about local avenues to advertise roles.
- Consider using value-based interviews to assess how candidates' values align with the pilot and approach.
- Develop standard policies and procedures and scope adequate time and resource to develop them for example safeguarding, lone working, health and safety.
- Know the local landscape and referral pathways, like the Optivita service mapping exercise.
- Map the strategic direction of key partners at a local level and opportunities to align key priorities, outcomes and Key Performance Indicators (KPIs).
- Map key partners and develop referral pathways and information sharing agreements in line with General Data Protection Regulation (GDPR) guidance at the start of the pilot.
- Co-produce and develop the service with parents and develop a co-production charter and strategy.
- Demonstrate the return on investment benefits where match funding is provided.
- NWL ICB to adapt its approach and processes when working closely with community partners in terms of power dynamics and the type of support grass root organisations required in its Integrated Care thinking and approach.

Recommendations Community connectors

1. At the scoping stage of a pilot proposal, factor in recruitment processes and timescales with clear timelines.
2. Map the geographical area in terms of services and provision available.
3. Factor in time (1-1½ months) to undertake a thorough new starter induction, training programme and introduction meeting with key partners.
4. Operational policy development around lone working, health and safety and practice guidance requires 3-6 months to develop and embed into practice.
5. Clinical supervision of community connectors (whichever model is favoured) requires dedicated time from the GP. This is essential and needs to be recognised in programmed activities (GP contracts).

Community engagement and Co-Production

Innovation grants

We purposefully allocated a proportion of the pilot site funding towards community and local voluntary sector organisations with a focus on perinatal and early years' health and wellbeing priorities, which were broadly aligned with the ICB and local epidemiological needs assessments. Each borough had an umbrella organisation for their local Voluntary Community Services (VCS) which facilitated the grant application processes. These included the advertisement of the scheme, setting up a panel to shortlist and select finalists and ensure transfer of funding, and its subsequent monitoring/reporting. It was emphasised that the recipients should work closely to integrate their projects with the GP leads and the wider local working groups.

The individual grants varied from £7000-25,000.

Where there were complementary projects, individual organisations were encouraged to collaborate where possible.

Table 5 lists the successful projects in Harrow to demonstrate the scope and variation of project type.

Table 5. Projects funded through early years innovation grants

Adult & Community Development Academy (ACDA) **Email: info@acda.org.uk Website: www.acda.org.uk/**
The Adult & Community Development Academy is delivering a 12-month community-based English for Speakers of Other Languages (ESOL) & Digital Skills for Health outreach service funded by Harrow Giving through the Optivita Parents & Early Years Innovation Fund. The service will focus on the needs of local families enabling them to gain new skills and knowledge, become more independent, preserve, and increase their health, wellbeing and safety. This ESOL & Digital Skills for Health outreach service is aimed at reducing barriers to health engagement by actively engaging with Harrow communities who are disproportionately disadvantaged and are at greater risk of poorer health outcomes due to their lack of English language and digital skills.
Best Beginnings **Website: www.bestbeginnings.org.uk/baby-buddy**
Best Beginnings are the creators of the free multi-award-winning, interactive pregnancy and parenting app, Baby Buddy, a powerful public health intervention in the guise of an interactive and accessible mobile app. Reaching almost 10% of the national birth cohort in the UK, Baby Buddy is supporting families from all backgrounds to have the knowledge and confidence to look after their mental and physical health and give their children the best start in life. Baby Buddy Local Harrow aims to integrate the award-winning free Baby Buddy app across maternity and early years pathways across Harrow to support parents from all

backgrounds gain access to personalised evidence-based information and local services and support.

Families in Action Together – Also known as Wealdstone Baby Bank
Email: w.babybank@gmail.com
Website: www.facebook.com/wealdstonebabybank/

We address significant gaps in access to essential services (e.g., healthcare, education) in our community through: Hosting healthcare/other professionals to the baby-bank regularly for sharing information /signposting purposes. Implementation of six tailored workshops designed to empower parents with the necessary skills and knowledge to support their children.

HASVO
Email: info@hasvo.org Website: www.hasvo.org

Our project aims to empower Harrow's Somali and Arab communities through educational workshops and culturally tailored videos, addressing health inequalities. With a focus on reducing tooth decay, minimising emergency visits for minor illnesses, and enhancing health literacy. Key topics include improving immunisation rates, optimising prenatal and postnatal health, and supporting early childhood development. The initiative involves collaboration with a video producer, healthcare professionals, and community leaders to produce accessible content. It will utilise workshops and social media for community engagement, knowledge sharing, and promoting healthier practices.

Dad Matters (Home-Start Barnet, Brent and Harrow)
Email: admin@homestartbarnet.org Website: www.homestartbarnet.org/

"Dad Matters" delivers a range of universal and targeted interventions aimed at male parents in the First 1001 Days, to improve their child's health and wellbeing outcomes later in life. Through our 'Dad Chats' and Workshops, we support dads with attachment and bonding, mental health, and access to information and services so they can help provide a nurturing environment for their newborns.

Ignite Youth - GLOW Up! Young Mums' Fitness Cafe
Website: www.igniteyouth.org.uk/

Glow Up! will bring together mums aged 13-25 in a mums' only space on a weekly basis during term-time for 2 hours. Activities will be free and take place in a safe, inclusive, and fun environment for mums to explore, express and challenge themselves through fitness and socialisation. Consisting of three core activities:

- **GLOW Up! Cafe:** a safe accessible and young mums' only space for them to have a healthy snack, and resources to take home, with other mothers and women youth workers in a non-committal but social manner. The cafe will also provide groups of mums with the knowledge and skills to build maternal resilience and confidence.
- **Glow Up! Young Mums' Fitness Club:** weekly fitness classes, delivered by a qualified Zumba instructor, who will provide fun and accessible ways for mums to improve their physical fitness and social skills.
- **Mentoring:** we will offer 1-1 mentoring for up to 10 people each year outside of sessions. Each session will focus on improving emotional and mental wellbeing and personal and life skills development, tailored to the individual needs and aspirations of each mentee.

These organisations have between them engaged at least 300 families with a variety of issues and provided practical and emotional support. Social isolation, caring responsibilities, financial difficulties, and mental health problems are predominant. The detailed reports of each are provide a comprehensive picture of the value to the local community (Appendices 9a-9g).

Lessons learned

A learning event was undertaken in January 2025, with the Optivita Innovation partners as Optivita was the most mature and mobilised. The session covered several areas. The key learning themes for each were:

(i) Application Process and Contract Award-Learning

- The tender turnaround was too brief.
- The tender was open during the school holidays and key people had arranged leave.
- The pre-application event for the main tender was useful as we were able to speak with Westminster about their set-up and learning.
- The pre-application session was useful; the tender aims and objectives for the smaller innovation tender was straight forward and clear.
- Main contract value was not adequate to cover all associated costs and only covered salary which meant applying for the bigger contract was not a viable option.
- Delivered a good engagement market event, however the contract value was not adequate to cover the pilot costs and Optivita has used its own funds to cover short falls.
- Awards were adequate to cover 6-months, but with recruitment and on-boarding mobilisation was delayed.
- It would have been helpful if the innovation grant awards were not set up to compete with each other and time/ guidance was provided to set up a partnership approach.
- The main bid was open for a 4-week period despite the perception of the group thinking it was 2-weeks.

(ii) Project planning and setting up and Co-Production with the community - Learning

- Undertake sessions for mothers to decide what support and help they need which is part of the day to day co-production practices.
- The time of the year made planning more challenging to set up; the award was advertised in September which was not ideal as organisations had pre-planned sessions in the run-up to Christmas.
- Recruitment, IT, GDPR, policies and procedures take time to set up which delayed mobilisation.
- Professionals need a minimum of 8-weeks' notice to get involved to reschedule clinics.
- Having VCS involvement at an earlier stage would have been helpful during the planning stages where a more centralised approach to GDPR, Joy App, and ground level intelligence could have been shared.
- Unable to co-produce due to time scales to set up and deliver.

(iii) Connections with GP, health and wider partnership – Learning

- Social prescriber played a key role in communicating and connecting users to services on offer.

- Each GP Practice/PCN have different ways of doing things; social prescriber spent time in maternity units in Northwick Park Hospital, children centres, and family hubs to reach people. However, this raised concerns among professionals about duplication of services that needed careful management.
- Set up a stand in Northwick Park hospital twice a week to reach dads supporting their partners with scans, which managed to reach 160 dads.
- With brand new teams it's important to meet in person, reach out, and build connections. Get to know the person behind the profession.
- We developed posters and drove to every GP practice and handed in our posters (with stationery (blu-tack) to make it easier for the practices to display the poster for wide-reach.
- We developed presentations for professionals, leaflets, mass text messages via the GPs to spread the word.
- Attempted to get advertising in the Harrow magazine which reaches every household in the borough but there was slow engagement.
- Visiting services in person was more effective than sending emails when promoting our services.
- Utilised the Harrow directory to contact every nursery, school, and organisation to find parents but response rate was very low.
- Consider the audience, wording and language used. Simple is better.
- We would like to utilise technology and improve our skills to reach parents and use the types of apps and platforms they currently use.
- Visibility and branding is important when undertaking outreach; having branded banners, clothing and material was useful when engaging with parents in maternity wings.
- Missed an opportunity in effective engagement with health visitors; they see every new born and hand out information packs.
- Could have made better use of directories such has Family Information Service (FIS) and Local Offer.
- Could have linked in better with registrars and handed out materials to be included within their new birth packs.

(iv) Monitoring for Impact-Learning

- The monitoring templates do not necessarily demonstrate the full impact of the service.
- Our service provision is session-led so much easier to measure and report on.
- Recording and use of the JoyApp would need tweaking and adjusting to support monitoring reports.
- We undertake pre- and post-surveys to measure impact and connections with key services such as weight, nutrition, GP and dentist registration, and but need to make this process simpler for parents.
- Building a strong relationship with the social prescriber is important, and being clear on consent and what can and cannot be done with information.

(v) Childs Voice-Learning

- Engaged researchers looking at ways we can engage CYP in research.
- We utilise illustrations for feedback which is effective for CYP and parents.

- We engage young people through questionnaires, co-designing services, and listening to recommendations as part of 'business as usual' work.
- All partners agreed that national learning about early years' child's voice would be helpful.

Recommendations

1. ICS to incorporate these experiences and learning into their commissioning strategies.
2. ICS to share the evidence base around how to effectively incorporate the under 5s child's voice in commissioning.
3. Future procurement exercises to factor in adequate timescales for organisations to partner up and consider joint bids.
4. Brent supported a joint contract application and once this matures additional learning will be useful for the sector.

Outreach events

Health and Wellbeing fairs
An important feature of our collaboration with the local communities involved with the pilot sites was the setting up of "Health and Wellbeing fairs" to showcase the professional and voluntary organisations which operated in the hyperlocal areas.

During the pilot period, both Harrow and Brent undertook these fairs and used the opportunity to launch their innovation funds at the same time.

Figure 19. Flyer for the Health and Well Being Fair in Harrow

The NWL ICB and Harrow Association of Somali Voluntary Organisations (HASVO) successfully collaborated and hosted the Harrow Babies, Children, and Young People's Health and Wellbeing Fair in February 2024. The fair hosted over 30 professionals coming together to raise awareness of the support services available to the local community. Stalls for different types of services and information were set up for the community to explore which included services such as CAMHS, vaccinations, and the Harrow Law Centre.

Figure 20. Layout of the Health and Well Being Fair venue

Two repeating workshops were also delivered for the local community on the topics of child speech and communication development, and child mental health; both were oversubscribed.

Figure 21. Photos from the event

The average cost of running the fair was around £3,500 which was less than £1 per person attending.

During this fair, the team collected data with an aim to assess how successful the event was in engaging the public and displaying the health and well-being services available to them. This was done by:

- Questionnaires to address how the communities felt about the event overall, their thoughts on how the information was delivered, and how likely they would attend another similar event.
- Stall holder feedback was collected from each stall on their views on the success of the event and/or what they would do differently for another similar event.
- Descriptive feedback HASVO from the fair was provided to the Optivita team
- Identifying the different ethnic groups, the fair attracted through a 'map and sticker' exercise.

A similar fair was held by the Brent team which launched the 'Willesden Babies, Children, and Young People's Health and Wellbeing Fair' and aimed to raise awareness of services available in the areas of:

- The importance of early years' health and wellbeing
- Risks of household smoking
- Undiagnosed asthma risks
- Recognising developmental delay
- Vaccine education

The evaluation team conducted a series of activities to collect data including:

- Collecting data from the community through questionnaires (similar to the Harrow fair)
- Collecting data from the stallholders
- To capture experiences of the event through drawings and illustrations

Impact

Harrow Fair

The fair was attended by over 250 members of the local community. There was a diverse range of people attending who were asked to indicate their country of origin via a red sticker on a map (Figure 22).

Figure 22. Country of origin as indicated by members of the community attending the Harrow Fair

A total of 48 questionnaires were completed from people from the community attending the fair. Data showed:

- 90% of participants scored the event a success (i.e., 5/5)
- 94% reported they learnt about a service or support that they were not previously aware of
- 33% reported that the information on mental health was the most useful
- 100% reported that the fair increased their confidence in seeking support available to them

Figure 23. A word cloud generated by the community who attended the fair

Feedback from a community member who attended the fair can be listened to here: https://youtu.be/sSbfeWO7tH4?si=Mv2Zaopdlu91NctK

Stallholder feedback

Obtaining stallholder feedback was challenging, with only a few stallholders completing feedback forms. However, the few who did reported opportunities for insightful learning, and for both networking and shared learning.

Community outreach event

Another initiative has been developed in Harrow to introduce members of the community to the Community Health and Wellbeing Workers (CHWWs) and other members of the hyperlocal preventive care team both within the NHS and local authority and VCS.

Figure 24. Advertisement of an outreach event planned as a direct outcome of the success of the Health and Well Being Fair

Figure 25. Photos from the event

The event was very well attended and have led to:

- Increased understanding of vaccination and responding to parent questions
- Increased awareness of GP services and support (e.g. helping parents to make appointments through the Providing Assessment and Treatment for Children at Home System (PATCHS), a non-urgent online consultation service that allows patients to quickly and easily access GP services online)
- Direct referrals being made of individuals to local speech and language therapy and health visitor support
- Introduction to the local Children's centre staff and family hub activities for infants and parents

Brent Fair

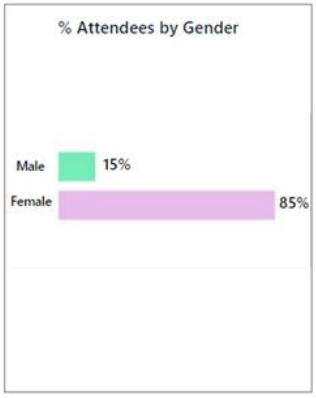
The Brent fair took place 13th June 2024 in Willesden Sports Centre. Table 6 shows the timetable for the event.

Table 6. Brent fair timetable

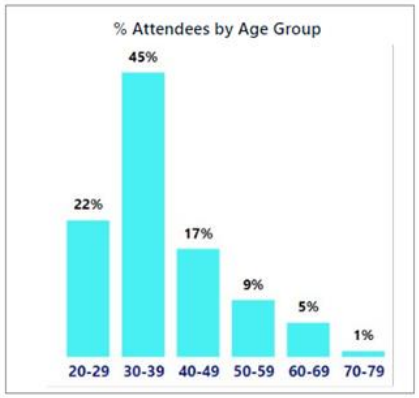
Item	Lead	Time
Welcome -Project Launch -Fair Objectives -Fire Safety/Toilets -Innovation Fund/Evaluation -Food Voucher **Main Hall**	Professor Mitch Blair Dr Muhammed Najim Dr Muhammed Najim Andy Moore/Gulnahar Savory Andy Moore/Gulnahar Savory Andy Moore/Gulnahar Savory	10:30 – 11:00
Speech and Language: helping under 5's become confident communicators **Room**	Alison Westwood & Isabella Sartori	11:00-12:00
Lunch & Refreshments- Main Hall		12:30-1:30
Face painting - Main Hall Bouncy Castle – Side Hall Mr Magic Bubbles – Main Hall		1:00-4:00 All day 1:00-4:00
Event Close		04:30

A total of 110 attendees visited the Brent Fair. The Brent team provided the information on the attendees by gender, age, and by locality and index of multiple deprivation (IMD) of Brent residents (Figure 26).

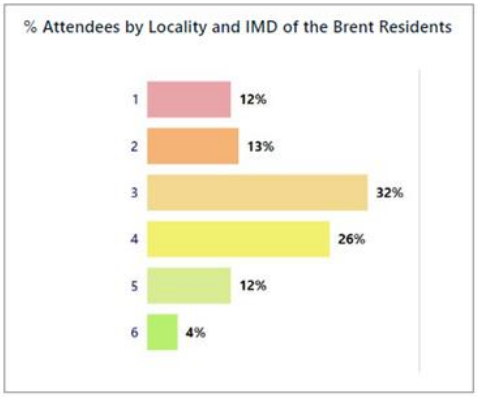
Figure 26. Demographic data of those attending the Brent Fair from the local community (n=110)



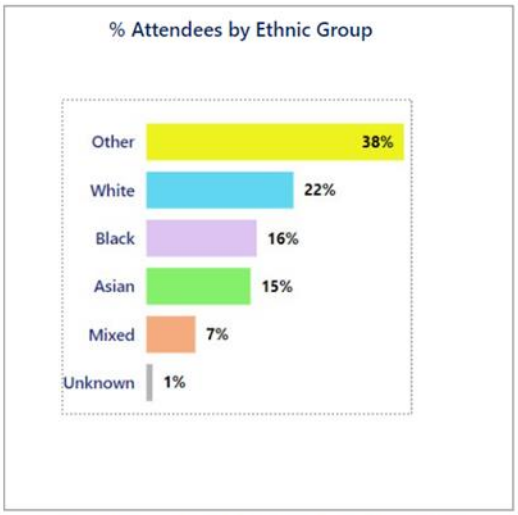
Most of the attendees were Female (85%)



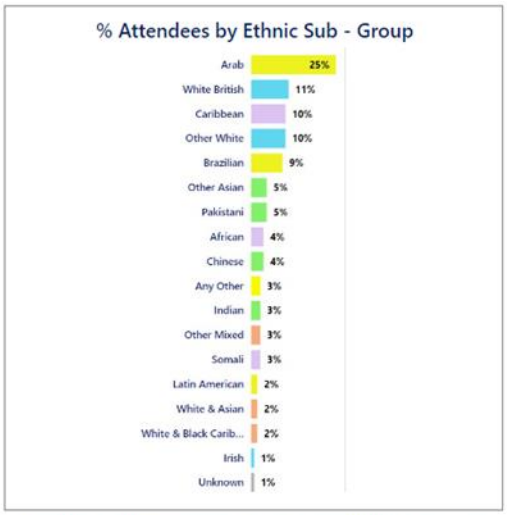
Nearly 7 out of 10 attendees we under 40 years old (67%)



Most of the Brent residents who attended were from deprived areas. A quarter were from IMD 1-2 (the most deprived quintile) and 83% were from IMD 1-4 areas



Nearly 4 out of 10 attendees were from 'Other' ethnic backgrounds (38%) and White attendees were the next largest group (22%)



A quarter of attendees were from Arab communities and the next biggest group was White British (11%) followed by Caribbean (10%) and Other White (10%)

A total of 74 questionnaires were completed by the community attending the event. Data showed:

- The fair was rated, on average, 4.6/5
- 63% reported that the fair increased their confidence in learning about services related to household smoking
- 75% reported that the fair increased their confidence in services related to childhood development (e.g. speech, language, walking, and growth)
- 93% reported that the fair increased their confidence in the health and wellbeing services available to them.

- 57% of the community reported visiting more than 5 stalls

A deep dive of the data was explored to identify the most popular stalls visited on the day by the community. Data showed that 57% of the community reported visiting more than 5 stalls with the most popular stall being the healthy eating stall, followed by the vaccination stall; 35% reported being the most satisfied with the advice they received around vaccines.

Stall holder feedback

Stallholder feedback was gathered by the Clinical Lead, Mitch Blair (MB).

MB visited each table in turn in a systematic approach asking each stallholder how many children and families visited their stall and what impact they felt their presence had on the audience who attended.

- Each stall was visited by 30 to 40 parents each (range 18 to 57).
- Oral health infant feeding and healthy eating stalls were extremely busy and had the advantage of being the first stalls as parents entered the main hall of the sports centre. The oral health stall was able to direct parents to dentists who were taking new NHS patients under the age of 17 and in particular were baby friendly. A mother was sitting at the stall with her nine-month-old infant and was immediately shown via the NHS app how to access her dentist using the postcode for her house.
- The Brent Health matters clinical team saw 57 people screened for diabetes, blood pressure, and weight management, with two referred on as new cases of newly identified hypertension.
- The immunisation vaccination table had 34 engagements and conversations with a variety of parents from different backgrounds who were considering immunisation for their infants and had many questions that they wanted answered. This stall provided the opportunity for parents to have a longer conversation with two specialist nurses. Although there was provision for infants to be vaccinated on the day, none of the parents attending took advantage of the opportunity to have their child vaccinated.
- Two mental health stalls provided a lot of information, particularly for adolescent mental health issues. This is of particular value to young parents in the area who may well have possible mental health issues. The insights from this team were invaluable in that they stated quite clearly that family and friends were the first port of call for most young people with mental health issues and therefore using peer mental health/wellbeing champions in schools might well be a strategy that Brent would like to consider in the future.
- Citizen's advice Bureau and Brent Health Matters employment team (Brentworks) stated that the most common matters that were discussed were housing and Universal Credit. They had 25 individuals at the stall that were directed to resources to support them in their locality.
- The health visiting stall gave away 25 packs of health vitamin drops to those that visited the stall as well as explaining how the services worked in the parent areas. Speech and language therapists carried out two workshops with 12 families each that were very successful and well received. Two referrals were made directly to the service.
- A triage officer for the early years' service hosted the early years team /family hubs and Start for Life which had 12 positive engagements from 30 families where families were connected to the local family hubs in their area.
- The water safety team were promoting swimming lessons and had 10 definite recruitments on the day with five to six further online applications for water safety and swimming lessons.

Lessons learned

- The concept of a “Show and Tell Fair” was well received both by the participants who were stall holders and the audience. There was a vibrant atmosphere and a lot of sharing of information not only between parents, but also between stallholders themselves who were curious about each other’s services. A number of referrals were made on the day to different stalls as parents were being directed from one area of the room to another.
- The whole event was facilitated by activities for children including a bouncy castle, and a children's entertainer in the main room itself. I personally enjoyed meeting so many of the agencies that are working in the locality and having the time to spend with professionals and finding out about their particular insights of how we can best help the local community. The event was used to launch the ‘community innovation fund’ to provide information for the audience and encourage bids for projects to be generated from the community. Incentives (£10 Sainsbury’s food vouchers) to attend were used but were probably not entirely necessary to ensure attendance and a substantial number were not collected on the day.

Recommendations

1. Attention to detail around signposting especially for workshops and children's activities.
2. Evaluations of events which involve a number of partners should be designed collaboratively. *(Imperial College carried out its own evaluation but Brent Health Matters had staff to also carry out their own evaluation with similar overlapping questions. The advantage of the Brent Health Matters evaluation was that there were some very probing goal orientated questions asking parents to set goals after the day with a view to following up after six months to check if those goals had been achieved).*
3. The acoustics in a large hall was difficult and therefore a fully functioning personal address system is vital. This would allow for a proper introduction for the day when people all people can hear appropriately.
4. Incentivising completion of evaluation forms with food vouchers, in this case Sainsbury's (£10), was helpful in ensuring a good response rate. A QR code was used for electronic data collection via a Qualtrics link, providing options of how to feedback.
5. These events provide an excellent opportunities for both service providers and service users. However, it is vital to ensure that appropriate filming and photographs can be taken on the day. This requires consenting and organisation in advance with the various communication teams and ensure appropriate joint governance is followed.
6. The return on investment in community outreach events; the cost per attendee was estimated at around £15.60 per head including all refreshments and room and equipment hire, vouchers, and child entertainment and creche facilities, etc. The value to the local community was in terms of information exchange, new knowledge, referrals to services and the building of trust. Several attendees subsequently applied for innovation grants.

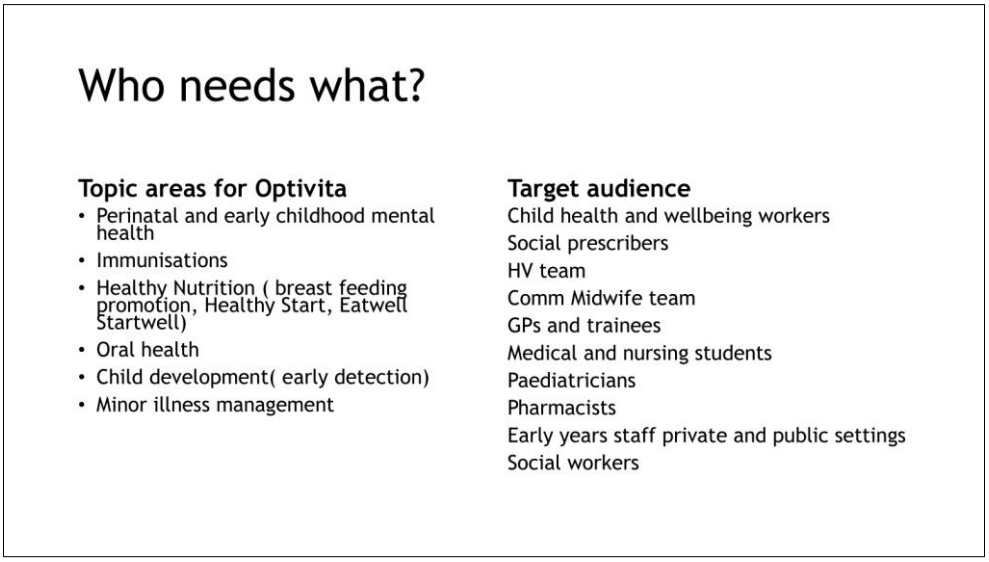
Integrated neighbourhood teams

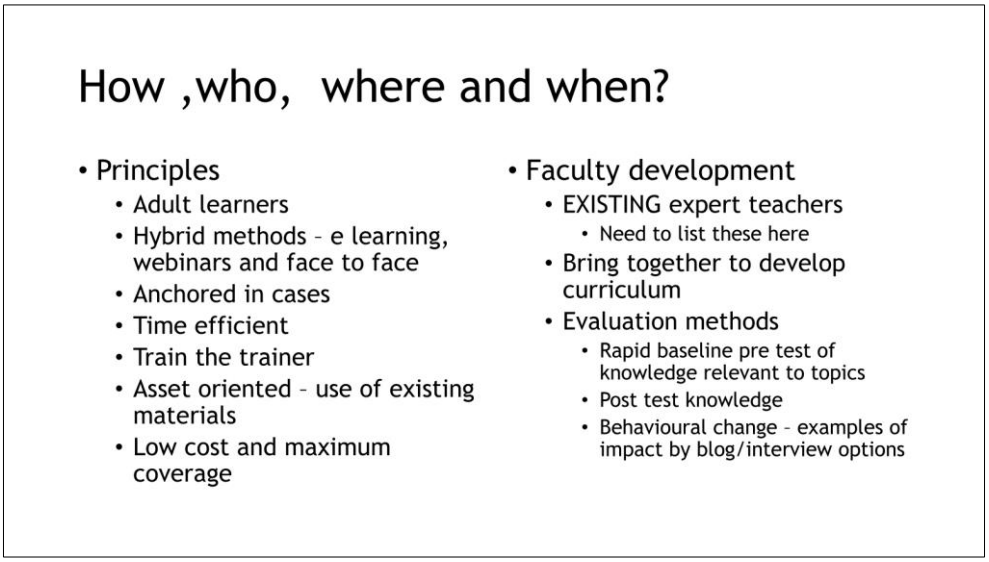
At the time of this pilot, the concept of INTs and how they operate is still formative. In one of the sites, the INT cuts across two separate PCNs with their own clinical directors, staffing and a shared population of interest. We have carried out a number of pieces of work to help further connect the pieces of the "jigsaw of services" which exist in the three hyperlocal areas. The purpose of bringing people together to work towards a common set of goals in improving child health and wellbeing is described in the introduction. Initially, we carried out a training needs assessment in Harrow at the start of the pilots and went on to commission a detailed training needs assessment in all three areas with the support of the IHV.

Training and Learning for Early Years workers

Figure 27 indicates the initial plan and intentions as set out in September 2023 and presented to the Borough Partnership in Harrow.

Figure 27. Planning and training for the early years workers



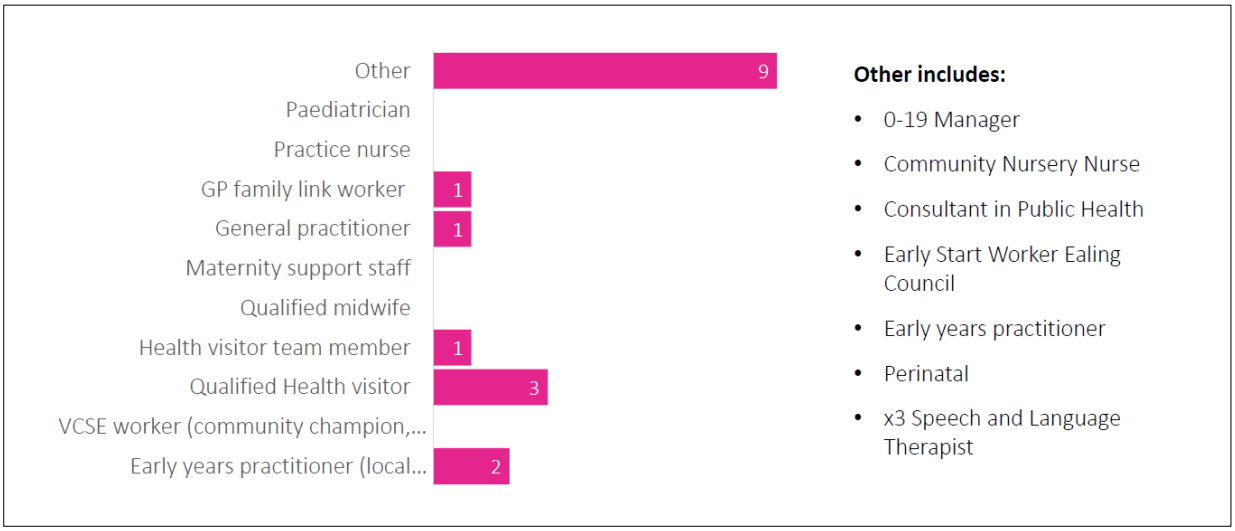


It was hoped that there would be capacity to develop an 'Early Years Academy' in Harrow or perhaps across all three boroughs. A multiprofessional interagency group responsible for leading and delivering educational activities are needed to address the key ICB and local priorities. Unfortunately, due to local cost pressures and organisational restructuring, this idea was postponed. However, local public health colleagues in Harrow site worked very closely with us to provide updates for all local staff in the following areas:

- Making Every Contact Count
- Oral health
- Optimising immunisation uptake

Multiprofessional intersectoral Early Years Learning Needs Assessment
In addition, we commissioned the IHV to carry out a Learning Needs assessment (Appendix 5). for all 3 sites and all professionals involved with the Early Years Pilots. Staff input can be seen in Figure 28.

Figure 28. Staff input into an early years learning needs assessment



Main findings
1) There are plenty of existing training opportunities available but little time or incentive to complete or attend.
2) Poorly curated to allow a clear idea of what the individual is expected to know.
3) Adult learning principles are key and making use of existing experience and multiple formats.
4) Generic and specific training needs clearly identified.

Joint INT learning events – 'Munch and Learn'
These are morning meetings (Figure 29) held at a local children's centre every few weeks with the intention of showcasing a particular topic of mutual interest to the team. The format is networking over breakfast/brunch followed by a short presentation and then further questions and time to connect with each other. The first of these focused on the rationale and details of the Healthy Child Programme and the importance of early brain development. This attracted

family hub staff, allied health professionals, the innovation grant holders, HomeStart, Dads Matters, and Disability services amongst others with highly positive feedback.

Figure 29. Flyer for the 'Munch and Learn' event

Promotion of early child development with allied health professionals
A scheme which started in Harrow to train all early year's staff in early child development and promotion of speech communication and language in the early years has been running for over 10 years. It has over 120 staff trained to date, and has won an NHS Innovators award[23].

The service's universal and targeted offer set out to achieve two main aims:
1. Upskill and empower the Early Years workforce to support children and their families with speech, language and communication needs.
2. Provide universal and targeted early intervention support for speech, language and communication to children and families

Previous impact has been considerable on service efficiency:

- A reduction in the number of referrals to the Harrow Preschool Speech and Language Therapy (HPSLT) service from 98 in the month of October 2021 to 45 in the month of October 2023.
- A reduction in children discharged following initial assessment as not severe enough for service criteria from 38% in January 2013 to 1% in January 2023.
- A reduction to the HPSLT service caseload from 683 in September 2021 to 523 in September 2023.
- A reduction in children waiting more than 18-weeks for HPSLT intervention from 305 in September 2021 to 127 in September 2023.

- A reduction in children waiting more than 50-weeks for HPSLT intervention from 58 in September 2021 to 0 in September 2023. 93% of children with mild to moderate SLCN who received targeted support in Children's Centres did not require referral back to the HPSLT service.

This scheme has been embedded into the current CHWW team with monthly supervision provided, and is aimed at the earliest identification and support in the first 1000 days. The scheme is also now embedded into the Ealing team's work with the two-family health link workers attached to both GP practices.

Parent feedback
"He is attending more to listening, he is using some words which are used here, he is improving in taking turns and waiting"

"Yes, more confidence with putting his words together in a sentence"

"He has more eye contact, more expressions. Saying two words. He understands and shows me and says what he wants"

"Yes, she started asking more questions – what is this. She repeats words" "She is improving in her daily talk"

Pharmacy support for minor illness
A substantial number of infants and young children attend the ED and UCC of with primary care sensitive conditions and low acuity illness. This is due to a wide range of factors including parental confidence, difficulties in accessing primary care, low health literacy levels, and preference to attend the hospital.

The Pharmacy first scheme allows many of these children to be diverted to local community pharmacies; a well-respected and easily accessible resource for parents with virtually no waiting times and suitable consultation space.

A part of our INT work, we have developed a very productive collaboration with our Local Pharmaceutical Committee and have trained over 35 pharmacists in NWL to improve support to pregnant women and parents/carers of young children. The pilot had expected to increase a focused offer in the 3 pilot sites in a bid to reduce unnecessary ED attendances. Unfortunately, due to internal processes and reorganisation, this part of the pilot has not been able to progress within the timescale of the project.

Lessons learned

- The concept of an INT is at an early stage and many processes are required to be put in place to ensure suitable governance and information exchange between the partner agencies as well as community connectors. This is easier in a single PCN but two of our practices centred around a hyperlocal area are in two separate PCNs which has meant some delay in developing the same access to records or supervision arrangements or where community workers might be hosted. One of our team has drawn up useful guidance on IG issues which are being included in the Early Years Toolkit to enable others to expedite the permissions required, which will support the team work around the families.
- Learning together and getting to know the people working in the hyperlocal team is an important step in ensuring a cohesive and efficient form of support to the families in the

area. We have sought to facilitate this through regular local learning events as well as community get togethers.

Recommendations

Governance
Discussions around information governance and clinical supervision and support need to take place as early as possible in such a pilot as it can take over 6 months to agree and obtain the correct approvals and documentation.
NHS e mails should be offered to all community connectors working in the HLPCT to improve security of data exchange between providers.

Training
Every attempt should be made to curate and deliver both generic and specific knowledge, skills and attitude training in early years using adult learning methods as per the recommendations of the IHV report (see IHV link for full report) The training should be monitored as part of the clinical supervision and appraisal processes for staff. A Borough or sector-wide approach with full workforce lead involvement is recommended so that a clear strategy and timescale is agreed.

Speech and language therapy led promotion of communication, is cost effective and skills up a large early year's workforce to enable early identification and support at a UNIVERSAL level and should be sustained.

Minor illness Pharmacy intervention should be commenced as soon as possible as a means to divert children safely from the ED and UCC services in the areas. This has already been demonstrated to be effective in NE London as described in the ICB Business case which was agreed in April 2024 but has been delayed during this specific pilot period.

What do professionals say about the pilot?

Summary of online surveys and qualitative interviews with professionals

Background
Setting up early years services to meet the needs of local families with young children is complex. The delivery of these services to provide support and to signpost families where necessary rely on many professionals, health care services, and local community services working together.

Aim
We aimed to understand professionals' (also referred to as 'participants' in this section) perspectives and experiences of setting up and/or delivering early years services across the three pilot sites.

Methods
We used an online survey and a semi-structured qualitative interview to capture professionals' experiences. The survey was designed to identify expertise, involvement with delivering early years services, and experiences of working with other teams. To complement this, we created a semi-structured interview for a 'deep dive' into professionals' experiences.

The survey was developed by MB, BR, and LL, and formatted onto the Qualtrics online platform. A link to the survey was distributed by LL by email to all teams involved at each pilot site. The initial email was sent on 15th January 2025, and two reminder emails were sent one week and two weeks respectively after the initial invitation.

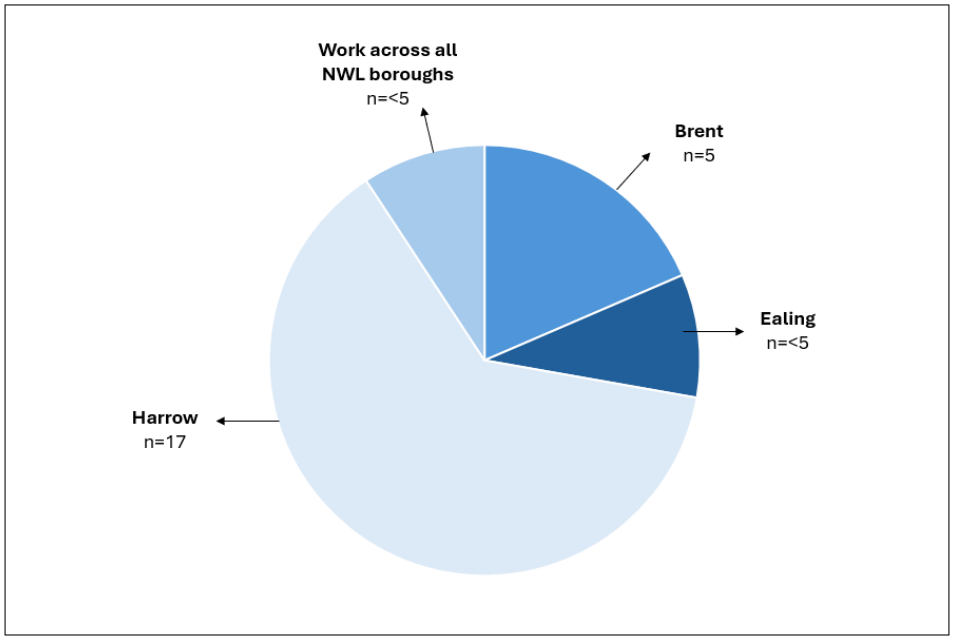
The qualitative semi-structured interview for professionals was developed by MB, BR, and LL. LL and BR coordinated interview times and dates; all interviews were conducted by BR during January 2025, took place online using Microsoft Teams, and were recorded and transcribed.

To follow all confidentiality and GDPR guidelines, all the data collected from participants (the professionals involved in delivering early years services) via the survey or the interview were pseudo-anonymised.

The survey took a median average of 12 minutes (IQR: 9,17) to complete. The in-depth interviews lasted approximately 45 minutes.

Results
Participants
A total of 27 participants either completed an online survey (n=17) or were interviewed (n=10). The highest representation of participants were from the borough of Harrow (Figure 30).

Figure 30. Number of participants interviewed by borough



Most participants were female (n=22), from White ethnic backgrounds (n=10), and within the age range of either 31-40 years or 41 to 50 years (both n=9). Community Workers / Family Link Workers were the roles held by most participants (n=11) who either completed the survey or took part in the interview (Table 7).

Table 7. Participant characteristics

Characteristics	n
Sex	
Male	5
Female	22
Age range	
20-30 years	<5
31-40 years	9
41-50 years	9
51-60 years	<5
61 years or more	<5
Ethnicity	
White	10
Mixed/Multiple ethnic groups	<5
Asian or Asian British	6
Black or Black British	9
Arab or Middle Eastern	<5

Most participants who completed the survey or participated in an interview were Community or Family Workers (n=11) followed by Project or Programme Leads/Managers (n=8; Table 8).

Table 8. Participant roles in the early years services

Early Years Role	n
GP Clinical Lead/Co-Lead	<5
Community/Family Worker[1]	11
Nurse (e.g., health visitor/midwife)	<5
Project / Programme Leads[2]	8
Social Prescriber	<5
Youth Worker	<5

[1]Inlcudes Community Health Workers, Family Link Workers, Family Support Practitioners
[2]Includes Project Leads, Programme Leads, Project Coordinators, Programme Managers

Involvement in delivering early years support services
In our survey, we asked participants to indicate how long they had been in their role of delivering the Early Years Pilots. The majority of participants (53%; n=9/17) who completed the survey reported being in their role for less than six months.

The most common reason for getting involved in delivering early years services was own interest and motivation reported by 44%. Other reasons included an arising opportunity, or through a recommendation.

*"I always like giving back and helping families" (*Project/Programme Lead)

"I was very interested in children, you know, Children's Health, particularly children's mental health and families, mental health" (GP/Clinical Lead)

Opportunities arose for involvement with the early year's pilots; participants expressed that it was a natural progression of their role / their role evolving, or through responding to the changing needs of their local community.

"I think it's just been a progressive journey over time..." (Project/Programme Lead)
"...because we cater for the needs of the community, it was actually responding to a need of the community in terms of actually addressing some of their concerns, the issues around early years". (Project/Programme Lead)

Recommendations to become involved in the early years pilots were through being recognised for relevant experience / expertise.

"I've covered all the child healthcare safeguarding leads....my [colleague] knew that. And somebody put forward my name and she chatted to me and said would I be interested" (GP/Clinical Lead)

Case finding and population health
We asked participants to tell us which population groups their sites focussed on. Participants could indicate more than one cohort group. Children under-5 years with neuro-developmental impairments was reported to be the highest cohort focus (53%; Table 9).

Table 9. Focus of cohorts being supported across all pilot sites

Cohort focus	n
Pregnant women and children <2 years	47%
Infants aged 6-8 weeks attending for their GP review as part of the Healthy Child Programme	29%
Children aged <5years with suspected pre-school asthma	41%
Children aged <5years with neuro-developmental impairments	53%
Households where smoking has been identified	*(n=<5)*
Mental health issues identified perinatally	29%

Participants also specified that their sites focussed on other cohort groups which included 'young mums aged 25years or under', 'pregnant women and children under the age of 5 years', or that their services were 'universal', i.e., open to all families.

Decisions on which cohort groups to focus on for all the sites was reported to be largely led by GP records (47%), followed closely by clinical experience, service demands, and using regional data (Table 10).

Table 10. How the sites identified which cohorts to focus on

Identifying cohorts	%
Clinical experience	41
Service demands	41
Using local data	29
Using GP data	47
Using regional data	41

However, most of those who were interviewed did not always know how the target cohort groups were identified as these decisions were made either before they became involved in the early years pilots, or they were not part of these discussions. However, those who were involved expressed that there was a mixture of looking at local datasets and using current knowledge and experience on the ground of the needs of their local communities.

"They identified the area that we wanted to run it in. There was a lot of vulnerable people in terms of maybe immigrants that come in... there was different information that they had already they'd already obtained... I think that's how they selected that particular area because they realized there was some need within that area" (Youth Worker)

"...we took an extremely targeted approach to how we engage families. So, we looked at a range of data sets. So public health data, education data. Community based intelligence, so from some of our partner agencies and people like that." (Project/Programme Lead)

Local, regional, and GP datasets were often used to identify cohorts but this rarely included using the WSIC dataset which is specific to NWL residents. Only 6 of the 27 participants stated that they / their teams had used WSIC datasets to identify their target groups.

Intervention and delivery
Most participants indicated that they had sufficient staff/teams in place to deliver the early years services. For those that indicated they did not have sufficient staff, this was mainly due to funding or capacity.
"There is no dedicated funding for the required number of staff needed to deliver effectively" (Project/Programme Lead)

"Due to other [staff] commitments" (GP/Clinical Lead)

A total of 76% participants reported that it took (or will take for the less matured sites) more than five months to be able to fully deliver the intervention at their site. Barriers for not being able to implement the intervention sooner included GDPR issues, funding, and time constraints.

"Time constraint. Delays in project – prolonged planning/designing phase, reduced time for implementation" (GP/Clinical Lead)

"GDPR is the main reason why myself and team haven't been able to fully work according to our job profile roles!" (Community Health Worker / Family Link Worker)

"Accessing data was big issue" (Community Health Worker / Family Link Worker)

"Lack of referrals of [cohort group] to the project has prevented us from being able to be fully running the sessions" (Youth worker)

However, all participants indicated that successful delivery of the services would improve the needs of local families with young children. All participants who completed the survey agreed that their services would provide parents with support and confidence to deal with their child's needs (Table 11).

Table 11. Benefits of the delivering early years services across all sites

Perceived benefits of services	%
Improved knowledge for families of where to seek help/signposting	94
Faster / efficient referrals to the right team	88
Improved child development	82
Improved child health	82
Parent support / confidence to deal with their child's needs	100

"And we've already begun to see lots of very, very vulnerable families supported…and become more integrated…we'd like to extend it to more families, but we're definitely already seeing the benefit…" (GP/Clinical Lead)

Integrated Neighbourhood Teams
Almost half of all participants surveyed or interviewed (48%) reported that they currently attend an MDT, and reported that they found it to be either 'extremely useful' or 'very useful'.

Of those that did not currently attend an MDT (52%), 50% had attending an MDT previously, whilst participants who did not attend or had never attended said that this was due to 'not being invited', or limited 'time/capacity'.

"We haven't received any invite…we contact the local GPs…I know how busy GPS are, but [the MDTs] might have been a good avenue to be invited to something like that, but we haven't received any invite /information on that. Otherwise, we would have happily gone along" (Youth Worker)

For those who attended MDTs, we asked whether they felt there was any professional expertise missing from the sessions that would be helpful to have. Responses of 'Children's Social Workers', 'Housing Officers', 'Health Visitors', and 'Allied Professionals from all areas' were reported as missing expertise from the MDT sessions which they thought would be helpful to address all needs of the local communities.

Most participants reported that different professionals coming together was very helpful, but there were challenges to bring teams together at hyperlocal level to meet the needs of the communities. Most (n=11) reported that limited time/capacity was the most challenging issue for bringing together teams at hyperlocal level (Table 12).

Table 12. Challenges with bringing teams together at hyperlocal level

Challenges	**n**
Data sharing	<5
Governance	<5
Funds	<5
Time/capacity	11
Communication	6

"…it takes three months to planning for in the next meeting and the next conversation. So, you're a year down the line before you even do anything and things like that. So, I think the time that it takes (Project/Programme Lead)

"…there's never enough resource; there's never enough time and these are quite common things…" (Project/Programme Lead)

Finally, we asked what participants valued the most in their relationships by working with other professionals during the early year's pilots. Learning and knowledge exchange was the most valued. The comments participants shared with us included:

- Learning from other clinicians / gaining knowledge from their expertise
- Relationship building / building useful networks and contacts
- Sharing information/learnings/expertise from different professionals contributing to a shared common goal
- Open and transparent communication which has led to more effective problem-solving and the ability to respond swiftly to the needs of families and children served by the program
- The empathetic response and the care that everyone shows is inspiring

Summary, limitations, and implications

The online survey worked well to capture the views of service providers using a method that did not seem too onerous for those completing the survey. However, responses were low despite reminders, and the majority of those completing the survey had been in their role for less than six months. As a result, they were not necessarily aware of all the processes needed to set up the intervention at their pilot site, and this limited capturing information needed for a better understanding of providing the early years services. Nonetheless, the information that was provided complemented the qualitative surveys to capture delivery of the early year's pilots. Our semi structured interviews worked very well for an in-depth dive into participants experiences of delivering the early years pilots which in turn, complemented the information captured from our online survey. As with the surveys, not all those who were interviewed knew about the setting up of the interventions at their sites or how their target population groups were identified. This limited the information gathered to build a bigger picture of the processes involved to deliver the intervention to meet the needs of the local communities. Increasing the number of professionals interviewed and surveyed would add value to learning and improved understanding of the early years services delivery.

Lessons learned

- Professionals value this work, both for the patients they serve and for themselves. They perceive that families have improved knowledge about where to seek help, faster and more efficient referrals to the right team, improved child health and development, improved support, and additional confidence to deal with their own and their child's needs. The method of using an online survey worked well, was time efficient, and responses were comprehensive.
- Professionals are learning from other clinicians which adds to their own knowledge whilst also developing relationships and useful networks and contacts. This is contributing to a shared common understanding of management goals for the family. The nature of the MDTs is such that there is open and transparent communication which has led to more effective problem-solving and the ability to respond swiftly to the needs of families and children served by the program. The “joy of work” is often referred to in terms of care for the family and for each other.
- A number of barriers to joint working have been identified with dedicated time and team adequacy of communication being the most important, in addition to issues of data sharing and governance, maximising inclusion of the wider team members interfacing with a child and family.
- The MDT meetings of the GP CHHs evolve constantly over time and often start with simpler ‘doctor-to-doctor’ queries of a clinical nature. With increased levels of trust and development of relationships, the discussions become richer and more complex in terms of tackling the wider determinants of health. Family navigators in central London employed by the local authority have regularly attended GP CHH MDTs.
- A successful extension of the monthly MDT has been trialed with the focus on perinatal mental health in Harrow and has been very successful and brings in other members from different organisations than the standard monthly meeting.
- During the pilot, Michael Griffiths, Programme Manager NWL ICB was working on the development and use of BI data packs and WSIC dashboard reports for the child health hubs to use to inform earlier proactive care.

Recommendations

1. The effective chairing of these meetings often by the GP leads, needs to take into consideration how members of the team can be fully included; natural power relationships exist and the leads need to ensure that all voices are heard in the most efficient and effective way. This will support the families discussed and also encourage team members to challenge decisions where appropriate. One consideration might be to place indicative timings against the individual case discussions.
2. It is noted that family navigators and health visitors are essential key people who have the ability to further improve the connections between family hubs and child health hubs through the existing MDTs in both. The co-location of staff in part or whole is known to improve this connectivity.
3. Consideration should be given to focused MDT meetings around HI and Rising Risk Users (RRU), asthma, or mental health. The ICB clinical lead for asthma (Dr Stephen Goldring) and his team are already helping to develop this initiative.
4. It is recommended that a workshop is developed to further this work stream and explore the barriers and facilitators which might need to be considered.

What do parents say about the pilot?

Parents' feedback of using the early years services

Background
Understanding successful delivery of early years services requires hearing from the service-users, that is, the parents who use the early years services. Their views and experiences can help improve service providers' understanding of the needs of the local population, and ensure that providers are meeting population needs have a wide reach.

Aim
We aimed to understand mothers' view of using the early years services including what worked well and what may not have worked well, and barriers and facilitators of service reach.

Methods
MB, BR, and LL created a semi-structured interview. Mothers were invited to participate by the local organisations involved across all three sites. Due to low response rates, and time constraints to pursue this, only one interview was completed. However, to gain more feedback from mothers, organisations asked mothers to send in a written, audio, or video of their experiences of using the early years services.
All confidentiality and GDPR guidelines were followed; data presented are pseudo-anonymised.

Results

Participants
Participants were from Harrow or Brent; information was collected from 5 parents in total. It was agreed that we would not pursue mothers from Ealing based on advice from the Ealing StartWell Clinical Leads; building trust with families takes time and it was not feasible to ask families to participate in interviews whilst they were in the processes of building trust with their communities.

How mothers were referred to the local services
Some mothers were referred by a clinician whilst others made direct contact with their clinician for a referral or reached out to the early year's services directly.

"Basically, my son was very ill... [I] took him to the GP... and then the GP referred him to the A&E and then... we have to refer you to the specialist"

"I'm so pleased I found the courage to reach out to my GP to enquire about services / support available"

"I was first referred to this service after my 8 week postpartum checkup at GP direct"
"I got in touch with [name] from Blossom"

Reasons for needing support from early years services
The help families needed ranged from medical issues to housing and/or finance. These different issues for which families are seeking support justifies the need for integrated services to be varied in their care to ensure they are able to help or signpost families to the relevant organisations (from medical issues to housing issues) for help.

"I was struggling heavily with some finances, and I was in desperate need for some stuff for my child."

"...my son needs it because [his] allergy [is] very high...with everything... the weather event, the grass, the trees, everything...the food...[he] cannot eat seafood, [he] cannot have dairy. Anything to do with gluten basically leaves [us] with dry food."

"Having SEN twins can be challenging"

"...there was a water leak from the bathroom to the kitchen and they [housing officer] said this is your ultimate, if you if you refuse it, you make yourself homeless. And I was just a single mom with three children at the time"

How the services helped the family

From practical to emotional help, the organisations and workers which the families interacted with were vital to mothers' feeling that they were being heard and supported, and that there was help and support available to them.

"They understood my pain and that's what you need...when you very worried about something and simply sit front of you and when you're talking about your story and they listen, that's what they [people] need"

"I met Blossom employees and found the sessions useful in that we could say what issues we were having and there were several people with a variety of life experiences to give advice and different perspectives"

"I was invited to Breakfast with Baby at the Blossom Hub...it was really nice to chat to other mums in the area and I found it to be a friendly, supportive group"

"...putting me in touch with parent / carer forums to enable discussion and learn more about EHCP"

"[She] have spared her time to understand, she empathises [with] the situation... she was very much happy to help me where it was possible for her do so and I must say she has helped me a lot...her special efforts to look after me"

"I got in touch with [name] from Blossom, she spent her time to understand what my requirements are, and she talked to me about my life a little bit, obviously to understand where I am coming from"

"Baby massage was informative, relaxing and we both enjoyed the sessions - since it was the same people each time, we could get to know each other over the course of the week"

"Suggestions were offered for how I might approach solutions, and I was given contact information for talking therapies should I feel I need more assistance"

"...they treat people equally...they help the people"

How families describe their experiences overall

Overall, experiences for all mothers was positive. They were all very grateful for the support they received and the different ways in which they could be supported, e.g., either directly through the community health worker or family link worker, but also through the groups or classes they attended where they had opportunities to meet other mothers going through similar situations.

"Was hard to reach out and admit I needed help but glad I did"

"[Blossom worker] has called to check in periodically"

"I have felt supported throughout and it's been very helpful to have someone to discuss my worries with, especially since my family are not close by..."

"I feel so comfortable to talk to her and without feeling a bit awkward of asking for help which is the main thing"

"...if we have people like [name] and the institute like Blossom, it's just blessings"

Summary, limitations, and implications

All the parent feedback we received was positive. In our one semi-structured interview, we had asked the parent whether there was anything she did not find helpful/did not work well with the interactions she had with the early year's services, but she had had a very positive experience and could not find any fault with the support which she received. In the interest of balance, it is important that views of those who have not had good experiences are also captured.

Unfortunately, we were only able to secure one interview which was completed, and there were challenges in recruiting more parents to participate mainly as it takes time to build relationships with the mums and be able to encourage them to agree to an interview. The written/audio/video experiences of parents providing feedback were not structured, therefore it was difficult to elicit detailed views on both good and not so good experiences.

Capturing the views of parents is vital to the success of early years interventions. All sites have expressed the time needed to build trust with families. Often, the root causes of issues, which manifest in other ways, is identified over several meetings. To be able to secure more interviews with families, which is crucial to evaluate early years impacts, researchers also need to build these relationships with the families by attending sessions or events where they can interact with the families and build trust. However, academic evaluators need to be supported by those delivering early years services to help facilitate the need to inform practices of delivering of early years interventions to local communities.

Lessons learned

- The importance of parents being listened to in a respectful way which includes social, emotional and cultural "intelligence" and requires time both to develop relationships and trust and allow parents the confidence to identify their needs more clearly and define their own goals.
- The practical support given to parents with continuity of relationship with key individuals is highly rated by parents, enhanced by a real understanding of the individuals who might visit them at home.
- Home visits on a parent's "own turf" has informed an opportunistic approach to needs assessment i.e. by seeing first-hand the environmental circumstances that a parent and family is living and relating within.
- There are very high levels of need in the community in terms of cost of living and debt, poor housing condition and food poverty, especially in the most disadvantaged

Recommendations

1. Training of staff in active listening should be essential for all staff
2. Consideration should be given to use of standardised tools in all sites for ascertaining social determinants (SDH-Q) and monitoring progress against goals set (MYCaW; see Appendices 3 &4), this will allow longitudinal follow up of cohorts of parents and families and measure changes over time. It takes time for community workers to develop sufficient trust with a family to undertake these in a non-judgemental, respectful way.
3. Clinical decision quality is a major factor in resource utilisation and efficiency in the system and should be better quantified. Future research with parents and professionals alike would benefit from a researcher in residence or in situ observation of interactions to better understand what characterises a productive relationship, and to be able to describe in more depth the interactive and decision-making processes.

Case studies from all three sites

Twenty-one anonymised case studies seen by the early years professionals from all three sites were shared with the team (Appendices 6 & 7; these list each case, how they were referred, and actions that were taken. There is limited follow-up data available from a number of these as they are still active).

Themes
The themes emerging from the case studies are:
- Engagement: a number of phone calls, emails, and in person visits were made in order to engage individuals. Often there were numerous successful contacts before parents felt able to speak to the team members.
- Referral sources: most of these were identified by the GPs in opportunistic encounters. As the community workers embedded themselves, more referrals came from this source.
- Existing community groups: including postnatal classes where parents in need of support could be identified.

Common issues emerging (often multiply) included:
- Loneliness and language barriers
- Transition to parenthood and transition to work
- Navigating the system
- Inter-partner relationships, marital issues, criminality, sexual assault
- Parental mental health issues
- Infant and child illness and how to deal with these
- Child development and possible autism/ADHD and support for SEN
- Finances
- Housing (overcrowding and physical environment)
- Nutrition (breast feeding, weaning)

Actions taken
- Listening: the most important element of these encounters was the opportunity for families to be able to share their stories in a less time pressured setting, preferably at home, rather than a 10-minute GP consultation.
- Practical and emotional support: many families were helped with accessing or having equipment supplied such as safety locks, baby materials nappies, a buggy, food vouchers, clothing, etc.
- Encouragement and empowerment: community workers were successful in helping families to be more confident and self-sufficient, e.g., being able to access charities and voluntary agency support, and upskilling individuals to also volunteer. Another aspect provided opportunities for parents to meet with each other and connect with other community members.
- Referrals made to agencies: referrals were made to over 20 different agencies working in the neighbourhood or wider area. These included legal services, speech and language therapies, Blossom maternity, HomeStart, and CAMHs.

Outcomes
- Space and time: parents valued the time given by the workers often over many hours and several meetings
- Decrease in loneliness
- Increased confidence
- Reduced stress and anxiety

- Encouragement to seek language classes
- Improved Digital literacy
- Readiness to return to work

Lessons learned

- The importance of community presence and connecting with people.
- Being able to identify what is important and priorities from a parental/carer perspective.
- A recognition of the importance of parent goal setting as a means of monitoring impact.
- A standardised assessment tool such as MYCaW or social determinants measures is necessary to support the evidence base for this type of intervention.
- This is an effective way of addressing health inequalities and meets the needs of the Core20 plus 5 programme

Recommendations

1. To use this learning to co commission services together with parents and carers
2. ICS needs to review its strategy around co production with parents and wider community with an emphasis on the power dynamics which can be barriers to effective and meaningful collaboration
3. ICS to use its expertise to improve communications and branding of integrated care teams and their role
4. ICS to consider how best to engage parents and VCFSE organisations in training and upskilling ICS workforce

Specialist clinics

In response to both the case finding and population health management data, the GP leads in each area established a specialised clinic.

1. **Create Brent: Preschool respiratory clinic**
2. **Optivita Harrow: Parent Group Consultations for perinatal mental health**
3. **StartWell Ealing: GP early years enhanced review**

These clinics were established late into the pilot period and have gradually increased in activity as the staff and equipment has been put in place. Data is being collected continuously and, in some cases, has yet to be analysed fully.

Brent, Create: preschool respiratory clinic

The Early Years Pilot in Brent, led by Kingsbury and Willesden (K&W) South PCN, and funded by NHS England via Northwest London Integrated Care Broad (ICB), focuses on addressing significant health inequalities among children aged under-five in the Willesden neighbourhood. This is one of the borough's most deprived areas and targeted interventions are in place for respiratory health, smoking cessation, and neurodiversity support. The pilot aims to deliver improved health outcomes and community-wide benefits. Early data from the initiative (the first 14 cases) demonstrates measurable successes, including a 100% increase in the number of asthma action plans for clinic attendees, enhanced inhaler use, and positive engagement with smoking cessation services. Positive feedback from those reviewed, as well as clinicians involved, highlight the effectiveness of a multi-disciplinary and integrated approach to health delivery in underserved populations.

The pilot also delivers the challenges of innovation through community-driven projects funded by the Innovation Fund, addressing oral health, nutrition, and health equity. While challenges such as delays in IG and resource constraints impacted progress, the pilot has provided invaluable learning for future initiatives. The project showed an example of building a service which delivers high value outcomes and can be used as the template for the potential development of CYP services nationally. By integrating clinical care with community-led solutions, it offers a replicable model for tackling early years health disparities and informs strategies to sustainably improve child health outcomes across England.

Cost benefit

The cost benefit analysis is described under the 'Pilot Sites Cost' section, and more detail is provided in Appendices 9a-9g.

- Referral Criteria: GP search for patients with "more than 3 short-acting beta agonist prescriptions in the last year"
- Team – Senior paediatric registrar (Imelda), GP with experience in paediatrics, paediatric respiratory nurse specialist, children's community support worker, project manager.
- How many seen - 13 (14 booked, 1 did not attend (DNA)) from Sept 2024-December 2024

Personalised Asthma Action Plan (PAAP)

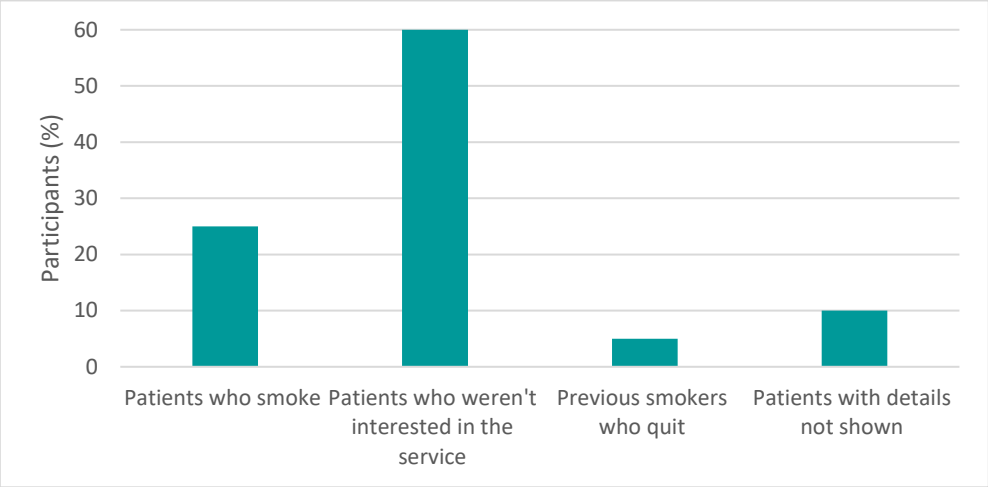
- How many had valid PAAP before - 3/13

- How many had valid PAAP after – 13/13 (100%)
- 13/13 (100%) had their inhaler technique checked & reviewed
- 7/13 patients (54%) had medication changed or issued
- 7/13 patients (54%) had skin prick performed
- 4/4 (100%) improved their asthma symptoms on 2nd visit

Smoking Cessation

Of smokers who lived in a household with a child aged 0-5 years, 60% were reported not to be interested in the smoking cessation service (Figure 31).

Figure 31. Percentage of smokers living in a household with a child aged 0-5 years



Typical case from the preschool clinic

A family of three with a strong atopy history

The early years' pilot respiratory clinic for under-5's in Willesden is under way. As part of this clinic, a family with three children, each with multiple atopic diseases including asthma, wheeze, hay fever and eczema, was seen. Between them, the children had in excess of 20 different inhalers, spacers, nasal sprays emollients, EpiPens, antihistamines and eczema treatment creams. These were being stored together and were sometimes shared between the children. This is not good practice for many reasons, including the spread of infection when sharing emollient creams or inhalers. Furthermore, it was established that due to the sharing of inhalers, the number of requests for each inhaler were not accurate on their GP records. This can also lead to assumptions that their respiratory tract conditions were better or worse than they actually were. The current medication they were each using did not match accurately to the GP records for that child.

Actions taken

- Time was spent rationalising the medicines, discarding old medication, labelling medication appropriately, and separating those for individual children.
- Acutely one child with infected facial eczema was put on a course of antibiotic and steroid.
- Family was educated on how and when to use each medication including inhaler technique, and how to apply creams.
- A formal diagnosis of asthma was made and coded.

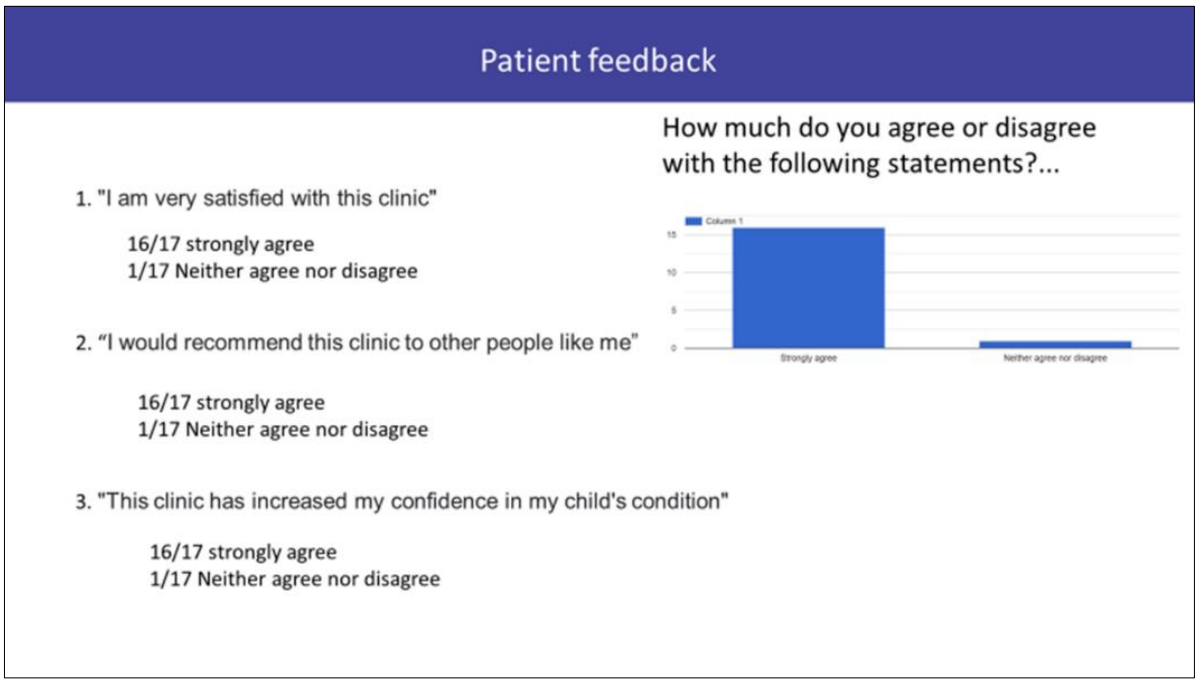
- Skin-prick testing was performed which identified allergies that were previously not detected as the children were taking antihistamines at those times, i.e., false negative results. Now the family could identify what may be triggering each child.
- A dehumidifier was provided to combat mould, which may be triggering asthma symptoms in the children (especially as one was proven allergic to a certain strain of mould tested in the clinic via skin prick testing).
- A home visit was undertaken, and the community worker was able to work with the family to find a better solution to storing medicines, so each child had their own individual medication box.
- These simple steps meant that at follow up clinic, each child's symptoms were better controlled, and the family provided positive feedback.

Learning points

- Not to assume parents/carers are taking their prescribed medication.
- Education and explanation of medication to parents/carers.
- Education of practical aspect of medication to parents/carers e.g. inhaler technique, how to apply creams.
- Individually assessing patients in group sessions.
- Importance of joint care and integration; able to address social determinants, asthma, hay fever, eczema, all in one clinic.
- Learning for clinicians on all levels.
- Reduced potential hospitalisation via optimisation of medication.
- Importance of follow up prior to discharge.
- Importance of home visit to assess social determinants.
- Good relationship built with extended time with family/patient – 30 minutes vs. 10 minute rushed GP consultation.

Asthma Clinics: feedback from parents

Figure 32. Patient satisfaction with the asthma clinic service



Optivita Harrow: parent group consultations for perinatal mental health

Parenthood involves major psychological and social lifestyle changes that can be stressful for parents and may result in new parents experiencing less confidence in fulfilling these new roles. Early parenting interventions have been developed to help support new parents to acquire the knowledge and skills to fulfil these new roles, with the hope that this would improve their confidence levels. Preliminary evidence highlights significant improvements in parents' confidence following parenting interventions. However, the evidence base remains mixed and limited. Additionally, within the UK, there are issues with access to perinatal mental health services, particularly within underrepresented and ethnically minoritised communities. There have been attempts to increase the availability and acceptability of parenting interventions for those from socially excluded and low-income families and this has come with mixed success. Therefore, there is a need to continue to trial early parenting interventions for those in communities traditionally not accessing services targeting those from ethnically minoritised groups, with the hope of improving parental confidence and wellbeing, and access to services.

Number of attendees to postnatal drop-in groups
From August 2022 to December 2024, 38 parents attended postnatal drop-in groups.

(No sessions ran in September 2022, February 2023, May 2023, February 2024 and March 2024. There was a pause with the groups between March 2024 to around July 2024 due to the handover of the project from Sphere PCN to Blossom charity).

Quantitative data: outcome measures
The outcome measures that are being collected include the Karitane Parenting Confidence Scale (KPCS)[24] and the Patient Activation Measure (PAM-13)[25].

- 54 parents completed the outcome measures from October 2022 to December 2024.
- Parents completed both measures at the start of the drop-in session, and again at the end of the drop-in session, providing a pre- and post-measure.
- 12 parents completed in full both pre- and post-measures: 22.2% response rate.
- Total pre- and post-PAM-13 completed measures: 19.2%.
- Total pre- and post-KPCS completed measures – 13%.
- Total missing pre-PAM-13 measures: 51.90%.
- Total missing pre-KPCS: 17.30%.
- Total missing post-PAM-13 measures: 70.37%.
- Total missing post-KPCS: 64.80%.
- Missing data from the 20th Dec 2022 group: 6 parents; missing data from the 30th December. 2023 group: 3 parents; no sessions in Feb or May 2023.

Qualitative data
An MSc student, Sheli Algranati, based at the Royal Holloway, University of London, is working in close collaboration with Dr Jamila Sherif, to evaluate an Optivita postnatal group consultation for new parents in ethnically minoritised groups. The work is currently ongoing but an outline of the work is provided below.

Postnatal Group Consultations
Group consultations are an efficient way for primary care practices to give more time to individuals with long-term needs. The aim is to bring individuals together in a facilitated group

setting to help them to better manage their own health while sharing their experiences and learning new skills[26].

This Postnatal Group Consultation brings together groups of parents (who come under the Optivita inclusion criteria) with babies aged 0 – 6m who have been identified by any health care professional, Blossom staff member, or who have self-referred. This support could be for mental health, infant feeding, self-care, baby care, or many more issues that affect new parents.

Health care professionals who work with new parents such as Early Support, Perinatal Improving Access to Psychological Therapies (IAPT) Practitioners, Maternal Trauma and Loss Service Practitioners, Infant Feeding Specialists, and Health Visitors, are always welcome to attend but they are not specifically invited due to the unpredictability of parents' attendance and the need to ensure that the health care professionals' time is used wisely.

Through invitation (Appendix 10), parents were invited to attend a monthly-run Postnatal Group Consultation. The set-up of these consultations is shown in Appendix 11.

Parents who attend the group are commonly recommended and assisted with the following referrals (not an exhaustive list):
- IAPT Talking Therapies
- Children's Centre (including registration)
- Trauma and loss services
- HomeStart for volunteers to go into their home to assist with and model parenting duties
- Infant feeding services (including support group and drop ins)
- Drawing into other Blossom Services such as Baby Massage, Breakfast with Baby, ESOL with baby and Transition to motherhood discussion group.

Parental attendance to the sessions is unpredictable. To improve attendance, the following was identified:
- A GP referring the parent and verbally requesting them to attend.
- The Optivita Social Prescriber phoning and texting the parents on more than one occasion explaining what the group is about and what will happen.
- Starting the groups at a later time later; this has been difficult logistically for staff and room availability but is being considered.
- A video to show more information about what happens in the group, introducing the leaders, and practicalities, i.e., where the prams can be left safely during the sessions. This video is now in production.

Example Case Study

A mother with a 10 week old baby was unable to attend the Postnatal Group Consultation but was in great need due to feeling anxious about her unsettled baby. The Social Prescriber and the Specialist Perinatal Group Facilitator were able to arrange a one-to-one meeting with the mother before the next group consultation which she attended.

Although an unsettled baby was the primary reason for her referral, there were other issues identified during the consultation:

- Anxiety due to previous professional experiences relating to birth and newborns. Birth trauma that she hadn't recognised due to rationalising her experience based on professional knowledge and experiences. The Social Prescriber and the Specialist Perinatal Group Facilitator explained how birth trauma naturally raises parental anxiety levels.
- The Social Prescriber and the Specialist Perinatal Group Facilitator discussed different soothing techniques the mother could try with the baby including ways to increase her partner's confidence with baby soothing to provide her with more breaks.
- The Social Prescriber and the Specialist Perinatal Group Facilitator discussed simple ways for her to have moments of peace and rest.
- The mother had been previously advised to stop formula top-ups in addition to breastfeeding and was overwhelmed by this as her only breaks from constant breastfeeding was her partner providing top-up feeds by bottle. The Social Prescriber and the Specialist Perinatal Group Facilitator discussed paced bottle feeding to make sure that baby 'worked' for the top-up so she could see whether the baby really needed it. Other ways her partner could provide support so that she could have breaks were also discussed.

At the end of the consultation, the mothers goals were to:

1. Respond to the Trauma & Loss service to which the Social Prescriber had made a referral.
2. Attend Blossom Baby Massage with the Specialist Perinatal Group Facilitator to learn more baby soothing techniques and gain support from other mothers.
3. Attend the 'Transition to Motherhood' discussion group at Blossom Hub.

At the end of the consultation the mother seemed visibly relieved.

StartWell Ealing: GP early years enhanced review

GP early years support

This work is centred around the Healthy Child Programme (HCP) and is designed to identify issues in 0–3-year-olds who require additional support and seen in the GP practices. The patients are referred onto the family link workers for more detailed assessment and also promotion of development. The local paediatric therapists are using a training programme for the link workers which is evidence based and has already had significant success in Harrow[23].

<u>Key learning objectives for family link workers</u>

- Understand typical development for children aged 0-3 years in the areas of child's early play, communication, motor, sensory, engagement and participation, with a specific focus on 0-12 months.
- To learn to observe parents interacting with their children using a structured framework.
- Recognise when children are not developing typically and when they may need additional support.
- To learn a range of interventions and be able to model these to parent/carers to help them support the development of their child's skills.
- To understand the principles of parent/carer coaching and when it is appropriate to implement.

- Be able to make time timely and accurate referrals to paediatric therapy services.
- Signpost parents/carers to appropriate services.

At the time of this report, 27 children aged under five years have been seen with a variety of issues. The most common themes for which parents in Ealing are requiring support:

Support needed for parents

- Difficulties coping with parenthood (mother & father)
- Difficulties coping with children needing support for special needs and disabilities
- Depression / anxiety
- Financial worries
- Own needs/disabilities (bi-polar, autism)
- Loneliness / isolation

Support needed for children

- Special needs and disabilities
- Behavioural issues
- Feeding

Other common themes are language barriers and some reluctance from parents to attend sessions recommended by family link workers which would increase the family's support networks. Details of each case is shown in the Appendices 7 & 8.

Lessons learned

- These three clinics required careful thought about how families would be identified and engaged with services on offer. The time taken to develop a trusting relationship with statutory services cannot be underestimated and in many cases, it took several attempts for families most in need to engage.
- The set up of clinics also required additional administration support (e.g. communication to families, appointment arrangement, follow up)
- from the practice staff, already under some pressure with the usual day-to-day routines.
- Developing and agreeing clear process pathways helped to visualise the services on offer as well as work out what was needed to run the clinics.
- GP time was paid for as part of the pilot funding but sustaining this within existing funding streams will be a matter for local decision makers. The PCN Clinical Directors and the Child health leads are individuals who need to be involved at the earliest planning stage of such projects.
- The information governance and the necessary permissions to share data for clinical care with appropriate community connectors requires early consideration and being mindful of the delays which are inherent in obtaining such permissions.
- Procurement processes for additional equipment can be facilitated by multiple use of such equipment in the practice with other adult and child populations e.g. point of care testing for eosinophilia

Recommendations

1. Specialist clinics have been set up at specific practices within a PCN. In order to provide equitable access to all practices either in a PCN or INT will require agreement by individual practices and the design of inclusive pathways.
2. Information and clinical governance requirements need to be considered as early as possible when initiating the clinics
3. Administrative support must be designed into the operational requirements of establishing and ongoing monitoring of clinics.
4. Senior trainees in paediatrics, close to CCT, are in a good position to support such clinics but must be in turn have supervision from a named consultant paediatrician with the necessary expertise.

Toolkit

This BCYP toolkit has been created as an improvement tool to help staff and service users set-up, create, monitor, and measure impact of early years GP CHH programmes in all PCN locations across NWL. The toolkit is informed by the processes undertaken by the sites delivering the early years pilots. Through the sharing of experiences, tools, and techniques to aid development, support improvements, and further understanding of impact and child outcomes, this toolkit includes processes that were necessary to inform others who are developing and implementing similar early years programmes.

The toolkit is designed to be interactive and easy-to-use with practical information about service development, pathways and processes to provide equitable access, professional collaboration, and integration of child health and care. It includes summaries of key information and techniques to enhance services involving staff, patients, and members of the community. Sections have been created for ease of navigation and can be explored in any order. This is supported by sharing case studies and examples of where the early years work has been successfully set up in practice.

An 'improvement journey' has been developed to test feasibility and implementation, and to evaluate the impact and sustainability of child health integrated care services (Appendix 12). This includes a narrative, improvement methodology and tools, project management tools, and measurement. The process involves seven stages:

1. **Engage:** Initial discussions to introduce the broader improvement programme & methodology. Opportunities to identify improvement projects through programme developments and open discussions.
2. **Scope:** Conversations with the team of project ideas and to identify development opportunities to support its delivery.
3. **Train:** Practical teaching on improvement tools for individuals and/or teams. Opportunities to begin developing a project plan in a training environment.
4. **Plan:** Setting up a project for success by ensuring it has an aim, measures, and a clear change idea. Ensuring that stakeholders have been considered and engaged with the project.
5. **Improve:** Using Plan-Do-Study-Act (PDSA) cycles and measurement for improvement to test, adapt and build belief in change ideas.
6. **Spread/Sustain:** Diffusion of successful interventions into new areas. Ensuring that improvements are sustained and new ways of working developed through PDSA cycles are fed into practice.
7. **Next steps:** Continuous improvement is embedded into business, the project is closed, presented to stakeholders, and lessons are learned are shared.

The toolkit is free to use and will be available online during Spring 2025 through NIHR NWL ARChttps://www.arc-nwl.nihr.ac.uk/; links will be provided through other key websites (i.e., ICB, NHS Futures).

Use and reporting of the toolkit in any outputs (i.e., blogs, publications, reports) should cite the toolkit correctly: ***Ritchie L, Ahmad K, Hargreaves D, Ram B, and Blair M. Early Years Toolkit for GP Child Health Hubs. NHS North West London Integrated Care Board. 2025.***

Conclusions and reflective note – Professor Mitch Blair

This 2 year pilot project successfully established hyperlocal preventive care teams in three North West London Boroughs. The key components were well functioning mature GP Child health hubs, local authority family hubs and purposeful engagement of the voluntary sector. The community connectors, whether social prescribers, community health and wellbeing workers, family link workers and indeed community champions are the essential glue in the system which has facilitated service integration for the most vulnerable families in these localities; by offering practical and emotional and culturally appropriate support in addition, bringing to light cases for discussion to the GPs who are directly supervising them or to the monthly multi-disciplinary team meetings for wider consideration. The community innovation grants have helped local charities to build their capacity and align themselves further to both the needs of the families in as well as to local public health priorities in their areas. The value of the outreach community fairs and health focused events has been immense and at relatively low cost in terms of raising community awareness amongst several hundred families and connecting many to relevant services.

The pilot set up novel clinics focused on perinatal mental health, preschool asthma and early child development. Both the quantitative and qualitative data shows us that we are going in the right direction of travel in terms of effectiveness. Further follow up of families who have received interventions should allow continuous evaluation over time to demonstrate full impact as intended.

This was a transformative process and as such, required highly motivated clinical leadership as well as effective operational support. The amount of time and energy required to develop an effective, trusting and truly collaborative relationship with all partners cannot be overstated.

The toolkit which goes with this report is published separately and will help those who wish to establish similar integrated neighbourhood teams and scale this initiative in other areas both in North West London, nationally and internationally.

The NHS is currently under enormous pressure to meet the key missions set out in this parliament. Most of the emphasis is on demand management to ensure improved access to GP and specialist services and procedures. The guidance on Neighbourhood Health published 30th Jan 2025 reiterates the desire the 3 major shifts from hospital to community services, treatment to prevention, and analogue to digital, with greater use of existing resources within the voluntary, faith and social enterprise sectors.

When we talk about prevention, we have to be clear about the 5 levels: primordial (social determinants); primary; secondary; tertiary; and quaternary. Most of the focus currently is on secondary and tertiary prevention, the prevention of disease progression through screening and treatment and the rehabilitation /minimisation of handicap. Seven per cent of the population make up 46% of total hospital costs. As far as children and young people are concerned, this is about improving effective support for those with long term and complex care needs as well as meeting the needs of the mental health epidemic which is affecting 8% of this population. However, this places primordial and primary prevention at a much lower priority and requires a substantial pivoting of focus simultaneously and for much longer if we are to succeed in stemming the incessant demand on the current services. Some describe this as a “split window” approach to planning i.e. *simultaneous* action taken to address the reactive and proactive care processes. The guidance describes five key guiding principles for INTs to succeed and which I have attempted to address in the context of the Early Years pilots.

1. ***A mechanism for joint senior leadership with shared values and outcomes.*** In our Early Years Pilots this was well developed in Harrow and Brent with strong Borough based partnerships which embraced the pilots and their intentions and helped shape them for local needs. However, people move on and the churn in the systems both at ICB and Local Authority level has meant considerable delays in decision making and support. A shared outcomes framework similar to Every Child Matters, along with the operational support, is what is needed across the partnership to allow sufficient focus on prevention for long enough to have an impact.

2. ***A collaborative high support high challenge culture***. This can only be achieved as trusting relationships develop. I have had over 25 years' experience of working in partnership with the Harrow and to a lesser extent Brent and Ealing's local authority children's services and the voluntary sector, allowing me a unique understanding of who does what and how best to leverage the incredible talents of individuals working in the area and who share the same passion and desire to improve health and wellbeing in the early years. We have not been afraid to challenge each other safely and as a result have been able to increase the resources available for the pilot through the inequalities funding stream. There is no doubt that the sheer number of individuals involved in early years activity in health, local authority and the voluntary sector together with the complexity and instability of organisations and their operations has made this a very challenging project to deliver within a two-year time frame.

3. ***Visible clinical and professional leadership and management together with effective partnership with local communities***. This has been demonstrated most effectively with Dr Mando Watson's leadership together with Dr Niamh McLaughlan, and Duncan Ambrose of the NWL ICB CYP programme in bringing together a wide range of different parties to strengthen the integrated care teams in the entire sector. This has been strengthened further with appropriate Business Intelligence support and dedicated project management support, although the fact that this project had three separate project managers and two programme leads during the 2-year pilot period indicates the need for stability and continuity of the team to ensure delivery of the project outcomes.

4. ***Effective processes.*** This has been a major challenge and weakness in this project and could have been vastly improved by earlier engagement with information governance leads, and finance professionals working in the system to ensure complete understanding of what was being done and how best to move money around the system. A mature system should have transparent and clear operating procedures regarding communications, contracts, governance and reporting. The last of these was adequate but regrettably the other functions were not agile and chaotic and created considerable delays in project completion together with immense frustration. This has led to some tension in one of the sites which gradually disengaged from the main central project team. The learning here is to ensure that any grants or funding applications being considered from outside sources require very careful and thoughtful planning to ensure that there is sufficient capacity and prioritisation in order to undertake the work.

5. ***Making best use of all funding arrangements.*** A truly effective interagency partnership will consider how to plan and train its workforce, how to pool part or all of its budgets for joint work, and how to share data and information in a timely and effective way in supporting the professionals involved in direct care. The funding which was available for this pilot effectively kick started and facilitated some of this type of work but now the challenge is how to sustain it both to allow its full impact to be achieved and secondly to

allow the system to readjust and transform its business as usual. The voluntary sector and the community resources in an area are effective actors who are only too willing to engage when asked but also need to be supported in growing the future local workforce. Their knowledge of the social cultural and emotional needs of the families living in a particular locality is invaluable and will contribute to services being designed in a way which are more accessible, efficient and effective than are currently.

The guidance also describes six *core components* of neighbourhood health:

1. ***Person level linked longitudinal dataset.*** We are fortunate in NWL in having the WSIC system and its various dashboards. The challenge which has been brought into relief by this pilot is how a live interagency data dashboard for early years could make a major difference to staff in terms of creating a visibility of both the specific health and wellbeing issues which need to be addressed but also how much progress we are making for cohorts of children, whether that be improved mental or oral health or school readiness and adequate child development. A 1000-day dashboard has been proposed to the ICB many years ago and needs to better prioritised so that data can be harvested from several different information systems across the agencies. This must be live and credible data for the INTs to trust and be able to take action at local level. The National Data Platform has a number of tools which can be better utilised for population health management and direct care for these cohorts of children and I look forwards to seeing these better utilised.

2. **Modern general practice**. This requires improved access to practices for those who are currently utilising urgent and emergency care for low acuity issues. Our experiences in this pilot have demonstrated how parents lack the health literacy required to feel confident about their children's health and development and varied ability in digital literacy to be able to access the current systems of primary care appointment and interaction. The child health MDTs in the INT provide a considerable improvement in efficiency, effectiveness and general quality of clinical decision making- the basis of a cost-effective service. This has been proven already and is particularly valuable for those children with complex care needs. The Pharmacy First initiative, which we have embedded in the pilot, has not yet commenced but has the potential to make around 30% savings on acute care provision by diverting parents to trusted local neighbourhood professionals who can prescribe for minor ailments.

3. ***Standardising community health services.*** The NHS Guidance highlights this in relation to the mental health of children and the need to better support schools by closer links with existing services as well as building alliances with VCFSE organisations. However, in the context of early years, there is a national shortage of community midwives and health visitors which has resulted in the diminution of universal services for all families. This is as a result of poor investment over a long period as well as retirements of large numbers of staff. This has led to increased targeting of services at the expense of strong foundational universal services delivered by highly qualified staff. This requires some real effort to be made in pulling together commissioners of early years' services and workforce leads in the ICS in order to address this important issue.

4. ***Neighbourhood MDTs***. The current BCYP INT developments with child health hubs has been very successful and what is needed now is some thought to better engage practices and the wider staff groups who can bring cases and offer their support for others. I have personally seen how effective these meetings are in terms of relationship building, joint learning and streamlining services for families. What needs to happen now is a closer link to other MDTs which exist in the family hubs or MASH teams. In the figure which describes

the integrated neighbourhood team structure, it is clear that family hub navigator's/link workers as well as health visitors are the key connectors between the component parts and thus both need to have this recognised in their job descriptions and work programmes.

5. ***Integrated intermediate care and hospital at home***. This part of the national guidance stresses the value of "assessments and interventions delivered at home where possible". We have found that the home visits made by the community health and wellbeing and family link workers, has allowed families to explore their needs in their own natural space. This facilitates the development of trust but in addition, gives the worker an invaluable opportunity to observe, in her own right, the condition of the home and interactions with the wider family and neighbours. Parents are put at ease and are much more likely to consider how best they can be supported with their needs. A non-stigmatising universal and comprehensive home visiting service has been of proven benefit in many countries and in parts of the UK for all age groups. Infants, children and families deserve to have similar opportunities at local level in NW London and this will contribute to all five levels of prevention.

6. ***Urgent Neighbourhood services***. In the context of early years, this goes back to how effective responses can be made to worried parents of a "sick" child. The default for too many, is to call an ambulance or go to the emergency department, in part because of perceived or real issues in accessing primary care. My own team's research has indicated that children with complex care needs in the neonatal period are frequent attenders to the UCC and ED. The ability to "see and treat" and "hear and treat" could be enhanced by having ambulance crews with a direct video link to a senior on call paediatric trainee, improved access to GP "hot hubs" with support from community nurses. The PATCH team of community nurses in NWL could develop improved first contact services, especially for those infants and children with complex care needs already known to the hospital specialist services. The neonatal unit nurses at Northwick Park offers a direct telephone link to the Special Care Baby Unit (SCBU) and the Neonatal Intensive Care Unit (NICU) which is well utilised and allows parents to be directed appropriately and safely.

All of the above speaks to the notion of an agile workforce, able to work across organisational boundaries, the need to upskill teams, especially in dealing with neuro-diverse and mental health issues, improving staff awareness of the INT for BCYP and associated organisations which can help support a family other than traditional hospital or GP services alone. The workforce capacity needs to be increased with a wider skill mix team but with assurances that task delegation is appropriate, and supervision is sufficient.

My own clinical and research career started in prevention of ill health in young children, working in many different countries and with policy makers internationally and nationally. I believe that prevention in all its forms, is most effectively delivered in mature, stable community teams working in an integrated way with specialist and voluntary sector organisations using the insights from the community to create the best possible services.

Glossary

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ARC	Applied Research Collaboration
BCYP	Babies, Children, and Young People
BI	Business Intelligence
CAMHS	Child and Adolescent Mental Health Services
CCT	Certificate of Completion of Training
CC4C	Connecting Care for Children
CHH	Child Health Hubs
CHWW	Community Health and Wellbeing Worker
CYP	Children, and Young People
CYPRR	Children and Young People Rising Risk
DNA	Did Not Attend
ED	Emergency Department
EMIS	Egton Medical Information System
ESOL	English for Speakers of Other Languages
FIS	Family Information Service
GDPR	General Data Protection Regulation
GP	General Practices/Practitioner
HASVO	Harrow Association Somali Voluntary Organisation
HIU	High Intensity Users
HLPCT	Hyper-Local Preventive Care Team
HPSLT	Harrow Preschool Speech and Language Therapy
HCP	Healthy Child Programme
HV	Health Visitor
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance

IHV	Institute of Health Visiting
IMD	Index of Multiple Deprivation
INT	Integrated Neighbourhood Team
KPI	Key Performance Indicator
K&W	Kingsbury and Willesden
KPCS	Karitane Parenting Confidence Scale
LADs	Learning Analytics Dashboards
LNWUH	London North West University Healthcare
MASH	Multi-agency Safeguarding Hub
MDT	Multi-disciplinary Team
MYCaW	Measure Yourself Concerns and Wellbeing
NHS	National Health Service
NHSE	National Health Service for England
NIHR	National Institute for Health and Care Research
NWL	North West London
OHID	Office for Health Improvement and Disparities
OT	Occupational Therapy
PAAP	Personalised Asthma Action Plan
PAM	Patient Activation Measure
PATCHS	Providing Assessment and Treatment for Children at Home System
PCN	Primary Care Network
PDSA	Plan-Do-Study-Act
PHE	Public Health England
PHM	Population Health Management
PICO	Population, Intervention, Comparator, Outcome
QOF	Quality and Outcomes Framework
RRU	Rising Risk Workers
SALT	Speech and Language Therapy
SDH-Q	Social Determinants of Health Questionnaire
SEND	Special Educational Needs and Disabilities
UCC	Urgent Care Centre

UEC	Urgent and Emergency Care
UPRN	Unique Property Reference Number
VCS	Voluntary Community Services
VCSFE	Voluntary Community and Faith Social Enterprise
WSIC	Whole System Integrated Care

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Appendices

Appendix 1. Data analyst report

Data analyst time for ONE Borough (Harrow) is detailed below

This estimate is based on the planned work to look at profiling clinically children 0-1 and 0-5 as well as the demographics looking at dental extractions, complex care needs, immunisations, SEND and child in need, language therapies, etc. Please see the detailed activity breakdown by activity based on the whole year (260 working days)

Optivita (Analysis - Band 8b)	Hours	Percentage in a year	working Days (260)	working Week (44)
Data extraction from WSIC (SQL[1] queries)*	75	29%	5	1
Data requests / liaise from Other Services (Council children services, Community etc)*	37.5	14%	10	2
Analysis - data analysis /interpretation/ Quality Assurance / graph & infographics/ report writing / slide pack	112.5	43%	15	3
Mapping (Digital Service hours)	37.5	14%	5	1
Total	**187**	100%	**35**	**7**

[1]*SQL: Structured Query Language*

**Data extraction or data request from internal or external organisation might require more time depending on the analyst's capacity in extracting the*

Notes from Rob Nicholls re difficulties in extracting from multiple data sources. In terms of estimated time for extracting the data:

- **Health Visitor Data:**
  - A very approximate estimate: It might take about 30 to 50 hours to produce data on the Health Visitor data for 1 year and 2 to 2½ year checks from WSIC for another borough.
  - This assumes that the data is already being fed through to WSIC for the borough in question.
  - This includes the time needed to explore the data and construct flags for the two different health checks and to liaise with colleagues from the provider regarding the results obtained.
  - This estimate assumes that the data recording won't be exactly the same as it is for the Harrow Health Visitor service; if the data is exactly the same, we could reduce the time down to perhaps 20-30 hours.

- **Child Immunisation Data:**
  - Difficult to comment on this as useful data has not yet come through.
  - If the measles, mumps, rubella (MMR) data on Foundry is useable, it may take 5 to 10 hours or so to get the data needed from Foundry and check it against national COVER (cover of vaccination evaluated rapidly) data etc.
  - Reliable, detailed data on other childhood immunisations (other than MMR) has not come through therefore it is difficult to give a time estimate for any other childhood immunisations.
  - The WSIC data does not appear to be useable for child immunisations data. If the WSIC data was useable, it might take 40-80 hours or more to construct the performance indicators using all the relevant SNOMED (Systematized Nomenclature of Medicine Clinical Terms) codes. But that is not relevant because the WSIC data appears not to be useable).

Appendix 2. PICO Table of Pilot sites

	Harrow	Brent	Ealing
POPULATION	Children under 12 months living in two postcode areas HA2 8 and HA2 0 and who are registered with GP Direct and Shaftesbury Medical practices (approx. 1000) Approx 850 children under five living in these areas.	Those children under five years who are registered within the K and W South PCN who reside in the Willesden Green area	Children under five years who are Ealing residents registered with Greenwell PCN
INTERVENTION(s) Who and What will they do	3 x 0.5 WTE and 2 x 15 hours Community health and wellbeing workers. 1x 0.5 WTEWTE Parent/Carer, Baby and Children social prescriber for the PCN. Operational Lead 0.5 WTE Clinical lead (6 hours per week. Job Share split between two GPs, 4 hours and 2 hours. WSIC dashboard High Intensity Users , Family hub and health visitor education events, community pharmacy accreditation project CHWWs – Families with under-fives at GP Direct and Shaftesbury Medical Centre contacted to engage with the service. Visiting households on a monthly basis within the defined geographical area in South Harrow, CHWWs will ensure families receive tailored wellbeing and holistic maternal and child health advice and support and are signposted to relevant services where needed. SPLW – referral-based service from the two PCNs or self-referral. The Community Perinatal Support Programme (CPSP) provides a social prescribing model of care for additional support in antenatal and postnatal care of mothers and babies (0-2 year olds) from vulnerable, high-risk groups. The SPLW will offer; monthly antenatal and postnatal group consultations to support with parenting confidence and maternal	1 WTE Children's Health and wellbeing champion/link worker Specialist primary care respiratory clinic monthly Paediatric registrar and allergy asthma nurse Identify households with smokers and offer smoking cessation advice Increase immunisation uptake identify preschool asthma unscheduled care /poor adherence to treatment through monthly MDT specialist respiratory clinic in community Raise awareness of parents in area of early neurodiversity and link to support	2 full time -time family link workers Clinical GP lead one day a week Administration workshops and working with health visiting professions linking to specialist services bimonthly Hub MDTs to discuss families

	wellbeing; one-to-one social prescribing support and perinatal monthly virtual case discussion (Perinatal MDT) SLT – raising the awareness of SLT best practice with families and early identification and referral of SLT issues. Identify families through the workers who require additional support in pregnancy and early infancy		
COMPARATOR	Infants in comparable postcodes in Harrow or infants living in the target areas 5-8 years before intervention (time series analysis)	Those in another PCN in Brent or time series analysis of similar cohorts in previous years	Those not receiving interventions in comparable area in Ealing
OUTCOME	Reduction in infants who attend ED with minor illnesses not requiring treatment or admission Cost savings to NHS ED services Parent patient activation measure+/- Karitane confidence measure MYCaW measures from parents Speech and language measures	Age at confirmation of preschool asthma Numbers of children identified at school entrance with previously unidentified neurodevelopmental disorder Reduction in smoking households of target population Reduction in Ed attendance for preschool asthmatics	Improved parent confidence in managing behavioural and emotional issues Reduction in numbers of children attending at school entry with significant emotional and behavioural issues not previously identified

Appendix 3. Social Determinants of Health Questionnaire (SDH-Q)

Fig 2: The Social Determinants of Health Questionnaire (SDH-Q), a social risk screening tool used as conversation opener in community setting

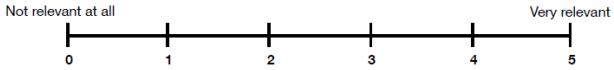
Social Determinants of Health Questionnaire

This questionnaire aims to identify areas of everyday living which can be missed during appointments but impact families and their healthcare. It will be given out to all families coming to our clinics. We hope to improve our services by picking up on these issues and worries so we can offer advice and support.

For each statement, please mark on the scale how relevant it is to you and your family i.e. how closely each statement fits with your situation.

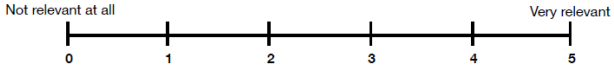
1. Lack of access to affordable and reliable transport has made it difficult for me to get to this medical appointment or has caused me to miss medical appointments for my child/ children in the past.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



2. I worry about being able to pay for my housing and/or my electricity/heating bills.

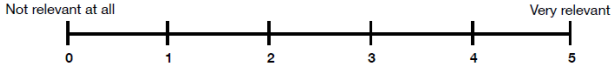
How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



3. I worry about where my family live due to one or more of the following problems:

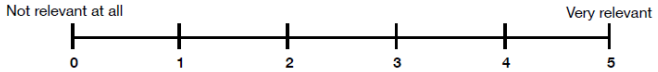
- **Pests e.g. bugs, mice or rats**
- **Mold, damp or leaks**
- **Broken heating/oven**
- **Missing smoke detectors**
- **Difficulty accessing house/flat (e.g. due to a disability, too many stairs, poor lighting)**
- **Not enough space**

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



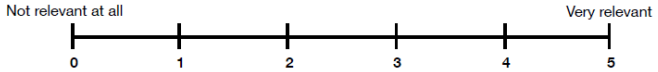
4. I am not always able to afford basic or everyday items for my children such as nappies, a cot, school uniform or toys.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



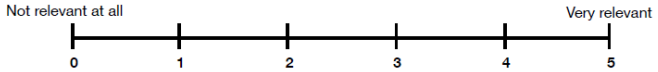
5. There are times when I worry about providing enough food for my family.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



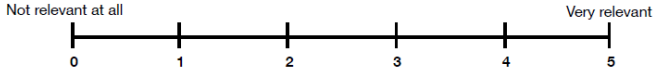
6. My home is not always a place I and/or my children feel safe.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



7. I feel well supported by my family and/or friends.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?



Appendix 4. Measure Yourself Concerns and Wellbeing (MYCaW)

Measure Yourself Concerns and Wellbeing (MYCaW)

First form

Date form first completed:_____

Please write down one or two concerns or problems which you would most like us to help you with.

1.

2.

Measure Yourself Concerns and Wellbeing (MYCAW)

Follow up form (self completion version)

Today's date .....

Look overleaf at the concerns that you wrote down before (please do not change these).

On this side of the form, circle a number to show how severe each of those concerns or problems is now:

Concern or problem 1:

0	1	2	3	4	5	6
Not bothering me at all						bothers me greatly

Concern or problem 2:

0	1	2	3	4	5	6
Not bothering me at all						bothers me greatly

Wellbeing:

How would you rate your general feeling of wellbeing now? (How do you feel in yourself?)

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Other things affecting your health

The treatment that you have received here may not be the only thing affecting your concern or problem. If there is anything else which you think is important, such as changes which you have made yourself, or other things happening in your life, please write it here.

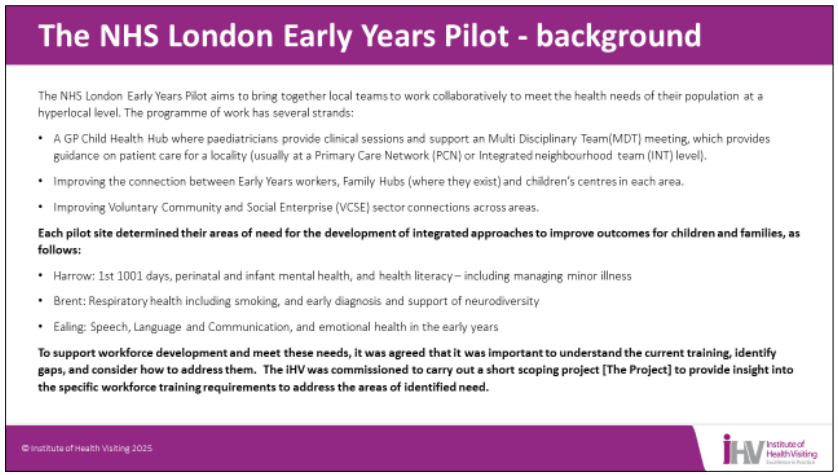
What has been most important for you?

Reflecting on your time with this Centre, what were the most important aspects for you? (write overleaf if you need more space)

Thank you for completing this form.

MYCAW. Measure Yourself Concerns and Wellbeing (self completed at follow-up version)

Appendix 5. Institute of Health Visiting Training Needs Analysis



Survey responses

Total of 17 responses*

Range of practitioners and roles

Tailored responses – relevant questions completed by respondents (as applicable to their role)

* Full details of the survey results can be found in Appendix 1

Workshops

Workshop one – Weds 11th Dec (12:30 - 13:30)

Seven attendees

Workshop two – Mon 16th Dec (16:00 - 17:00)

Five attendees

Analysis process

Survey and workshop feedback collated → Inductive: High level thematic review → Themes generated → Areas for consideration

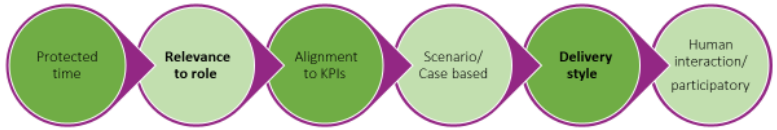
Theme 1

Learning opportunities

Current learning opportunities are:	Positive Informal learning opportunities included:
Driven by KPIs	Supervision
Dependent on the employing organisation	MDT - Team meetings
Access to learning opportunities are varied - dependent on the professional's role	Collaborative events
Focused on statutory and mandatory training	Master classes
Ad hoc and no strategic plan across agencies/ localities	
Bias towards e-learning	
Single profession focus (rather than multi-disciplinary/ multi-agency)	

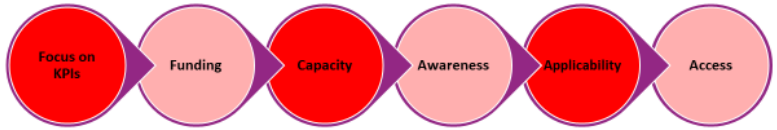
Theme 2a

Facilitators for engaging in learning



Theme 2b

Barriers to accessing learning



Theme 3

Current local training opportunities

Overall, there was a significant amount of training, however this was reported to be uni-professional and focused on a limited number of specific topics.

For example:

- **Primary care focused on immediate clinical care –** e.g. immunisations, asthma management.
- **Health visiting –** e.g. speech and language, fathers' needs, oral health.
- **Midwifery –** focused on the Saving Lives Care Bundle, Oliver McGowan training (Learning disabilites and autism).
- *CLCH learning academy* offered a significant range of training on a wide range of topics – but staff lacked awareness.
- Psychology /psychiatry training focused on core role.
- Immunisation training for those staff administering vaccinations.

See survey slide results in Appendix one for more details of specific training identified related to each of the Early Years Pilot areas

Theme 4

Confidence and training needs - for specific local early years priorities

Topic	Practitioner confidence – low to high	Would like more training
Perinatal mental health	Mixed	80%
1001 critical days	Mixed	70%
Infant mental health	Mixed	80%
Health literacy, including minor illness	Mixed	80%
Respiratory health	Lower overall	88%
Smoking	More confident	58%
Neurodivergence	Mixed	88%
Speech, language, communication and emotional wellbeing	More confidence	52%

Theme 5

Types of training

Themes for desired training identified in the survey and workshops have been grouped as follows:

Knowledge-based training focused on "health" topics

Skills-based training

Attitude-based training

The following slides take into consideration the workshop participant views and outline a proposed **generic curriculum** for all early years staff.

Knowledge

Suggested generic training for all staff working in EY pilots

Awareness of:

- Early years development – and the importance of prevention and early intervention
- Perinatal and infant mental health
- Impact of poverty – loneliness, housing, finance
- Health literacy

Skills

Suggested generic training for all staff working in EY pilots

Support and training for:

- Having sensitive conversations with families on risk factors that can impact child health and wellbeing
- Relationship building – improving engagement
- Asset-based approaches – building on families' strengths, including personalised goal setting
- Making Every Contact Count (MECC)

Attitudes

Suggested generic training for all staff working in EY pilots

Training and education that builds confidence and supports the following areas:

- Equality and diversity
- Empowering
- Compassion and empathy
- Cultural competency

Specific learning

This can be built upon with the addition of specific priority topics as required, for example:

- *Perinatal mental health*
- *Neurodiversity/Child development*
- *Respiratory health*
- *Minor illness etc.*

Theme 6

Preferred methods of training delivery

Small group - participatory

Self directed

Bite-sized

Webinar

Suggestions for future training delivery

- Half-day sessions face to face
- Hybrid supervised e-learning time, 45 mins on a number of topics
- Adult learning case-based roundtable discussions / participatory: 3 topics – topic experts / facilitators move around the tables (model successful with GPs especially)
- "Munch and learn"- mini teaching sessions which are face to face, interactive, interprofessional and supported with refreshments
- Time for self-directed learning BUT not all in own time

Limitations of the analysis

Small sample of practitioners
Engagement overall low
Themes were generated from across the survey and focus group – however, some respondents engaged in both (may skew weighting of some themes)
The themes provide ***initial*** insights to support understanding of training and learning development in the future – these assumptions need to be tested and regularly reviewed to address the changing context of child health.

Discussion and recommendations

- Training and education can be aligned to **knowledge**, **skills** and **attitudes** (KSA) identified from the needs assessment.
- Consider separating generic KSA and more specific, focused areas depending on the local circumstances and roles.
- Consider locally **HOW** training should be delivered according to local preferences/ context and the various methods of supporting staff.
- Consider the benefit of **GENERIC** training for all staff engaged with families in the EY so there is an established/ consistent level of awareness across the whole Borough.

Appendix

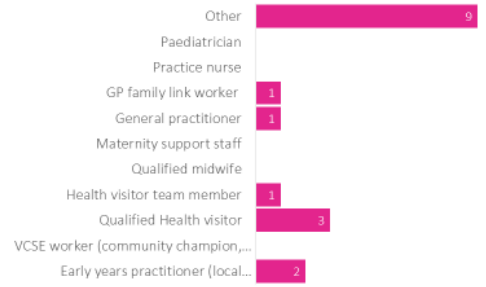
Survey questions and results

06/01/2025

www.ihv.org.uk

Survey results

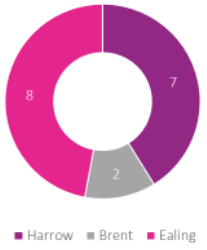
Background – Job Role

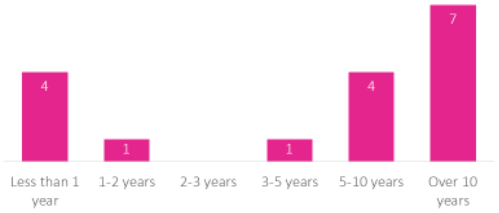


Other includes:

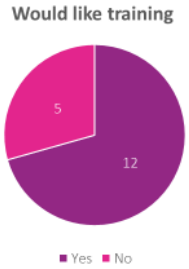
- 0-19 Manager
- Community Nursery Nurse
- Consultant in Public Health
- Early Start Worker Ealing Council
- Early years practitioner
- Perinatal
- x3 Speech and Language Therapist

Background – Work Location & Length of service





Knowledge, confidence & understanding - 1st 1001 critical days



Training 1001 Days

Memorable training attended in the last three years:

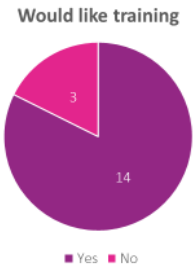
In house
- Breastfeeding training
- Sleep training
- Signs of safety
- Child Health Hub MDTs training via case studies
- ICON
- Safeguarding – bite-sized
- Team Around Family training
- 0-19 conference (CHCL, Harrow Early Years Conference)

External
- Baby massage – IAIM
- Brain Development in under 2s - Michelle Fernandez WHO - 'Promoting communication in the Early Years Clinical Effectiveness Network
- Breastfeeding training
- Infant 2 school training
- BBC Tiny Happy People Champion training
- Immunisation
- Incredible Years - baby

Not specified
- Self-directed learning - MECSH training
- Early language Implementation Measure
- MECSH
- Domestic violence

What training would you like:
- ½ day or bite-size on early development & impact of abuse
- "Access to HV team signposting parents e.g. issues around social determinants"
- Communication and feeding development
- Development and bonding and attachment
- Impact of parental mental health on infant/ child mental health
- Newborn and Infant
- Training parents to understand the importance of interaction with their children
- Everything
- Any training relating to Early Years

Knowledge, confidence & understanding - Perinatal Mental Health



Training - Perinatal Mental Health

Memorable training sessions/programmes attended relating within the last 3 years

In house

- It is very useful having perinatal professionals as part of MDT PCN meetings
- Local perinatal training and regular meeting to discuss clients
- Safeguarding
- Perinatal mental health training at Away day
- Domestic violence

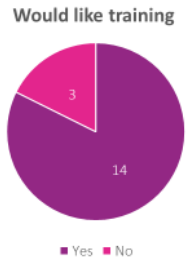
Not specified

- Born to bond
- LSCP conference, 12 June 2024 external
- Perinatal mental health
- Perinatal team training
- Trauma-informed care
- Wave
- Neonatal ODN

What training would you like:

- ½ day or "lunch and learn" with focus on impact of unhealthy relationships
- x2 Impact of parental mental health on the child
- Perinatal red flags, how to refer to perinatal service, self-referrals are now being accepted in Harrow and Brent to promote awareness on this
- Joint care and more integration
- New birth visit
- Supporting parents in Early Years
- Everything

Knowledge, confidence & understanding - Infant Mental Health



Training - Infant Mental Health

Memorable training attended in the last three years:

In house

- Baby Friendly training - whole day
- CAMHS MDT cases via child health MDTs Safeguarding in children

External

- Hanen.org - regular training through webinars and research updates
- Incredible babies

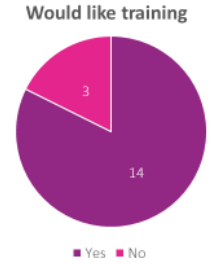
Not specified

- Born to bond
- x2 Infant mental health
- Other update 7 minutes learning FGM

What training would you like:

- Overall impact on the developing foetus
- Overall it is good to refresh
- Overall training on infant mental health
- What resources are available for young people with mental health
- Everything

Knowledge, confidence & understanding - health literacy, including minor illnesses



Training - health literacy, including minor illnesses

Memorable training sessions/programmes attended within the last three years:

- x6 Attended no training (one as new in role)

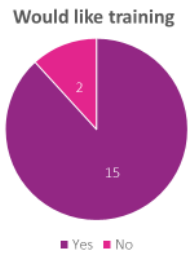
Not specified

- Common physical disorders in infancy Public Health

What training would you like:

- ½ day on colic, constipation, cough, cold
- Overall health literacy training
- Perinatal-maternal/newborn
- Everything

Knowledge, confidence & understanding - Respiratory Health



Training - Respiratory Health

Memorable training sessions/programmes attended within the last three years:

- x7 Attended no training (one as new in role)

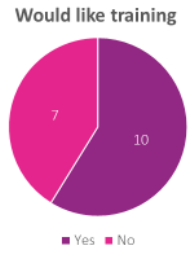
In house

- Asthma training
- Early year clinics – case-based learning

What training would you like:

- Anything
- Asthma nurses to teach Health Care Assistants and nurses in GP surgery about inhaler technique etc
- Lung development/ community respiratory infections/ RSV/ Bronchiolitis/ Chronic Lung Disease and aspiration pneumonia
- Overall training on parent respiratory health
- Relating to children
- Specific to different age groups
- Bite-sized or lunch & learn
- Everything

Knowledge, confidence & understanding – Smoking in the home (Antenatally & postnatally)



Training - Smoking in the home (antenatally & postnatally)

Memorable training sessions/programmes attended within the last three years:

- x4 Attended no training (one as new in role)

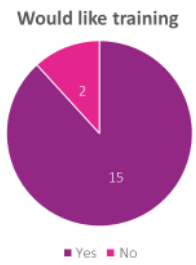
Not specified

- Smoking cessation

What training would you like:

- Updated advice on smoking
- What services are available and how to refer
- Vapes
- The direct impact on the baby and early development. What gives the greater negative impact to the baby? Mum attempting to give up smoking and being very anxious and distressed throughout the pregnancy. Or mum continuing to smoke and being less stressed and anxious through the pregnancy despite the risks to the baby's of mum smoking?

Knowledge, confidence & understanding - Neurodivergence



Training - Neurodivergence

Memorable training sessions/programmes attended within the last three years:

In house

- Autism Education Training - SEND Team
- Early Years conference
- "Keeping younger children in mind 0-5 ; Dr Julie Bithell Lead Child & Adolescent Psychotherapist KCW Specialist 0-5s CAMHS Service Lead /Parent-Infant Psychotherapist"

External

- Hanen

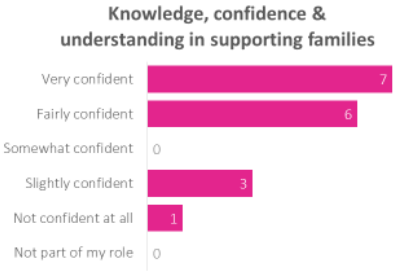
Not specified

- Training in previous role through working in a school setting

What training would you like:

- ½ day
- Around ADHD
- Autism
- More knowledge in this area
- Overall training on neurodiversity
- Supporting neurodiverse parents amongst different cultures
- Everything

Knowledge, confidence & understanding - Speech, Language & Communication, & Emotional Health



Training - Speech, Language & Communication, & Emotional Health

Memorable training sessions/programmes attended within the last three years:

In house

- ELIM Speech and Language Therapy Service
- SAL training with SAL service
- Liaise with HV or GP if we have concerns
- Termly training sessions with SALT team as part of role

External

- Learning Language and loving it training (10 years ago)

Not specified

- Wellcomm training

What training would you like:

- Just a refresh
- Everything

Current training available

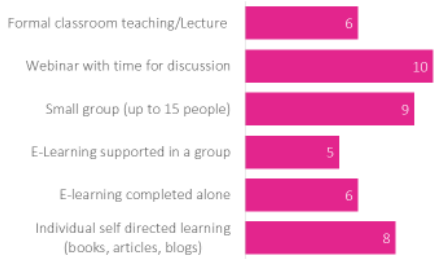
- x13 said there was none, or they didn't know
- x8 said this question was N/A to them or they haven't looked for training
- x5 said they couldn't find anything
- x1 said none with the same titles
- Others listed the following training:
  - Asthma
  - Early Language Implementation Measure
  - ICON
  - Master class in Perinatal and Infant Mental Health (For staff working in CNWL)

Barriers & preferred learning styles

Barriers to training:

- Current demand for mandatory training (it is felt by some that some mandatory training is not always relevant to their role)
- x2 said no training was available
- x2 said training was not accessed due to lack of staff/workload pressures
- Funding

Favourite learning methods



Appendix 6. Ealing-StartWell Home Visit Data

Support needed by parents

Patient #	Age at Referral Date	Action 1	Action 2
1	7 Months	• Home visit, discussed playgroups and the importance of getting out	• Follow up T-call 4/11 Mum doesn't want to attend Playgroup at this time
2	14 Months	• Home visit, discussed playgroups and physical inability to bear weight on her legs • Home visit 12/12 with a translater, 2 older children in school, baby sick in hospital • Home visit 7/10 was happy with home visit and will contact us when required • Home visit 5/12 discussed high anxiety towards impending birth of 2nd child	• Attended Ealing Anchor 15/11 with mum and baby, very successful • Will follow up January 2025 • Will follow up January 2025
3	2 Yrs	• Home visit out of area 7/11 discussed feeding as mum still b/feeding • Request for healthy card, signposted	• Sent info, playgroups and development checks also info on English classes • Will follow up January 2025
4	3 Months	• T/Call, mum doesn't want home visit as working with early start	• Mum requested a home visit were we discussed baby's rash, mum has lots of support from family but wants to meet other mums - invited mum to our family group
5	7 Months	• Home visit 17/10, discussed mums m/h and financial stresses, arranged to accompany mum to several playgroup and library visits, mum hasn't attended anything with us	• Signposted to Ealing Advise, food bank,
6	2 Yrs	• Home visit 25.09.24 higly anxious parents, suspected autism, mum failed to bond with both children following traumatic birth, dad is the sole carer and struggling	• Attended playgroup session with mum dad and both children
7	8 Weeks	• Home Visit 9.12, both parents have depression and financial worries, temp housing • Home visit 6.9.24 discussed attending playgroups • Mum declined a home visit, well informed of local activities	• Food bank, baby bank • Attended library • Attended playgroup with mum • Will follow up February 2025
8	18 Months	• Home visit 28.11.24 discussed mums worries about her son being autisic and pulling his hair • Home visit 10.10.24 mum very isolated expressed lonliness and lack of support	• Hasn't engaged with us attending activities in local area • Attended Playgroup 11/11
9	5 Months	• Home visit 11.12.24 mum diagnosed with Bipolor , very well informed with all local activities, no longer has feeding worries	• Will invite to Homestart programme in January
10	3 Yrs	• declined home visit and in house visit , wont engage with us re	
11	11 months	• Two year old sibling, mum had children through surragacy and feeling very isolated • Home visit 17/10/24, mum feeling overwhelmed with older children and their m/health as well as her own. Son is autisitic and mum struggling financially. Mum happy to have added support • Home visit 9/10/24. Mum very anxious, struggling with leaving the house, two older children , older son in trouble with authorities and not attending college. Mum heavily reliant on him to help her leave the house	• Sent a lot of information regarding play activities and sports for their older boy • Have attended library sessions with mum and arranged park playdates twice mum is having physical issues as having knee surgery • Mum has not followed up with planned activities and has cancelled. Has sent a text saying her mental health is not great and offered support and advice • Food bank vouchers and Baby bank voucher issued. Mum began to lessen contact and refused Homestart volunteer when initally agreed.
12	17 months	• Fussy Eater and mum concerned about food intake. Spoke to mum on phone as she cancelled planned home visit. Stated working with a dietician and prefers that	• f/up with phone call to see if issue has improved
13	3 months	• Home visit 14/11/24. Mum wanted information on local community groups	• Sent all local infromation, particularly focussed on Dormers Well as this is local

14	1 year	• Home visit 15/10/24Mum has limited English, two older children in High School. • Highly emotional and spoke to GP about visit as showing medication and stating cannot sleep • Telephone call and spoke to dad, he advised they were leaving the country to return home to family, some concerns as did not have contact with mum	• Repeated attempts at contact. Translater spoke to mum, attended a play activity with mum and Windmill Childrens Centre • Arranged to be a GP surgery when they were attending for appointment with nurse. Failed to show. Believe family have left UK
15	2 months	• Home visit 11/09/24 mum was very anxious regarding her older son and behavioral issues • Spoke to dad on the phone, complex medical needs for baby. Dad feels they are very supported at present but was interested in support offer for future when they have got used to routine in their home • Family in temp housing and feel inadequate housing. English very limited, struggled to explain role even with friend translating. Have tried to arrange a call with translator	• Signposted local workshops for behaviour and helped to begin referral for CAHMS, regular contact through email and phone • F/up to ensure support stilll in place, social isolation possible • See notes that Early Start are involved with family and did a home visit, have attempted to contact worker to work together but have not had response • email sent to P officer looking into extendinding nursery hours agreed to attend child group with mother
16	missing	• Mother of 6 children, single parenting. Have arranged Home visit 17/12/24 high levels of stress due to past trauma, emailed s/w to engage and offer support	• home visit 14/1/25 discussed past trauma and restarting therapy , emailed womens and girls network who will take mother on in feb
16	20 months	• Home visit 8/10.24, social isolation, single parent and was not leaving her home as felt overwhelmed after cancer recovery. • English additional language	• Arranged Park activity (failed to arrive) and library visit for play. Son really enjoys all social interaction so helped mum to apply for 2 year old funding for nursery.
17	19 months	• Home visit 22/10/24 Mum repeatedly attending doctors with her 3 children • Does not leave the house except to do school runs	• Have continued to contact mum and invite to playgroups and sessions. Mum has not engaged to date
18	11 months	• Home visit 06/09/24. Mum and son in small living accomadation, mum concerns about his feeding and using a syringe to feed baby. Baby is overweight and nocturnal. • Mum has anxiety due to past trauma of arriving in Uk and disclosed information that has prompted perinatal involment for therapy	• Attended playgroup and library sessions on multiple occasions with the family. Attended a food workshop for solid foods.
19	2 months	• Mum did not feel she wanted contact at this stage as baby was too young and she did not want to leave house or allow people inside house	• Have followed up with a phonecall and mum is still not open to a home vist - feels she is well informed regarding local support networks
20	5 months	• Telephone call with mum as referred for feeding issues and isolation. Mum stated that she has the support of family and does not need and family link work at this time	• F/up telephone call in February
21	4 years	• Home visit 07/11/24. Single parent. Abusive marriage and child has complex medical needs. Financial concerns as being taken to court for arrears in previous accomodation	• Have spoken on the phone to mum and emailed as she is overwhelmed with court demands, signposted Ealing Advice and offered advice if payment plan needs to be put in place
22	3 years	• Home visit booked 16/12/24 . Speech delays and behavioural issues	• information sent to mum re childrens groups Umaima can attend at log cabin, food voucher issued
23	8 months	• Child has heart issue, not sitting correctly. Hv wants mum to attend groups. Have attempted contact but mum will only reply with Whatsapp, sporadic. Does not wish to engage	• Will f/up to see if mum will attend a group session
24	4 years	• Referred due to not eating enough food, wanting breast milk as new baby in the house • Mum did not want a home visit, cancelled a visit to surgery, gave advice over phone regarding mealtimes about it being a family activity. Sent NHS information through email to mum regarding picky eating and so on • Telephone conversation through silent sounds. Mum doesn't require FLW services at this time • Feels supported through family and friends • home visit arranged 23/1 mum with low mood	• F/up with phonecall to see if he is now eating a more balanced diet • To Follow up in February 2025
25	10 months	• Child has complex genetic issues, home visit arranged for 27/1/24	• home visit completed, mum overwhelmed with impending reduancy waiting to start IAPT invited to our family group • home visit competed, mum not quite ready to take child to childrens centres yet as worried about picking up illness's • gave info for when she is ready, will email carmelita house for info on suitable nursery places for when mum returns to wok
26	4 years	• Child issues with school lunches home visit arranged 15/1/25	• home visit competed, mum has 5 children and all living in a 2 bed house, we liased with child's school, and also rang the housing officer and rang hathaway childrens centre for mum to take her youngest to with us in attendance as requested
27	3 Months	• telephone conversation with mum, has depression. Not interested in a home visit now, invited to our family group	• due to attend our family group 29/1/25

Appendix 7. Case Studies Table

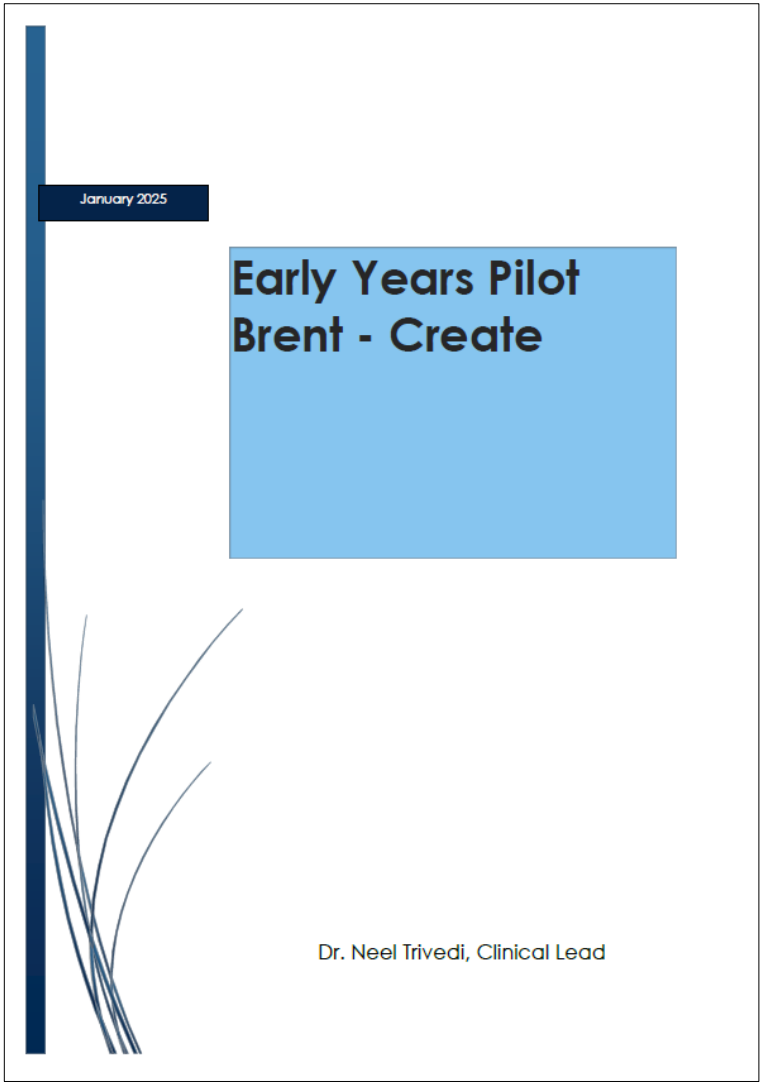
Case studies from all three early years sites

Note: Harrow used a standard template to record case studies whilst Ealing and Brent did not have a standard template, hence there is missing information for some case studies.
Number of case studies: Harrow n=15; Ealing n=5; Brent n=1

Site	ID	Area of Need	Number of Interviewees	Family Description	How contact was Initiated	Need Connected	How Contact Was Initiated / Method of Accessing	Key Issues	Support Provided	Outcome	Community Engagement	Role of Family Comments	Reflections/Learning
Harrow	001	SALT, MA, CHIMM	• 2 in-person observations • 1 virtual • Phonecall	• Mother lives with 2 children under 5 years old. • Separated from children's father but he visits • Mother and father do not get on – Section 17 Safeguarding place	Referred by EP	• Help with transition e.g. CAFT attendance • Housing- facing eviction • PMQ1 Health – level of anxiety • Housing problem- damp and mould	• Phonecall • PM Graphic • Emails • Face-to-face meetings	• Relationship with Health Visitor • Housing- struggling with evictions and damp/mould, child's asthma etc • Child's ASD, new transition • Domestic abuse • Concerns about their 2 year old's speech and language	Signposted to organisations: • Harrow Law Centre- housing advice • Harrow Citizens Theatre • Harrow Council • Head Start Hub • Breastfeeding Baby Bank • Specialist Language Therapy • Talk and Play Sessions at the Children's Centre • Baking the apples • GP • Referral letter to Assessment & Health • Advice on progressing child's language skills • Liaise with SALT	• Positive that knowledge of services supports their needs • SALT provided time and space to discuss concerns	• Attends playgroup Children's Centre • Attends playgroup Mosque		• Issues with housing are the cause of physical and mental wellbeing • Multiple issues without a resolution in sight • SALT keeping the plan to work on hold until the housing situation
Harrow	002	Social Communication Collaboration with CHIMM	• 1 telephone call • Several texts	• Single mum • Has 2 children of • Child not toilet	Referred by HCP	• Stress and anxiety due to cultural pressures • Feeling unemployed • Baby has colic • Health visitor non-responsive • Financial stress	• Medical message • Phone call • Messages	• Loneliness • Stress • Financial difficulties	• Bought Advanced Anti Colic bottle & Suitably Blossom Baby Bank • Bought goggles with her friend from Children's Centre • Shared medications supportively passing clothes and nappies for child Signposted to: • Talking the apples • Homestart • Parents with Children Club • Sea Nursery • Baby Massage with Blossom • Harrow Law Centre for financial help • SALT study encouraged her to attend • Portfolio Group	• Mother does not feel lonely anymore • Having a Children's Centre with just the social prescriber group is unbelievable and confidence in parenting	• Mother attended activities with Baby at Blossom • Mother attended Children's Centre • Never came back from postnatal support group • Showing interest in Home Start programme • Mother has now settled in at Baby Bank • Mother is now working at Children's Centre	Mother has had positive experience of financial assistance but struggles with this, has got spare cup, also does not have able to put cot and no help in place	• Listening • Making mediation steps • Multiple factors affect parental and child physical and mental wellbeing • Holistic approach by CHIMM's and SPLM's can help families with a range of issues and help them to help themselves
Harrow	003	SALT, MA, CHIMM	• 2 in-person observations • Phonecalls • 5 emails • Messages	• Family of seven • Mother does not speak English; father speaks good English • 3 children (5, 4 & 1 year old) • Two boys' ages under 5 years • Mother has Puberty digital messaging between family there • Has had a cot stolen/ baby	Referred by EP	• Mediation/ mental health • Community based Elders to raise children • Overcrowded housing • Older children have CIN plan	• Mother's appointment at Dr C Nathan's Center but doctor retired • Another appointment at new Dr from Malcolm Puberty changed with the SPLM • Contacted other relevant parties, messages and e-mails to those struggled to set morning appointments • Maternity Champion spoke to mother and encouraged other to attend classes at Ewell Baby Unit(EBU) did not attend but contacted after when her baby born. Has attended EBU sessions since • Introductory Home Start but father did not want to take up offer to help mother at home with the children or the evenings • Children are regular to come to visits and did the family want	• Case Given to Special PMD • SPLM to monitor • Helped with housing • Liaising with CAMHS one of the children's aggressive behaviour) • Has only attended ASD for baby's breathing • Did not attend the week's check • No pledge with housing officer • No update from social worker for ongoing mother-in- meetings • Family not attending Home Start • Emotional connection to the cancel twins • Father's ex-partner called for no reason, to privately book with multiple messages and distress, SPLM to check calls and emails to Maternity Lead and Neuroscience • Maternity Champion will discuss relevant issues when with mother • Mother is happy to be at home, not isolated, but is pissed with her sisters, keen on engaging these cases – potentially accessing her fortnightly? • Supportive neighbours to no other support • Has some necessary tasks for resources but father's ex-did not need this	• Space for dad to talk and work to situations in housing and support from the wider family • Signposted to Children's Autism and ADHD but time wants hands-on support for the boys, not supportive him and mum was that cannot be if they do not offer this. • Signposted to baby bank- developed the proof to no • SPLM has had ongoing liaison with social workers, as can't be given further with housing issues. • Signposted to Good Mother and Homestart but they don't want this • Signposted to Bindi dad says it was too late to get in school to the start of the twins • Children's Centre has Coo Activities, but they have very long waiting lists for after school and holiday clubs. • Signposted to the Maternity Champion to help support mum via phone calls. • Signposted to Afghan Association in Harrow via the Key Champion to go to the first but after not been. • Offered reading Parties, family have been offered to visit with CLHMMY and SPLM to reading app to them due to cases of twins. • Continue to monitor mum's mental health and provide other opportunities to support. Holiday clubs. • Continue to monitor mum's mental health and provide other opportunities to support.	• Ongoing engagement from Uptake is weekly and Dad has access to Outcomes are ongoing at the moment as difficult are engaging them	• Multiple visits to the home and does attend groups, difficult to engage here. • SPLM has not met or spoken to her as yet, as supportive relations to how good the girl is the father.	Father has a very protective role, does not come into the home to support the family	• Multiple issues at the family's complex case • Difficulty of family to engage • Family has expectation of what they want but not always in the best interests / child • Uses SALT and PMD dad assessments, multiple parent sessions, observations, one-to-one sessions, communication between them • Hard to find 'you CAFT' help with collaboration, because not physical as Children and Adult e.g. housing, long waiting lists to be split effectively cases
Harrow	004	SALT, MA, CHIMM	• 2 in-person (Child and Mother)	• Mother lives with partner and baby • No other family nearby except partner's parents • Feeling isolated mainly	Referred by EP	• Low mood • Isolation	• Mother's mood and tiredness in particular group sessions/ services • Emails and phonecalls • Attended virtual	• Struggling with her sleep • Mother's need for structure and feeling useful • Useful and just pressure environment	• Signposted to Baking Therapist • Referred to Bindi • Signposted to Children's Centre • Providing space and time to talk about her concerns with mood, mother's social changes to life	• Mother has spoken with the positive about sure she is the parents staying with the now their baby visit • Speaking mother on how to spend quality time with her partner (she wants to spend quality time with her) • Encourage mother to engage in activities her not looking after baby - want to be productive	• Bindi • Children's Centre	Mother is very grateful and considers	• Uses SALT and mother's confidential findings • Promotion of activities • Regular check-ins are necessary given to her between sessions/appointments
Harrow	005	CHIMM	• 2 in-person	• Single parent • Has 3 other children aged 2, 7, & 9 years. • 9 year old has ASD and is in nappies - is only dependent child under 5 years age bracket • Children have an EHC plan, applying for DLA	• Referred by EP to SPLM	• Child has an EHC plan • Disengaged with social worker	• CHIMM contacted mother by phone and suggested one-to-one meeting at Children's Centre • CHIMM's mother to 2 children and school that she has with SPLM • Mother contacted CHIMM as she was being evicted and needed support with contacting housing department	• Eye and tooth decay engagement • Safety in house - risks with 4yo brother with ASD • 2yr old has severe eczema • Eviction order	• Practical and emotional assistance • Autism assessment for guidance • ADHD Autism Support Centre • Contacted housing department to help family as found supporting mother housing issues • GP to refer mother to energy depot re e-Coma treatment • Explored orientation organisations for dental support • Signposted to SEN Classes at Blossom • Other concerns raised: support to mother on classes, Home and mother to CAMHS' Talk, Play and Play group at the mosque • Provided family access to talk therapy groups • Ongoing - family and school supporting the family with multiple comorbidities in autism • Ongoing - referral for Home Start – some one to help mum with the relationship with dad	• Have a great connection with the family • Mother has been in contact with CHIMM and SPLM to support her children's needs, and her physical health support in weeks	
Harrow	006	SALT, SI	• 1 in-person	• Mother and father both Ex-Afghan Evacuees and Ex-British Military (WWII)	• Father and young child attended CHIMM's 'Meet and Greet' event • Father contacted CHIMM for help/support with housing	• New to UK, language barrier to access support • Housing need	• Father approached CHIMM for help • CHIMM contacted father to arrange at home visit to discuss needs	• Family new to Council's point of familiar with the local Area/UK • Support needed to universal Credit application • Family under the threat • Eviction notice received	• Signposted family to Rehousing Organisation who think Afghan families etc. • Signposted mother to Hestian Afghan Association in Harrow that provides domestic violence to Afghan women i.e. sewing classes, English classes • CHIMM will contact father of other two children and support them • Signposted to mother and children group at the mosque • Signposted to local Quaker youth club/activities for the 2 children who are attached	• None yet - ongoing support	• Mother regularly attends the local organisation Hestian Afghan Association	• Long-age Eastern European and African families have translation issues to understand context

Hanlow	007	CHIMH	• 10+ phone calls	• Mother and father • Twins boys with ASD • Elderly grandparents	• Referral by GP	• Mother struggling to support twin boys with ASD - financially, education, potty training	• Phone calls	• Mother needing support with twin boys with ASD who are taking phone calls (supported by Refuge, Hanlow) • Advised she needs support via Portage, Portage supposed to step - mother wants to continue home schooling but does not know how to get support for this • Mother does not support with boys having a contact visit • Mother needing support for all issues to push this forward, Hanlow Carers, needs support for managing behaviour for help with potty training	• Checking if not stated as a former boys' Carer because of the MHPC • Signposting mother with forward planning • Referred to CAMHS out of area • Referred to ADHD centre to support with toilet training and behaviours etc. • Contact made with Council education dept at homeless hearing - team for inactive homeless hearing has referred to mother • Referred to Hanlow Parent Carer Forum to help connect mother with other parents in similar situations • Referred to Help to Hanlow Refugee Hub to support mother with EHC plans and entitlement to funding • Referral sent from for CAMHS under 4s set, awaiting further	• Mother attending Hanlow Parent Forum group to find out more about the girl's diagnosis • Chimmy Jane discussed it with GP Clinical Lead about mother struggling that she does not have funds to buy a pushchair for the twins to then go out on their own as too difficult. CHIMH advised to contact CYP Direct funding through which CHIMH was able to secure funding for Emily to buy a pushchair.	• Hanlow Parent Forum	None	• CAMHS attends for child struggles, refers 5 years • CHYPEMP funding for low income families
Hanlow	008	Social Prescribing in collaboration with CHIMH	• 4 phone calls • 5+ text messages	• Full time mother of 3 month baby girl	Referral by HCN and GP Direct	• Problems with the switching • Adjusting to motherhood	• Regular contact with mother by phone call and in person on mothers needs	• Low mood. • Stress • Feeling low for not being able to breastfeed	• Referred to Hanlow Postnatal Support group • Referred to Built at Bloomsbury Counselling Package • Signposted to Talking Therapies and Baby Triangle Support	• Signposted to Postnatal Support group provided one-to-one advice on breastfeeding and bottle feeding • Mother had attended Built and Baby Massage and is now making new friends • GP contacted and provided email mother with support equipment, baby and mother medical advice • Mother is now meeting with Jane about motherhood • Mother does not feel lonely anymore	• Postnatal Support Group • Built • Baby Massage	• Postnatal Support Group	• Language barriers and some reluctance to further issues - still trying to establish further support that is needed	• Listening • Increasing mother's confidence
Hanlow	009	CHIMH	• 2 in-person	• Mother and father • 5 children, 2 have ASD • Mother has issues using trust as well as anxiety and suicides • No support network (not relevant and have it difficult to make friends • Mother has depression	Referral by GP	• Hearing correction affecting 2 years old daughter's health, seeking to connect to Hanlow	• Mother's relationship with Children's Centre	• Low mood, and irritation • Anxiety • Legal Advice • Daughter was admitted to hospital and is on consultant's referral and conditions, was tested by Hausdale Hospital home - much to do, was good at managing out this one a • Managing mental issues at the end	• Listen to mother's concerns • Provide reassurance that they are there to help • Referred to Talking Therapies • Invited to SALT team to ensure support was being provided • Invited to Hanlow Law Centre for legal advice • Signposted to Community Perinatal Support • Referred to Home-Start	• Clinic is now working with help of physiotherapist • Clinic is making progress with speech	None	• Mother has expressed happiness and gratitude with the support that is received	• CAMHS attends for child struggles, refers 5 years • SALT referred. • Talking Therapies referred.
Hanlow	010	SPLW& CHIMH	• 2 in-person	• Mother, Mohammed, and father Magdalena • Two sons (8yr old has ASD, baby Asiana 6 months old	• Originally referred by Carer Coordinator Hertsphere.	• Help with weight loss • Low mood	• SPLW met mother at Children's Centre	• Referred to CAMH • Signposted to Talking Therapies • Signposted to Postnatal Support group • Signposted to weaning groups and workshops • Signposted to Centre for Autism and ADHD • Regular reviews	• Mother has been to be a Maternity Champion with Hausdale • Mother has attended Postnatal Support Group • Mother is now working • Referred to Talking Therapies	• Mother has spoken with other mums at BMM	None	• Mother can be out quickly if part of possession with cute place to talk • Regular check-ins are appreciated • Usually he was under weight as well • Needs less, and an added weight safety	
Hanlow	011	SPLW	• 2 in-person • 5 virtual exchanges	• Mother, single parent of 3 girls • Going through divorce • Daughter's mother not to care parents' evidencing	• Referral by Children's Centre • Approached mother	• Struggling with getting her 3 years old daughter into nursery, and supporting her emotional	• Mother's own mum who she cared for, daughter's mental issues, domestic violence, Children's Centre • 2 + yrs issues, medication need, low mood • Financial issues • Needing to find nursery for daughter • Mother is struggling with getting through divorce	• Signposted to Dad Journal of Resilience • Referred to Built SALT services and Refuge • Signposted to CAH • Signposted to local libraries • Signposted to local activities • Signposted to CAMHS (Counselling and Online Assessment) • Email exchange for check-ins with progress with completing forms	• Mother has been supported to check benefits and communication and awaiting more support from SALT • Mother now has information to help with other local issues including mental health and agencies for financial help and the cost of living	• Mother has struggled with another mother at the Children's Centre who was also with SPLW/CHIMH	• Mother could offer to share with other mothers	• Referral sent awaiting [illegible] and other struggles, it will be [illegible] with Dad's mental health, and agencies for financial help and the cost of living • Family are not an issue, can change overtime, issues that may be due to virtual conference Eagle overtime
Hanlow	012	SPLW& CHIMH	• 1 in-person	• Mother being in hospital with husband, 3 months old baby, in care and husband's sibling. • Full dependent coupled by other mothers • Family are critical about mother's way of managing motherhood • Child has difficulty breastfeeding • Child has tongue tie and was operated on at Queen's • Child was also in hospital for several months and stayed	• Referred by GP	• Birth children • Mental Health • Confidence	• CHIMH was the contact SPLW was away • Planned contact through phone and email • Met baby girl but son was not to provide support	• Breastfeeding • Family attendance • Mental Health (including appetite and mood) • Wants to get out and about with baby • Benefits • SALT - mother opened to have a course taken (short), and has a stutter	• Signposted to Sure Locks, Bookstart, Antenatal and Breastfeeding classes • Planned contact • Signposted to Hanlow mosque playgroup • Signposted to Book Start Cost and, Baby Massage and Built • Invited mother to attend classes/postnatal group • Provide mother with information about Children's and Library Membership ideas • Encouraged mother to attend classes, Center for baby weigh and talk with health visitor about breastfeeding • Encouraged mother to ask relatives to help with specific jobs around the house to support her, and to discuss how to provide support • Follow up appointment planned	• Mother has information about applications for help with breastfeeding • Mother has had space to talk about concerns • Mother has information about free things • Mother has information about baby groups which she can attend • Mother has signed up to receive SALT support	• Not yet started by Face-to-Face sessions as baby is poorly	None	• Important to have quiet time space for children to book • Centers and SPLW have worked well together • Used to have 2 people as a first meeting, to have choices of each other, referrals and signposting
Hanlow	013	Positive Support Group	Not specified	• Mother continually ill and • Mother worried about leaving baby at nursery when returning to work	Not specified	• Anxiety • Financial - benefit entitlement when returning to work	Not specified	• Mother's anxiety • Daughter's development • Childcare options • Benefits	• Signposted to Hanlow Training Hub (for daughter's development) • Signposted to Next Hanlow Community Library • Encouraged to explore childcare options, i.e., childminders, who offer pre-nursery and home support • Helping mother to seek advice for Universal Credit terms and entitlements on returning to work • Continue to review progress and mother's wellbeing via her support	• Mother has been passed with the success to her sons' progress and to retain back to work	Not specified	• Mother has made referrals to improvement and support with assessment and booklet sending to her universal about going back to work	None specified
Hanlow	014	Positive Support Group	Not specified	• Mother has 1 baby electrically • Recently relocated from abroad • Mother does not usually live in but it was the first husband due to language barriers	• Postnatal Support session	• Concerns with social isolation, language barriers, anxiety around childcare and baby's health	Invitation to group session	• Perinatal mental health including anxiety due to language barriers, social isolation and financial worries and no support network • Baby's health concerns including developments, size of baby's head, rash on cheeks, birthmarks • Mother is reluctant to attend community groups	• Signposted to SALT classes • Signposted to local support group that has mothers who speak the same language • Recommended baby Triangle • Referred to Built • Will introduce mother to peer support models • Recommended mother attends baby weigh-ins and spoke with health visitor • Will provide educational materials and resources on common infant health issues	• Not yet – mother is interested to get support and regular check-ins will be conducted	None specified	None specified	• Highlighting importance of accessing practical and medical needs of new mothers • By helping mothers overcome language barriers and facilitating social connections, we provide a holistic approach to support their physical, emotional, and psychological well-being, ultimately enhancing their overall quality of life and empowering them to thrive in their new roles as mothers.
Hanlow	015	Positive Support Group	Not specified	• Mother and father of nine born • Father's sister is supporting family	• Postnatal Support session	• Breastfeeding difficulties	Invitation to group session	• Bad self-esteem and baby's weight • Nutritional concerns	• Educating on providing a variety of breastfeeding techniques and tips to encourage baby to latch • Referred to Hanlow Watch to help group access; discussed potential regularly • Shared various resources and advice on breastfeeding when latching difficulties • Encouraged mother to plan breastfeeding support groups to connect with other mothers • Recommended baby Triangle	• Evaluating progress through regular check-ins	None specified	None specified	• Importance of providing psychoeducational support for new parents, facing breastfeeding challenges • Combined gentle cues (e.g. gestures), community resources, and emotional support, mothers can work towards establishing successful breastfeeding practices.
Ealing	001	Family Link support		• Single parent • Mother has history of depression and anxiety • Has had one overdose attempt • 3 children who have different fathers, and contact issues • Father of the baby was drug dealer, she was spoken to and he left • Lots of contact between ex-partner with police	Referral from GP	• Stress due to eviction and council case and from Amelia being the worthless through her window • Breastfeeding issues • Struggling on benefits at 3rd child	• Home visit attended and attended by Family Link worker	• Anxiety is generating mother from leaving house - does not like going out to school run times and another mum to her three pick-up • Helped get social care company to her school reports and shopping • Financial concerns • Depression • Impending council tax return	• Mother is on the declaration to depression • Family Link worker attended home visit • Referred to Hausdale Team for support with mother distance • Signposted mother to baby weighing classes and other to accompany her to mother-and-child health • Recommended applying up and offered social company mother to these but has declined • Referred to baby Home-Start • Next check would be in April • Phone case and to visit to mum (mother did not agree) • Important due will to mother's time experience contact • Recommended to speak with GP about medication review	• Mother has made progress by attending baby massage group, three weeks course and mother's attendance session, to his page 66). • Homestart visit took place, however, mother declined to come to date with stranger visiting house to support communicating with them • Next Bank would like to issue for financial assistance • Mother has started social review and has been referred to mental health service. • Agree to attend Homestart therapy group	• Baby music age • Home-start		• Avoidance, some distance mother • Some needs to build strong relationships • Continue to support with this going forth with booking and development for the baby.

Appendix 8. Brent Early Years Report



January 2025

Early Years Pilot Brent - Create

Dr. Neel Trivedi, Clinical Lead

Contents

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Executive Summary

The Early Years Pilot in Brent, led by Kingsbury and Willesden (K&W) South Primary Care Network (PCN), and funded by NHS England via Northwest London Integrated Care Broad (ICB), focuses on addressing significant health inequalities among children under five in Willesden neighbourhood. This is one of the borough's most deprived areas. With targeted interventions in respiratory health, smoking cessation, and neurodiversity support, the pilot aims to deliver improved health outcomes and community-wide benefits. Early data from the initiative demonstrates measurable successes, including a 100% increase in the number of asthma action plans for clinic attendees, enhanced inhaler use, and positive engagement with smoking cessation services. Positive feedback from those reviewed, as well as clinicians involved, highlight the effectiveness of a multi-disciplinary and integrated approach to health delivery in underserved populations.

The pilot also delivers the challenges of innovation through community-driven projects funded by the Innovation Fund, addressing oral health, nutrition, and health equity. While challenges such as delays in information governance and resource constraints impacted progress, the pilot has provided invaluable learning for future initiatives. The project showed an example of building a service which delivers high value outcomes and can be used as the template for the development of Children and Young People's services potentially nationally. By integrating clinical care with community-led solutions, it offers a replicable model for tackling early-years health disparities and informs strategies to sustainably improve child health outcomes across England.

Pilot Area Selection

It is important to understand why this project was relevant to the selected region. Located in the London Borough of Brent, Willesden Neighbourhood, was identified as an area of high inequality with defined geographical borders. There is much evidence to demonstrate the challenges faced in this region, including factors such as low-income, employment, education, health, crime, and housing. The focus cohort was decided upon by the clinical stakeholders as areas of greater need and support.

0–4-year-olds in Willesden are, on average, more deprived than 0–4-year-olds in Brent overall. Over 50% of patients aged 0-4 years in Willesden are living in areas in deprivation decile 3, which is much more deprived than the average for England. (Deprivation deciles are numbered from 1 to 10. Patients in decile 1 are living in the 10% most deprived local areas in England, patients in decile 10 are living in the 10% least deprived local areas in England). By carrying out the project within this neighbourhood, the aim was to develop a sustainable intervention/model to directly contribute to positive health and socio-economic outcomes.

Early Recognition of Asthma in Children 0-5 - Early Years Pilot Asthma Clinics (EYAC)

Aims

The overall aims of this part of the project included:

- Provide specialist multiprofessional, multidisciplinary team, pre-school asthma community clinics
- Early recognition of asthma or 'suspected' asthma
- Early diagnosis, and where appropriate, coding of asthma
- Early intervention and management plans
- Improve parent/carer understanding of asthma
- Increase education (to parents/families) about preventable causes for asthma (e.g. by tackling social determinants)
- Emphasise importance of (valid/up to date) personalised asthma action plans
- Reduce burden on secondary care e.g. multiple A&E attendances for potentially preventable respiratory illnesses
- Better integration pathways between community and hospitals - building better relations between clinicians across multiple healthcare platforms
- Upskilling community clinicians e.g. GPs, to make more confident diagnosis and management plans in the community
- Address health inequalities contributing to poor health outcomes

Patient Selection

Whole Systems Integrated Care (WSIC) Dashboards are a suite of tools available to clinicians and care professionals who are providing direct care to patients. The WSIC Dashboard enables care planning and case finding through providing visibility across all care settings, this allows care to be targeted where it is most needed and provides an important role in integrated care.

A) Whole Systems Integrated Care (WSIC) data for preschool respiratory health

1. Patients aged 0-4 years old living in the Willesden Neighbourhood who live with a current smoker.

2. Patients aged 1-4 years old living in the Willesden Neighbourhood who do not have a diagnosis of asthma, but who have had prescriptions for asthma medications (in particular Short-Acting Beta-Agonists (SABAs)) issued on 3 or more occasions in the last 12 months.

3. Patients aged 1-4 years old living in the Willesden Neighbourhood who do not have a diagnosis of asthma, but who have EITHER had at least one prescription for asthma medications in the last 12 months OR who have a code in their GP record suggesting that they may possibly have asthma (such as codes for wheeze or chest tightness or suspected asthma or raised eosinophil count)

4. Patients aged 1-4 years old living in the Willesden Neighbourhood who do not have a diagnosis of asthma, but who have had an emergency admission to hospital for asthma or wheeze or non-specific lower respiratory tract disorders

Cohort 1 is to identify patients who live with a smoker so that smoking cessation support can be offered to the patient's relative(s) where appropriate.

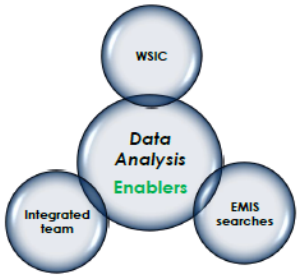
Cohorts 2, 3 and 4 is to identify patients who may have undiagnosed asthma so that these patients can undergo a specialist assessment to confirm whether they have asthma.

B) General Practice System Searches
Clinicians were able to develop EMIS searches which were used by individual practices involved in the pilot to find a small number of initial patients with possible undiagnosed asthma to invite to the clinics. These cases were similar to the above mentioned WSIC search of patients aged 1-4 years old living in the Willesden Neighbourhood who do not have a diagnosis of asthma, but who have had prescriptions for asthma medications (in particular Short-Acting Beta-Agonists ([SABAs]) issued on 3 or more occasions in the last 12 months.

C) Reactive Case Finding
Educating other surgeries within the Primary Care Network (PCN) about the EYAC pilot clinic allowed for a reactive case finding pathway. Patients who were opportunistically reviewed with (suspected) asthma could be referred into the clinic to be reviewed. The majority of cases here were undiagnosed and/or uncoded asthmatics in the primary care system, where clinicians may be concerned patients would have a higher risk of developing asthma. This allowed the clinic to actively seek and review patients who may require more immediate intervention.

Case Finding – Barriers and Enablers

Data Analysis:



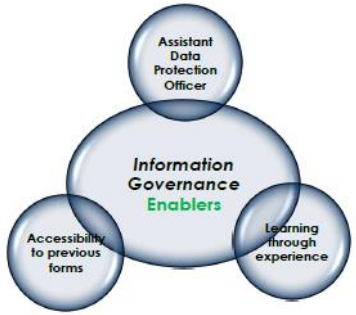
Enablers:

- NWL ICB's Whole Systems Integrated Care (WSIC) system, with the rich data set from GP records linked to demographic data, Hospital Admissions data and other NHS data sets, allowed in-depth analysis and development of cohorts of patients for assessment.
- Clinicians developing EMIS searches and provided advice on SNOMED codes etc, which helped with the development of the analysis in WSIC
- Attendance at project meetings enabled the information analyst to understand the emerging requirements for data analysis and the reasoning behind requests for data.

Barriers:

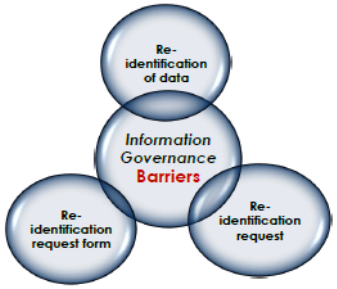
- Limited capacity of information analyst
- More dedicated analyst time needed at the start of the project; initial data analysis could have proceeded more quickly.

Information Governance / Re-identification of Data:



Enablers:

- It was very useful to be able to obtain expert advice from the Assistant Data Protection Officer regarding what to include in the Re-identification Authorisation Request.
- The experience and learning gained from going through the Re-identification request process means that an individual who has gone through the process would be able to navigate the process more quickly in future.
- It would be very useful to keep a library of completed Re-identification Authorisation Request forms, so that in future someone working on a Re-Identification Authorisation Request for a similar project can have some idea of what to put on the form, and what kind of process for re-identification is likely to work.

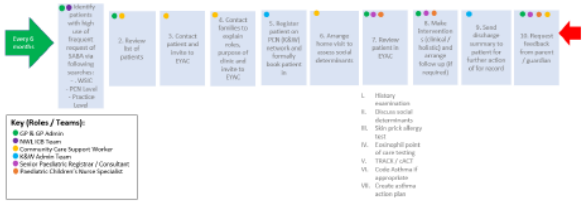


Barriers:

- Re-identification of data for various cohorts of patients from the WSIC system was a key part of this project, as the aim was to invite individual patients for clinical assessments (e.g. to determine whether they had asthma or not). Obtaining Information Governance approval for this re-identification of patients was very difficult and took several months.
- The process included a system where anonymised data was generated which had to be "identified" worked through and then "re-de-identified" before sending back. The form for requesting re-identification of data was difficult and time-consuming to complete.
- The process for requesting re-identification, this process could have started earlier, and could have been worked on concurrently while the data requirements and other details of the project were still being worked up.

The pilot project was able to get clinics for identifying asthma in young children up and running, despite the long delays in obtaining Information Governance Authorisation for re-identification of patients from the WSIC system. One main catalyst to project, was the ability of clinicians involved in the project having the skills to develop EMIS searches. These were subsequently used by individual practices involved in the pilot to find a small number of initial patients with possible undiagnosed asthma to invite to the clinics.

The Proposed Model of Early Years Pilot Asthma Clinics (EYAC)



The proposed model of the Early Years Pilot Asthma Clinics (EYAC) was heavily centred on a community-based multidisciplinary team (MDT) approach. Patients were invited to this specialist clinic in the community, with the aim to cover a range of needs. These include medication, diagnosis confirmation, care plan completion, consultant coordination, environmental health support, housing advocacy, benefits and support and patient advice.

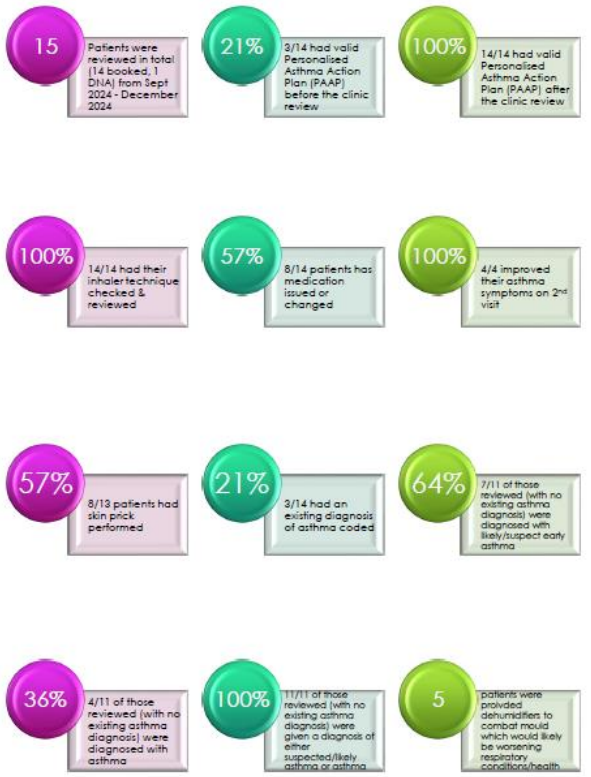
The team consisted of:

- Paediatric Asthma Nurse
- Senior Paediatric Registrar
- General Practitioner (clinical lead)
- Community Champion/Link Worker
- Admin support staff from the PCN

The Current Process

Reviewing and comparing the proposed and current pathways the only significant difference is the timeline of the home visit. Our community support worker struggled to obtain consent from the majority of families to do the home visit prior to the clinic. There were reservations expressed from families that the support worker was from social services and there may some potential determinantal outcome to the home visit. Here, we must also appreciate inviting an individual or team to your household whom you have never met before can naturally not feel safe. It was excellent learning for the team to appreciate the need to build a rapport with the family during the clinical review and build a good relationship to break down any barriers to home visits.

Data



Other interventions made from clinic included:

- Suggested referral for community paediatrician for Autism assessment – to be completed by own GP
- Referral to smoking cessation service (those living in households with smokers)
- Communicating with existing specialists to update symptoms/plan
- Issuing spacers to those that required who were not using (100%)
- Addressing non-asthma concerns e.g. social, other atopic conditions

Case Study 1

5-year-old male

Patient identification

- Patient was invited to the clinic after a Practice search indicated he had used/been issued more than 3 short-acting-beta-agonists within the year.

Medical History

- Conditions: Atopy, Eczema, Multiple Food Allergies
- Current Consultant: Respiratory specialist at NWL

Asthma Severity & Management

- Severity Indicators:
  - Last oral steroid use: 28/8/24
  - A&E admissions in the past year: 1
- Current Medication Issues:
  - Montelukast: Started two weeks ago, not currently taken.
  - Inhaled Corticosteroids (ICS): Prescribed but poorly tolerated (coughing reported post-use of Clenil).
  - Spacer Compliance: Poor adherence with spacer and mask.
  - SABA: Only medication consistently used.
- Key Message with Current Asthma Care
  - Although this patient had only recently been reviewed by their respiratory consultant, there was an extremely important discrepancy in the history with regards to use of the ICS inhaler and his overall asthma control.

Clinical Assessment

- TRACK Score: 25 (improved to 50 on second visit)
- Additional Tests:
  - FeNO: 32ppb
  - Skin Prick Test (SPT): positive 7x5, negative 0, HDM 12x9, grass 3x3, trees 3x3, SB, 3x3, cat 3x3, Alternaria 2x4, Aspergillus 5x4

Housing and Environmental Concerns

- Housing Situation: 3-bedroom council placed home with extensive mould and dampness. Occupants share one room due to mould issues.
  - Housing Association: Brent, awaiting confirmation of managing association.
  - Landlord Issues: Persistent mould and water damage, with landlord response pending.

- Environmental Conditions:
  - Mother's Actions: Regular cleaning with bleach and repainting.
  - Maintenance Challenges: Leak in toilet, ceiling damage, frequent replacement of furniture due to mould.
- Health Impact on Family Members:
  - Mother: Suspected respiratory condition (details pending).
  - 11-Year-Old Daughter: Autism, possible OCD.
  - Suliman: Asthma, rhinitis, food allergy.
  - Other Siblings: Awaiting additional health information.

Findings from Home Visit

Mould: Occupying main bedroom, and second bedroom.

Unable to use these two rooms.

5 people have to share one room as the other rooms feel unsafe.

Factors within control:

Mother keeps the house very clean. Regularly cleans with bleach. Mother repainting surfaces regularly. Everything within her control she seems to be attempting to fix but no significant improvement or resolution in this case.

Factors outside of control:

Leak in the toilet, mould on walls, ceiling appears to be falling in.

Care Plan

1. Medication Adjustments:

- Switch to montelukast granules due to poor tolerance of tablets.
- Fluticasone prescribed (to be administered in-clinic only for trial).

2. Consultation Coordination:

- Paediatric registrar from EYAC notified allergy consultant of medication tolerance issues.

3. Environmental Health Support:

- Community worker home visit scheduled to identify modifiable environmental risk factors.
- Parental consent obtained for assessment.
- Dehumidifier was provided to family to tackle damp / mould provided by the EYP team

4. Housing Advocacy:

- Consider formal housing complaint and referrals to advocacy groups.
- Document costs associated with ongoing repairs (e.g., replacing furniture, painting, cleaning supplies).

5. Benefits and Support:

- Current Benefits: Family has access to Disability Living Allowance (DLA) for older child, but not younger
- Additional Support Needs: Further assessment to explore eligibility for additional support services, grants, or local council assistance for mold remediation and household costs associated with ongoing damage

6. Patient advice:

- Avoid antihistamine 5 days prior to clinic for skin prick testing
- Given a written personal asthma action plan

Feedback from parent:

'I would like to share my positive experience since attending the asthma clinic with my son. Since we started going to the clinic, my son has shown significant improvement; he has fewer asthma attacks and is feeling much better overall. As a mother, I struggled to manage my son's asthma before visiting the clinic, but now I feel much more confident in handling his condition. The doctors took the time to explain everything about the medication and how to use it properly, which has been incredibly helpful. I now know how to recognize the signs of asthma and how to respond effectively. My son has experienced less wheezing and coughing, allowing him to play and enjoy activities more freely. The supportive environment at the clinic made it easy for me to discuss my concerns, and the staff was great at addressing the issues we face at home. They were very supportive and provided valuable insights into how to manage asthma triggers in our property. Overall, our experience at the asthma clinic has transformed how I manage my son's asthma, and I am grateful for the support we've received. Thank you for caring for my son!'

Financial modelling relevant to case study

Cost to family

Replacement of damaged items from excess mould/water leak e.g. replace beds, cupboards, flooring (in excess of £1000.00).

Continued maintenance cost of mould treatment and prevention e.g. regular bleaching and painting (in excess of £500.00).

Economic benefits to patient and family being able to be at school, work and thrive

Cost to NHS

Being prescribed an (preventer) inhaler regularly that patient was not using (£21.99 per month – projected annual cost £263.88)

Likely multiple GP attendances (£56 per visit, assumed 3-4 visits within year for uncontrolled asthma ~£224.00).

Likely A&E attendance(s) with worsening asthma symptoms (minimum cost £86.00 per visit).

Case Study 2

A family with three children, each with multiple atopic diseases including asthma, wheeze, hay-fever and eczema, were invited to the clinic after searches yielded frequent use short-acting-beta-agonists within the one year for all children.

Between them the children had in excess of twenty different inhalers, spacers, nasal sprays emollients, EpiPens, antihistamines and eczema treatment creams. These were being stored together, in a shared location and were sometimes shared between children. This is not deemed good practice for many reasons, including the spread of infection when sharing emollient creams or inhalers. This may also lead to confusion about which medication to administer to which child. To make matters more complicated, the medication was very similar but no necessarily the same. For example, there were at least three different steroid creams of varying strength. On further questioning, different creams were being administered on different locations of the body as well as different children.

Furthermore, we found that sometimes due to the sharing of inhalers, the number of requests for each inhaler were not accurate on their GP records. This can also lead to assumptions that their respiratory tract conditions were more controlled or less controlled than they actually were. The current medication they were each using did not match accurately to the GP records for that child.

Actions taken

The clinicians spent a lengthy amount of time rationalising their medicines – discarding old medication, labelling medications appropriately and separating those for individual children.

Acutely, one child with infected facial eczema was put on a course of antibiotic and steroid.

The family were educated on how and when to use each medication including inhaler technique, and how to apply creams, specifying where the creams were to be applied.

A formal diagnosis of asthma was made and coded.

Skin prick testing was performed, which identified allergies that were previously not detected in skin prick tests done as the children were taking antihistamines at that time i.e. false negative results. Now the family could identify what may be triggering each child.

A dehumidifier was provided to combat mould, which may be triggering asthma symptoms in the children (especially as one was proven allergic to a certain strain of mould tested in the clinic via skin prick testing).

A home visit was undertaken and our community worker was able to work with the family to find a better solution to storing medicines so each child had their own individual medication box.

These simple steps meant that at follow up clinic each child's symptoms were better controlled and the family gave us positive feedback.

Feedback from Parents Attending the EYAC

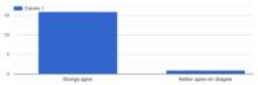
How much do you agree or disagree with the following statements?...

1. "I am very satisfied with this clinic"

   16/17 strongly agree
   1/17 Neither agree nor disagree

2. "I would recommend this clinic to other people like me"

   16/17 strongly agree
   1/17 Neither agree nor disagree



3. "This clinic has increased my confidence in my child's condition"

   16/17 strongly agree
   1/17 Neither agree nor disagree

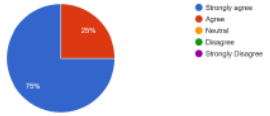
Feedback from Clinicians

How much do you agree or disagree with the following statements: "I feel like I am making a difference when working in this clinic"

4 responses

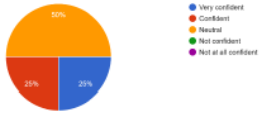
How much do you agree or disagree with the following statements: "I have learned a lot working in this clinic"

4 responses



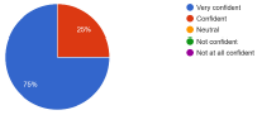
What was your understanding of asthma diagnosis in under 5's before you started working on this clinic?

4 responses



What was your understanding of asthma diagnosis in under 5's after you worked in this clinic?

4 responses



How useful do you think the home assessment was for improving asthma management for the patient?

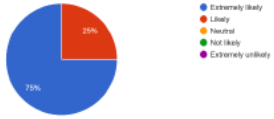
4 responses

How useful do you think the home assessment (e.g mould inspection) was for addressing environmental factors affecti ng the patients asthma?

4 responses

How likely do you think it is that the patient will engage more with asthma management due to the multidisciplinary teams approach and extended appointment time?

4 responses



How likely will your learning from doing this clinic positively impact your future practice in asthma management?

4 responses

How likely are you to implement changes based on your learning from this clinic?

4 responses

How well did the clinic address the social and environmental factors (e.g. housing) affecting asthma management?

4 responses

How much do you agree or disagree with the following statements "The use of Skin prick testing in the clinic had positive impact on the care given the patient"

4 responses

How much do you agree or disagree with the following statements "The use of checking inhaler technique in the clinic had a positive impact on the care given the patient"

4 responses

How much do you agree or disagree with the following statements "The use of providing asthma action plans in the clinic had a positive impact on the care given the patient"

4 responses

'I loved working in this clinic because I felt like I was providing great and holistic care to patients. It made me feel proud to be part of such a worthwhile piece of work. I truly believe we made a difference to the children and families we saw. The extended appointment times and MDT approach were key. I think the skin prick testing was extremely useful and so was having a specialist nurse as part of the clinic.'

'Excellent integrated approach. Learning on all levels. Enhanced clinical and practical knowledge in asthma. Group debrief and learning invaluable.'

'Seeing the patient improvement from the first time they came to the follow-up was fantastic.'

'The Clinic has been incredibly successful for families who often face challenges getting the help they need. Many parents shared how, after seeing multiple healthcare professionals, they finally felt listened to and supported here. The time and care given made a real difference in managing their child's asthma and improving their overall situation. What makes this clinic stand out is its focus on the bigger picture—addressing not just the medical side of asthma but also the social and environmental factors that make managing it harder. Home assessments have been especially helpful, uncovering triggers and giving families practical, personalised advice. Making this service permanent would help bridge the gaps between healthcare and council support, ensuring families get the ongoing help they need. The only thing I would change or want to improve in the future is the presence and support of public health teams and family wellbeing teams, which were missing. These families could benefit greatly from services such as financial benefits checks or housing support. If this clinic or its learning is continued, I would strongly recommend better integration of these teams within the borough and with non-medical services. Asthma is an environmentally driven disease, and we should all be working together to tackle it. If this approach were expanded to reach more families across the borough, it could make a huge difference. It's a clear example of how thoughtful, inclusive care can break down barriers, improve access, speed up treatment and improve outcomes for children with asthma. A similar holistic clinic should be rolled out to all patients with asthma.'

Looking at the anonymised feedback received the clinicians involved, it is clear that a positive impact was made on an individual level. Importantly, there was an obvious increase in understanding of 'Asthma Diagnosis in under 5's' and a unanimous belief that the clinic would positively impact their future practice in asthma management. Furthermore, the importance of the home visits and tackling social determinants in a holistic approach to asthma was made further evident.

Areas for Further Development

A lot of time was invested into the design phase, which left limited time for the initiation and roll out of the project. Recruiting the right team members took longer than anticipated due to the need for specialised skills and the current existing working patterns. This extended timeline required adjustments to the project milestones but also gave us the opportunity to ensure that we onboarded a highly competent and committed team.

The role of the community support worker as new and sometimes there was difficulty engaging with some parents or families, due to potentially a lack of understanding of the role on the family's part. To combat this in future we could send a clear summary of what the role of each clinician involved is with contact details where appropriate. As mentioned in the clinical feedback section, better integration of these teams within the borough and with non-medical services is required. This gap could be bridged by having a key contact such as a community support worker. The pilot highlighted the scope for a much wider role of an integral team member here.

Despite initial logistical and operational challenges, including scheduling, equipment availability, and other logistical hurdles, we successfully launched the clinic in September 2024. Overcoming these issues required collaborative problem-solving and adaptability, setting a strong foundation for ongoing operations. Having demonstrated how effectively the team could establish the clinic in a short-time frame, there is positive aspirations for future clinics.

Sharing findings with specialist relied heavily on clinicians having existing contacts to secondary care clinicians. There is a long-standing issue here between the lack of data sharing and access to records between primary and secondary care. This can lead to further delays in patient care and misunderstanding about any interventions that may have or have not already taken place.

Financial Modelling

Considering costs when setting up any new clinic in a healthcare setting is crucial for several reasons:

Budget Management: With limited funding, managing costs effectively ensures that resources are allocated where they are most needed. This helps to maintain financial sustainability and avoid overspending, which could easily derail the clinic's ability to operate long-term and there hamper any important evaluation data. An executive decision was made not to purchase the correct Eosinophil Point of Care Testing device as the cost was more than three times higher than the initial quoted cost. Given the short time-frame, the device would not have been used enough to justify the cost.

Accessibility: The service needed to be accessible to patients and families. Given this particular neighbourhood covers a wide low-income area, asking patients and families to travel long distances to be seen is more likely to increase 'Did Not Attend (DNA)' rates.

Sustainability: Setting up this type of clinic involves purchasing equipment, hiring clinical and non-clinical staff, securing infrastructure, prescribing medication. Understanding costs and projected helps when comparing to any existing models. The clinic may have a resounding success, however if the cost of running the clinic is significantly more than the current process, there is a strong case to not implement change.

Quality of Care: It is important that you offer care to at least the standard of existing care, with the aim to offer an significantly improvement on the current care model. This can be captured with feedback from parents as well as data collection, specifically here in regards to number of asthma admissions pre- and post-clinic review.

Cost of clinic - per clinic (once a month/1 clinical session)

[1]Equipment – skin prick testing, demonstration spacers/inhalers
[2]Staff – GP, Paediatrician, Paediatric Specialist Nurse, Community Support Worker, Admin, Project Manager

Estimated cost per clinic = £962.00
[assumption that 5 patients reviewed per clinic who are each issued 1 x SABA, 1 x ICS, 1 x spacer and have had skin prick testing, inhaler technique demonstration performed – N.B. this is likely overestimate].

Cost per child per clinic = £192.40

Cost (potential) savings to NHS:

[1]**Admission to A&E unit** - Initial triage assessment by nurse, Paediatric or A&E clinician review. Continued monitoring in A&E or paediatric assessment United for 24 hours, Admission to hospital ward per night, Consultant review per day

[2]**Medication** - Salbutamol nebuliser, Oxygen administration, Prednisone oral, Magnesium Sulphate infusion

[3]**Investigations and clinical interventions**
Cannula insertion, Blood test/pathology tests, Blood cultures, Chest X-ray (£70), Throat swab (£8), Viral PCR tests

[4]**Follow-up costs** - GP review post discharge within 48 hours

[5]**Streamlined administrative processes** - Immediate shared digital records with GP, reduced duplication of tests and delays of information received

The cost of a child attending A&E in the UK with an asthma attack depends on the level of care required. Below is a breakdown based on NHS tariff costs and healthcare reports**:

1. Basic A&E Attendance (No Admission) – £160–£250
If the child is assessed, given inhalers, and monitored without needing nebulisation or oxygen, the cost is around £160–£250.
This includes consultation, basic observations (oxygen levels, peak flow), and discharge with an asthma management plan.

2. A&E Attendance with Treatment (Nebulisation, Oxygen) – £500–£700
If nebulisation, steroids, or oxygen therapy is required, costs increase to around £500–£700.

This includes additional monitoring time, medication, and possible observation for a few hours before discharge.

3. Hospital Admission to a General/Paediatric Ward – £1,000–£2,500
If the child is admitted for further monitoring and treatment (oxygen therapy, IV medications, repeated nebulisation), the cost is £1,000–£2,500, depending on:
Length of stay (typically 1–3 days for moderate cases).
Frequency of nebulisation and staff monitoring.

4. Admission to High-Dependency Unit (HDU) – £3,000–£5,000+
If the child requires continuous oxygen therapy, intravenous medications, or intensive monitoring, the cost is significantly higher.
Typical HDU stays for severe asthma attacks range from 1–3 days, with costs around £3,000–£5,000+.

5. Admission to Paediatric Intensive Care Unit (PICU) – £5,000–£10,000+
If the child is having a life-threatening asthma attack and needs mechanical ventilation or continuous critical care, the costs rise dramatically.
A PICU stay of 3+ days can cost £5,000–£10,000+, depending on interventions like intubation, ventilation, and ICU staffing levels.

6. Other Possible Costs
Ambulance call-out: £250–£300 if taken by emergency ambulance.
Follow-up GP or specialist appointments: Usually covered by the NHS but has associated costs for the system.
Prescriptions: Children under 16 get free prescriptions, but inhalers, steroids, and emergency medications add to NHS costs.

Reviewing one child in the Early Years Asthma Clinic is **equivalent** (likely slight cost saving) to that child attending **A&E once and having no intervention**.

Reviewing one child in Early Years Asthma Clinic, who would have called an ambulance and attended A&E (with no intervention), would save the NHS approximately **£250.00**.

Reviewing one child in the Early Years Asthma Clinic and preventing them from attending A&E with a severe asthma attack is likely to save the NHS **£2257.60**.

Reviewing one child in the Early Years Asthma Clinic, who would have attended A&E and gone on to require HDU care would save the NHS a minimum of **£4557.60**.

From the cost savings of preventing one child from attending A&E and being admitted overnight, more than **two full clinics could be funded** –reviewing **at least ten further children**, all of whom have the potential to further **save the NHS £2257.60 each**, by not attending A&E after being admitted with an asthma attack.

Assuming total of 12 clinics with a total of 60 patients reviewed, if at least 5 are prevented from attending A&E with a severe asthma attack, requiring nebulisers and overnight admission, there would be cost benefit of the clinic. Note, this is only one attendance per child - it is likely that if

these children were not optimised early in this MDT approach, they could frequently attend A&E and therefore incur significantly higher costs to the NHS.

Please note these are estimate costs based on available data. To account for any gross discrepancy the clinic costs were overestimated and cost savings were underestimated.

**References for costing

2023/25 NHS Payment Scheme: 2024/25 prices workbook:
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2023%2F03%2F23-25NHSPS_Annex-A_2024-25.xlsx&wdOrigin=BROWSELINK

National Cost Collection Data Publication 2022/23:
https://app.powerbi.com/view?r=eyJrIjoiOTQwZjIwMiUtNDgwMi00MThmLWJhM2MtNmM5YWY2MTkwM2M4IiwidCI6IiM3YzM1NGIyLTg1YiAtNDdmNS1iMilyLTA3YjQ4ZDc3NGVlMyJ9

Learning Points from EYAC

There were some key learning points from the EYAC for the team involved.

It is important to not assume parents/carers are taking their prescribed medication. Running searches may yield important results but it is importance to cross reference these results with patient histories as they may be requesting medication but not using these.

Education and explanation of medication including the practical aspect of applying or taking medication to parents/carers (e.g. inhaler technique, how to apply creams) is imperative to ensure adequate compliance. Often, during a ten-minute GP appointment, the basics of how to use an inhaler or apply a steroid cream may be missed. Having a specialist nurse in the clinic ensured all patients were thoroughly reviewed with regards to their asthma/inhaler use.

Caution with assessing patients in joint family consultations was highlighted, specifically in Case Study 2, when reviewing the family with three children who present as a single appointment. What was extremely beneficial in this case, was the fact the team individually assessed each patient and not taking a joint history. This reduced the risk of any errors, both on their clinical records, as well as any errors with prescribed medication.

A holistic review of the patient and the family was crucial in tackling any social determinants. Understanding the existing factors which may be attributing to worsening health outcomes for patients is imperative in preventative medicine being practiced.

Importance of home visit to assess social determinants and witnessing the severity of the potentially harmful environment the family is living in. Case Study 1 is an excellent example of this. When a patient mentions mould, very rarely would anyone assume the level of mould would be as widespread as the images in the case study demonstrate.

Being able to address multiple clinical presentations in one clinic e.g. asthma, hay fever, eczema reduced repeated attendances to primary care and therefore increased capacity for other patients. Furthermore, addressing these at an earlier stage prevented worsening of the condition and the potential need for further or more potent medication and even potentially reducing risk of A&E attendances.

Learning for clinicians on all levels was a key aspect of the clinic. We all shared knowledge and were upskilled in different ways. This could then be shared with other clinicians, allowing for increase learning beyond the scope of the clinic/project.

Potential hospitalisation via optimisation of medication was a main aim of the project.

Importance of follow up prior to discharge allowed the clinicians to monitor for any side effects or lack of benefit to any medication changes or interventions.

Thorough history taking and medication review requires time. The patient in Case Study 1 had only recently been reviewed by their respiratory consultant, where it was noted that the patient was using their ICS inhaler appropriately. During clinic review this was found to be incorrect as the patient's mother felt he had an allergy to this. This would have potentially gone unnoticed until his next hospital review which was at least 6 months away.

Better relationships between clinicians and patients can be built with extended. The extended thirty-minute consultations allow for more thorough assessments but also improved rapport, in comparison to the often rushed ten-fifteen minutes primary care routine consultations.

Personal Reflection (as Clinical Lead)

Personally, participating in the EYAC was an invaluable, rewarding learning experience. It gave me the opportunity to work alongside other healthcare professionals, including a paediatric respiratory nurse specialist, a paediatrician with an interest in allergy, and a community support worker all of whom brought unique insights to patient care. I gained valuable knowledge on how to assess and manage asthma or suspected asthma holistically, gaining confidence not only the medical treatment but also understanding the extremely important factors including patient education, lifestyle, and environmental triggers. Observing and arranging regular reviews with the community support worker, the importance of communication with families of patients was really highlighted, and allowed the team to help them understand their child's condition and improve control of their asthma/respiratory condition. Additionally, I witnessed how a collaborative approach can lead to more personalised and effective treatment plans, as was demonstrated in the case studies. Overall, my understanding of asthma and my confidence in reviewing children with asthma improved significantly. Furthermore, the importance of teamwork in delivering high-quality, patient-centred care cannot be emphasised enough.

Next Steps

As the evaluation data is now due and the project is nearing its end date the focus is on data collection. Further data is to be collected, importantly looking at the children who have been reviewed in the clinic and their activity in the next 6 and 12 months. This will include how many times they have presented to A&E/UCC or the GP with asthma related symptoms, how many SABAs they have been issued in this time and how many courses of prednisolone have been issued in this time. Once this data has been collected and analysed it is important to appreciate whether the clinic has had any longer-term impact of the patients that were reviewed. This will support the sustainability discussion. Looking at the current both quantitative and qualitative data, it is clear that there has been a significant positive outcome thus far. If such a significant amount has been established within three months, it is exciting to imagine what could come from sustained funding for this project.

Smoking Cessation in Households with Children Aged 0-5

Background

Smoking is associated with adverse effects on those who partake but the wider impact of passive smoking is important to understand.

People who breathe in second-hand smoke regularly are more likely to get the same diseases as smokers, including lung cancer & heart disease.

Pregnant women exposed to passive smoke are more prone to premature birth and their baby is more at risk of low birthweight and sudden infant death syndrome (SIDS).

And children who live in a household with a smoker are at higher risk of breathing problems, asthma, and allergies.[1]

Opening windows and doors or smoking in another room in the house doesn't protect people. Smoke can linger in the air for two to three hours after you've finished a cigarette, even with a window open. Furthermore, even with limiting smoking to one room, the smoke will spread to the rest of the house where others can inhale it.

[1 https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/#:~:text=When%20friends%20and%20family%20breathe%20in%20your%20secondhand#:~:text=When%20friends%20and%20family%20breathe%20in%20your%20secondhand]

Children and Passive Smoking

Passive smoking is especially harmful for children as they have less well-developed airways, lungs and immune systems. In 2019, it was estimated that passive smoking was responsible for 50,000 child deaths worldwide[2].

[2 GBD 2019 Risk Factors Collaborators Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019]

Children who live in a household where at least 1 person smokes are more likely to develop:

- Asthma
- Chest infections – like pneumonia and bronchitis
- Meningitis
- Ear infections
- Upper respiratory tract infections (coughs and colds)

Passive Smoking and Asthma Association

Stopping passive smoking around young children is crucial in preventing asthma because exposure to passive smoke significantly increases the risk of developing asthma and exacerbates existing asthma symptoms.

Triggers for Asthma Attacks:
Passive smoke contains harmful chemicals that irritate the airways and lungs. For children who are already predisposed to asthma, exposure to smoke can trigger an asthma attack, leading to difficulty breathing, wheezing, coughing, and chest tightness.

Increased Risk of Developing Asthma:
Children exposed to passive smoke during early childhood are more likely to develop asthma. The chemicals in smoke can irritate the developing lungs, impairing lung function and increasing sensitivity to allergens that can trigger asthma.

Impaired Lung Development:
During childhood, the lungs are still developing. Smoke exposure can interfere with this process, resulting in smaller, weaker lungs and reduced respiratory function. Children may more susceptible to asthma and other respiratory conditions.

Heightened Sensitivity to Allergens:
Passive smoking makes children more sensitive to other asthma triggers like dust, mould, pollen, and pet dander. This can lead to more frequent asthma flare-ups and greater difficulty in managing the condition.

Increased Severity of Asthma Symptoms:
For children who already have asthma, exposure to passive smoke can make their symptoms worse, leading to more frequent visits to the GP, hospitalisations, and a greater need for medication.

Long-Term Impact on Health:
Ongoing exposure to passive smoke can contribute to the long-term persistence of asthma in children, possibly leading to chronic asthma into adulthood, as well as other respiratory diseases like chronic obstructive pulmonary disease (COPD).

Objective of Smoking Cessation Pilot

Identify patients under 5 years of age living in Willesden who live with a current smoker and are therefore exposed to tobacco smoke, so that they be clinically assessed and, if appropriate, their parents / carers / relatives can be offered smoking cessation support.

Patient Identification

Search criteria:

0–4-year-olds currently registered with a Brent GP practice who have a SNOMED code for living with a smoker in their GP record.

26 Search run via **EMIS** system found 26 patients

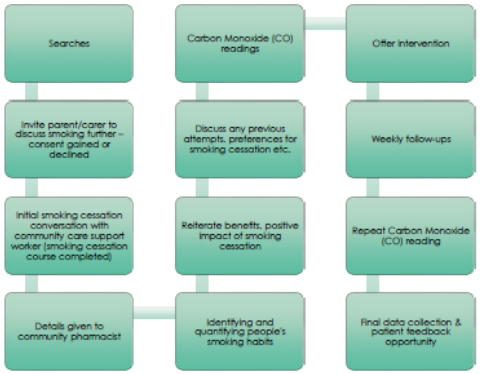
100 Search run via **WSIC** found 100 patients

Patient Review

The Early Years Pilot Brent Create has contracted a local pharmacist with experience in smoking cessation and who is based in close proximity to the Willesden pilot site. Practices within the neighbourhood sent a mass text message communication to identify patients interested in reducing or stopping smoking. To date (January 2025), eight patients have shown interest and have been referred to the pharmacist for review and further advice on the smoking cessations options available. Patients reviewed in the Early Years Asthma Clinic Pilot were proactively screened and referred if appropriate.

The outline of the pilot is summarised below. After the initial triage, patients are invited to a face-to-face review to discuss further details about their options. On initial review they would sign a formal consent form which was reviewed by the North West London current NWL GPs - Data Protection Officer (DPO) GDPR Certified Practitioner. Thereafter, the aim is to perform weekly reviews including Carbon Monoxide testing.

Pharmacists were specifically deemed appropriate for this project as the local service in Brent, The Brent Stop Tobacco service, is currently available for smokers who live or are registered with a GP in Brent, and who: are pregnant or living with someone who is pregnant, are in receipt of mental health support, smokes shisha and/or chews tobacco. The identified patients do not meet these criteria, therefore the project expanded to involve further support in the local community.



Barriers to Smoking Cessation

The following barriers can make quitting smoking a complex challenge, requiring a combination of strategies and support to overcome.

Lack of Local Support and Services, or accessibility to services. Removal of funding avenues from Public Health. Lack of local pathways or stricter guidance of whom to support.

Nicotine Addiction: dependency, making it physically & psychologically difficult to quit.

Habitual Behaviour: Habit forming - making it hard to break the cycle.

Stress & Emotional Factors: Use as mechanism for coping with stress, anxiety, or other emotional challenges.

Social & Environmental Influences: Peer pressure, social circles, and environments where smoking is common can make it harder to quit.

Weight Gain Concerns: Can discourage some individuals from attempting to stop smoking.

Previous Failed Attempts: Can lead to feelings of hopelessness or lack of confidence in one's ability to quit.

During the recruitment phase of the project here, twenty-five percent of the patients that were invited to the clinic declined on account of the fact they do not smoke. Sixty percent who informed the community worker that they did smoke declined any intervention, offering no reason(s).

Category	Number of Patients	Percentage
Total patients contacted	100	100%
Patients who smoke	25	25%
Patients not interested in the service	60	60%
Previous smokers who have already quit	5	5%
Patients with details not shown	10	10%

Table showing outcomes for those that were contacted in the Smoking Cessation Pilot

The project recruited a fairly low number of smokers overall, which was heavily attributed to difficulties obtaining further data about smokers living in household with under 5's as well as a time constraint. Nevertheless, the importance of local pharmacies in this pivotal Public Health matter was highlighted. Pharmacies are easily accessible to the local community. Patients have often already built relationships with their pharmacies and may have sought their expert advice and counselling already.

Financial Modelling

Cost benefit to individual

If a smoker consumes 1 pack per day, this would amount to approximately £4,380 per year. Over 10 years, this is about £43,800 spent solely on cigarettes.

Cost benefit to NHS

According to the NHS and various studies, the annual cost to the NHS of smoking-related diseases is estimated to be around £2.5 billion in England alone.
A 2015 study by the NHS estimated that the average cost of treating a smoker with smoking-related diseases over their lifetime is around £4,000 to £8,000 per person.
If a 40-year-old smoker quits (average age of parent/carer referred to Smoking Cessation Pilot), they are likely to reduce their risk of developing smoking-related diseases by as much as 50% over the next 10 years, depending on their overall health and how long they smoked.
According to the National Institute for Health and Care Excellence (NICE), smokers who quit at 40 can expect to save the NHS an estimated £2,000 to £10,000 over the remainder of their lifetime in avoided healthcare costs (depending on their health status and smoking history).[3]

[3] NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE An Economic Evaluation of Different Interventions to Promote Tobacco Harm Reduction Final Report DR MATTHEW TAYLOR, Deputy Director LILY LEWIS, Research Assistant November 2021:

The above numbers really emphasise the importance smoking cessation has in healthcare. One aspect that is difficult to allocate a number to, is the social value of smoking cessation. In particular here, looking at children whose asthma may be much better controlled as a direct consequence of household member stopping smoking. This could lead to reductions in school absences due to asthma, which may have a positive impact on their education, development and relationships. Children with less well controlled asthma may struggle with physical activities, which could have social implications and physical health related complications later in life. Better social integration, as a direct result of improved asthma control, or in some instances, the prevention of asthma, are likely to contribute to improved mental and physical health. If asthma is not prevented or well-managed in childhood, it can lead to chronic issues that persist into adulthood, limiting their social opportunities and economic potential. Preventing asthma in childhood breaks this cycle, contributing to healthier, more productive adult populations therefore reducing health inequality.

Next Steps

This part of the project is still in process. Once completed, the next step is to gather data on the total number of patients that were reviewed and further data collection around smoking cessation, Carbon Monoxide readings etc. These are to be mapped and projected. A cost saving for the parent/carer is to be calculated along with cost saving to the NHS, using NHS Tariffs.

It is important for future projects to improve existing identification of smokers who are living in households with children. One proposed method from this project, is to screen for this at the GP 6–8-week checks. Here, there could be the introduction of a mandatory field to ask if there any smokers in the house and a direct link to be sent to the household/families for any current smoking cessation pathway. This would rely on existing or presumed consent. General Practices or community pharmacies could be incentivised to identify more smokers in this group as well.

It is clear there needs to be better Public Health understanding and support available around this subject. This relies on a continued funding stream to sustain a service that can effectively improving smoking cessation uptake.

Conclusion

The Brent Early Years Pilot has demonstrated the potential of targeted, community-driven initiatives to address entrenched health inequalities among children under five. By focusing on respiratory health, smoking cessation, and neurodiversity support, the pilot has provided tangible benefits, including improved asthma management, enhanced parental awareness of environmental risks, and tailored support for families awaiting neurodiversity assessments. These achievements underscore the value of integrating specialist clinical care with community engagement and local resources, ensuring that interventions are both effective and culturally sensitive. The pilot's success highlights the critical role of multi-disciplinary teams and voluntary sector partnerships in creating sustainable change for underserved populations.

This initiative also provides key lessons for broader implementation and scaling. Addressing barriers such as information governance delays and workforce challenges requires systemic solutions, including streamlined processes and investment in specialized roles. The Brent pilot's collaborative approach—blending clinical expertise, grassroots innovation, and robust data analysis—offers a blueprint for future projects aiming to reduce health inequalities at scale. By embedding these insights into long-term planning, the pilot sets a strong foundation for transforming early-years health outcomes, not only in Brent but across the wider healthcare system.

Appendix 9a. Optivita Innovation Fund Monitoring and Narrative

	Adult & Community Development Academy	Best Beginnings	Families in Action Together	HASVO	Home-Start Barnet, Brent and Harrow	Ignite Youth
Number of families	28	71	60?	86	n/a	1
Individuals	33	124	80	92	n/a	1
Demographics						
BAME	x	x	x	x		
Single Parents		x	x			x
People on Low incomes	x	x	x	x		
Learning Disability						x
Neurodiversity			x			
Retired/retired age	x					
Working age	x	x				
Unemployed	x					
Refugees			x	x		
Affected by cost of living crisis						x
Limited/no English knowle	x	x				
Health conditions	x			x		
Other			mothers raised in care as children			
Volunteers Involved		n/a	6	7		3
Health Needs						
Social isolation			x			x
Mental health			x			
Language barrier				x		
Chronic health conditions	x			x		
Caring responsibilities	x		x			x
Depression			x			
Anxiety			x			
Lack of support network			x			
Digital isolation	x					
Other		neurodiverse child				
Quotes						
These quotes exclusively	Project Participar	Asian British (I	R, a young mo	Outcome: Moth	Project update	no case study yet
Photos provided	y		y	y		n
Permission to use case s	n		y	y		-

Wider benefits to the community	The Optivita project, though still in progress, has already delivered significant benefits to the community by **increasing health awareness**, promoting **preventive care**, and **fostering social connections**. Workshops and digital outreach have so-far helped boost **health literacy** on essential topics like oral hygiene, immunisations, and chronic disease management, enabling families to make more informed health choices. The project is gradually building a culture of preventive care, with families beginning to prioritise health maintenance to reduce future risks. Peer support networks, particularly for parents managing Type 1 diabetes in children, are strengthening as the project continues. Targeting low-income and refugee families has started to bridge health access gaps, empowering disadvantaged households with critical information and resources. By encouraging healthier lifestyles, such as smoking cessation, the project is contributing to a healthier environment. While ongoing, our project is already helping create a more

Appendix 9b. Families in Action Together

Harrow Giving

Grant Monitoring

Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	Families in Action Together
Name	Samreen Shah
Monitoring Period Duration (mm/YY-mm/YY)	09/2024-11/2024

What has been achieved through your project?

Please fill out the following information for the monitoring period.

How many Harrow families have engaged with your project?	25 through the workshops an average of 11 mums per workshop and 60 through the extra baby bank sessions
How many individuals have engaged with the project?	80
Where in Harrow are the majority of your families living? If possible please provide the postcodes of the families engaged.	
These are some of the postcodes we would be happy to send a comprehensive list if needed HA3 5JA HA3 7EB HA3 7DY HA3 7LZ HA3 7FG HA3 5DQ HA3 7NP HA3 7SA HA3 5DQ HA3 5RJ HA3 8RG HA3 5RT HA3 7NB HA3 5RB HA3 7JS HA3 7PB HA1 4BS HA3 7RT HA3 5FH HA2 8AZ HA3 7SL	

Harrow Giving

HA3 8DX HA1 2BQ HA2 0NQ HA1 1XZ HA3 7SP	
Please describe additional characteristics and demographics of the people who have benefited from this grant? (e.g. single parents, people with disabilities, people from black and ethnically diverse backgrounds, people on low incomes etc.) *If you have specific numbers this would be preferable.*	
- Single mums - Mums with mental health issues - Low income - Refugees - Black & ethnically diverse backgrounds - Mothers raised in care as children	
How many volunteers have been involved in your project?	6

What were the most common types of needs and/or challenges amongst the families you worked with? What rough percentage of visitors experienced these issues?
Among the mothers who participated in the group, all are low-income and face significant financial hardship. Many are single parents without a broad support network—either due to a breakdown in personal or community support or because they are new to the country. A large proportion of these mothers struggle with mental health issues, including depression and anxiety. Some also face challenges related to neurodiversity, such as ADHD. Additionally, a significant number of them have at least one neurodiverse child, which presents further challenges in managing their child's special educational needs (SEN). Two mothers who joined specifically for the workshops shared that they were raised in care, which adds another layer of complexity to their experience.

Harrow Giving is a trading name of Harrow Together (registered charity no. 1167770) and is administered by Voluntary Action Harrow Co-operative

Harrow Giving

What ways has your project made a difference to clients?

The project has created a supportive space where mothers can learn about and discuss issues affecting themselves and their children.

For example, the first session on oral health was very popular, attracting many new mothers. The session provided an opportunity for learning, but participants especially appreciated being able to speak with an oral health specialist about specific concerns related to their children. Several mothers used the opportunity to discuss ways to support their neurodiverse children and found it helpful to learn about referral options to community dental services.

Following the oral health session, we held a discussion session the next week. Many of the group returned and shared how they had applied what they learned, including speaking with their children about oral hygiene. Four mothers mentioned that, since the session, they had made positive changes to their own and their children's oral health routines.

The project has allowed mothers to learn together while also providing a space to discuss challenges and find practical ways to improve their situations. For example, learning about the "Conversation Café" was helpful for mothers who struggle with filling out forms. One mother shared that she had already used this resource since the session.

Through these sessions, mothers have gained awareness of community resources and have felt reassured that they are not alone in facing these challenges. For many, the project represents a first step toward feeling empowered to make positive changes. Since attending, several mothers have expressed interest in pursuing opportunities and services within Harrow to support their families and personal growth.

Tell us about any wider benefits to the community.

Harrow Giving

The project has addressed a strong sense of isolation and loneliness among mothers, which not only affects them but also has a ripple effect on their children. By bringing together women from different backgrounds and connecting them to topics relevant to life in Harrow, the project has provided an opportunity for these mothers to see that they are not alone in the challenges they face—and that there is support available.

On a practical level, the benefits include learning to care for their children's oral hygiene, discovering services in Harrow, and gaining insights into supporting their children's education. On a deeper level, the project has empowered these women to feel more confident in accessing local services and has fostered a sense of belonging in a community where they can find help and resources.

It's been inspiring to see that this experience has motivated some mothers to consider returning to education or work, seeing new possibilities for themselves and their families.

Case Study (MAX 350 words) – Please give a short description of an individual who accessed your project and how your services helped and supported them.

R, a young mother of eight, attended our first session on "Services in Harrow." Raised in care and struggling with mental health challenges, she has faced significant isolation, compounded by the responsibility of raising two children with special educational needs. With limited family support, R often feels overwhelmed and alone.

At her first session, R learned about several local resources, including the Green Doctors (a service that offers advice on energy efficiency and reducing utility costs) and the Conversation Café, a community support space. She also shared her difficulties with housing, and we were able to guide her to the appropriate support services. After this initial session, R expressed a sense of relief, saying, "All my needs have been met today."

Since then, she has become a regular attendee, actively engaging in discussions and making the most of the space. Through the group, she has found a supportive community that provides her with a newfound sense of belonging. For someone who has felt so isolated, this network offers her both practical help and emotional support, forming a safety net she can rely on. By gaining an understanding of the services available, R now feels more empowered to navigate life's challenges and knows she has a place where she is valued and supported.

Do you have photos that can be used alongside the case study?	Yes
Can we (Voluntary Action Harrow and Harrow Giving) use this case study and any photos publicly? It will be placed on our public website and communications.	Yes

Please email any photos, along with this form, to grants@harrowgiving.org.uk

Harrow Giving is a trading name of Harrow Together (registered charity no. 1167770) and is administered by Voluntary Action Harrow Co-operative

Appendix 9c. Ignite Youth

Harrow Giving

Grant Monitoring

Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	Ignite Youth
Name	Patricia Mitchell
Monitoring Period Duration (mm/YY-mm/YY)	01/10/2024 – 31/10/2024

What has been achieved through your project?

Please fill out the following information for the monitoring period.

How many Harrow families have engaged with your project?	1
How many individuals have engaged with the project?	1
Where in Harrow are the majority of your families living? If possible please provide the postcodes of the families engaged.	
HA1	
Please describe additional characteristics and demographics of the people who have benefited from this grant? (e.g. single parents, people with disabilities, people from black and ethnically diverse backgrounds, people on low incomes etc.) *If you have specific numbers this would be preferable.*	
• single parent • care experienced • learning disability	
How many volunteers have been involved in your project?	3

What were the most common types of needs and/or challenges amongst the families you worked with? What rough percentage of visitors experienced these issues?

Harrow Giving

Over the initial stage of the project, we have focused on outreach work to establish contacts and promote the project. We have developed relationships with staff at local organisations who support young mothers, such as Grainery Care, Cariad baby bank, Harrow YMCA & Grange Farm Estate community centre. Many of our contacts have mentioned they know women who would benefit from our service. As part of our outreach, we have already received a referral from Grainery care, a mother and bay assessment unit. We have also promoted our service in local baby banks to reach vulnerable young women who are experiencing financial difficulties, unemployment or have limited access to support and resources. In addition to this, we have attended coffee mornings at local libraries, job centres and primary schools to speak to mothers about our service.

From the community outreach work that we have conducted so far, it is apparent that our support may have to be adapted so that young mums find it easier to access the service. As an example, we are exploring the possibility of delivering a portion of the sessions at Grainery Care, in the mother and baby unit.

What ways has your project made a difference to clients?

Our safe space offers a supportive environment where young mothers can come together, socialise and share experiences. Through discussions and visiting speakers, we hope to improve parental confidence, as well as build knowledge and confidence in accessing available support.

Our weekly one-hour beginners' fitness class encourages young mothers to stay active, increasing physical and mental wellbeing. By engaging in group exercise, it can also reduce feelings of isolation and loneliness.

As well as our exercise classes, we have planned visitors and discussion in the upcoming sessions to cover the topics below:

- Early-years parenting education
- Dental care
- Mental health care
- Postnatal care
- Vision care
- Healthy Relationships
- Early intervention
- Nutritional education
- Employment

Harrow Giving

Tell us about any wider benefits to the community.
The programme has many wider benefits to the community: Reducing poverty and social exclusion: Our young mums' space provides young mothers with access to resources like baby banks, healthcare, job training and financial literacy courses, supporting their immediate needs and also their future goals. Improve mental health and wellbeing: The space offers a safe environment where young mothers can share experiences, reduce feelings of loneliness, and receive emotional support. Stronger community bonds: The group sessions build new relationships between young mothers, fostering a sense of community and reducing social isolation. In addition to this, our young mums' space and benefits serve as a model other communities can adopt, extending its impact and reaching more people.
Case Study (MAX 350 words) – Please give a short description of an individual who accessed your project and how your services helped and supported them.
As we have focused the first stage of the project on outreach work, we haven't seen enough of an impact on an individual to provide you with a meaningful case study. Once we establish regular sessions, we look forward to providing you with a case study on how our services have helped and supported them.

Do you have photos that can be used alongside the case study?	☐Yes ☐No
Can we (Voluntary Action Harrow and Harrow Giving) use this case study and any photos publicly? It will be placed on our public website and communications.	☐Yes ☐No

Please email any photos, along with this form, to grants@harrowgiving.org.uk

Appendix 9d. HomeStart (Barnet, Brent, and Harrow)

Harrow Giving

Grant Monitoring

Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	Home-Start Barnet, Brent & Harrow
Name	Guljabeen Rahman
Monitoring Period Duration (mm/YY-mm/YY)	08/24 – 10/24

What has been achieved through your project?

Please fill out the following information for the monitoring period.

Dad Matters Project Update

As this is a new area of work for us, the project has taken some time to get off the ground. There have been particular challenges around engagement with NHS and midwifery, including locality teams. Although there has not yet been interaction with parents in the reporting period, key achievements during this time have been:

Recruitment and Induction:

We have spent the first few months of the project focussing on recruitment and induction of a Dad Matters Coordinator. The post holder commenced in role from September. Since joining, he has completed an induction to the role and has attended several training courses on Parenting, Train the Trainer and Parent Infant Mental Health, which will enable him to provide 1-2-1 support as well as deliver workshops as the project develops.

Marketing and Development:

- Development of promotional material including posters, banner and branded uniform
- "Dear Dads" leaflet with information, resources and signposting details
- Social media including Facebook and dedicated webpage for project

Outreach and Engagement:

- Meetings with local stakeholders and voluntary sector groups, including Blossom
- Permission sought to start weekly engagement at Northwick Park Hospital maternity ward from 19th November
- An outreach plan is in place to visit community maternity venues, display posters and distribute leaflets (now printed) and engage with fathers.

We are confident that the work will pick up momentum towards the end of November, and we will be able to report on actual engagements and planned outcomes in time for the next monitoring report.

Harrow Giving

How many Harrow families have engaged with your project?	N/A
How many individuals have engaged with the project?	N/A
Where in Harrow are the majority of your families living? If possible please provide the postcodes of the families engaged.	
N/A	
Please describe additional characteristics and demographics of the people who have benefited from this grant? (e.g. single parents, people with disabilities, people from black and ethnically diverse backgrounds, people on low incomes etc.) *If you have specific numbers this would be preferable.*	
N/A	
How many volunteers have been involved in your project?	N/A

What were the most common types of needs and/or challenges amongst the families you worked with? What rough percentage of visitors experienced these issues?
N/A
What ways has your project made a difference to clients?
N/A
Tell us about any wider benefits to the community.
N/A
Case Study (MAX 350 words) – Please give a short description of an individual who accessed your project and how your services helped and supported them.
N/A

Do you have photos that can be used alongside the case study?	☐Yes ☐No
Can we (Voluntary Action Harrow and Harrow Giving) use this case study and any photos publicly? It will be placed on our public website and communications.	☐Yes ☐No

Please email any photos, along with this form, to grants@harrowgiving.org.uk

Appendix 9e. Adult & Community Development Academy

Harrow Giving

Grant Monitoring

Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	Adult & Community Development Academy (ACDA)
Name	Vick Virdee
Monitoring Period Duration (mm/yy-mm/yy)	06/24 to 10/24

What has been achieved through your project?

Please fill out the following information for the monitoring period.

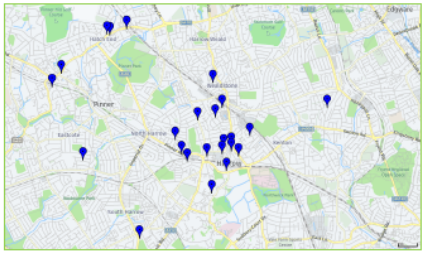
How many Harrow families have engaged with your project?	28
How many individuals have engaged with the project?	33

Where in Harrow are the majority of your families living? If possible, please provide the postcodes of the families engaged.

The table below shows a breakdown of the Harrow postcodes for all the project participants:

POST CODES	PEOPLE	POST CODES	PEOPLE
HA1 4ED	1	HA1 4NA	1
HA1 1EH	1	HA1 4TF	1
HA1 1JU	1	HA2 8PZ	1
HA1 1LD	1	HA3 5RF	1
HA1 1TH	1	HA3 9HR	1
HA1 1XZ	1	HA5 1NE	2
HA1 2BQ	1	HA5 2AR	2
HA1 2BX	1	HA5 3LW	2
HA1 2HD	1	HA5 4EE	1
HA1 2SE	2	HA5 4HP	1
HA1 2TB	1	HA5 4JS	1
HA1 3DN	1	Other	5
HA1 4EU	1	**TOTAL**	**33**

The map below shows a map with the Harrow postcodes for all the project participants:



Harrow Giving

The table below shows a breakdown of the demographics and additional characteristics of the project's participants focusing on gender, age, employment status, education, ethnicity and ESOL level.

GENDER:	
Female	23
Male	10
AGE GROUP:	
19 - 24 years	1
25 - 34 years	6
35 - 44 years	10
45 - 54 years	6
55 - 65 years	4
65 - 74 years	4
75 years or over	1
Not provided	1
EMPLOYMENT STATUS:	
Employed	5
Unemployed	13
Out of work - looking for work	7
Out of work - NOT looking for work	5
Studying	2
Not provided	1
EDUCATION:	
Below Primary education	6
Lower secondary education or equivalent	8
Upper secondary education or equivalent	5
Post-secondary education or equivalent	4
Higher education or equivalent	10
ETHNICITY:	
Asian or Asian British - Afghani	1
Asian or Asian British - Chinese (Hong Kong)	11
Asian or Asian British - Indian	6
Asian or Asian British - Nepali	2
Asian or Asian British - Other	2
Asian or Asian British - Sri Lankan	1
Asian or Asian British - Pakistani	3
Black or Black British - African	4
Other Ethnic Group - Arab	1
White - Other	2
ESOL LEVEL:	
Pre-entry	13
Entry 1	9
Entry 2	8
Entry 3	2
Level 1	1

2

Harrow Giving

The table below shows the breakdown of the main barriers experienced by the project's participants:

BARRIERS:	
Lack of confidence	11
Low income	25
Low skilled	14
Not having a Level 2 in Maths and English	19
English language needs	33
Digitally excluded	27
Negative experience of education	4
Long-term health conditions	1
Aged 50+	11
Childcare responsibilities	21

The key highlights from the above identified barriers are:

- 100% of the project's participants identified their low **English language skills** as a main barrier.
- Almost 75% of those who we engaged with on the project were on a **low income.**
- Around 80% had stated that their lack of or low **digital skills** were an issue.
- About 63% of those who engaged with the project highlighted their **childcare responsibilities** as being a challenge.

Another significant barrier noted as one of the largest issues for non-engagement was childcare. We had several parents who were very keen to join our sessions but were not able to as they didn't have adequate childcare in place or expected our service to provide a crèche facility. This meant that many individuals missed out on accessing our sessions.

For future sessions we will be taking the above into account when planning our delivery to ensure that as many Harrow residents who are suitable can engage with our project's activities.

Our English and IT for Health is a programme of learning about child and family health matters, accessing support and services, raising awareness and building confidence for speakers of English as a second language. Health inequalities are higher amongst those who have English as an additional language needs. When English is not your first language, navigating a new healthcare system can be an overwhelming challenge.

The groups we are working with were statistically more likely to develop conditions such as heart disease, stroke, diabetes, respiratory health, experience baby loss and miss vital appointments for vaccinations and screening checks. This programme helped to address many if these issues in a relaxed and engaging manner that was also accessible while supporting participants to improve their health knowledge, understand the relationship between services and individuals, interact effectively, and make informed decisions.

Our ESOL and IT for Health programme has provided Harrow residents with the chance to learn and develop important skills that will in turn lead to better opportunities and outcomes for them and their families which can profoundly impact their future.

Harrow Giving

By engaging with our ESOL and IT for Health programme participants have reported improvements in the following areas:

- Level of English language skills
- Confidence in speaking in English
- Level of Digital Skills (IT)
- Understanding of local Children's Health Services in Harrow
- Overall understanding of the importance of Health
- General confidence, self-esteem and wellbeing

Participants were asked whether they were registered with a GP and with a Dentist. This was to ensure that anyone who wasn't registered would be provided with the relevant information to help them get registered especially as we were supporting a number of participants who were recent arrival to the UK.

We also asked participants whether they were confident in:

- Booking an appointment with their Doctor / Dentist / Nurse or Health Professionals
- Speaking with a Doctor / Dentist / Nurse Health Professionals in person or over the phone
- Attending an Online Doctor's Appointment / Consultation e.g. using 'PATCHS'
- Asking the pharmacy for help and advice
- Using NHS 111
- Using NHS App
- Describing your / your child's symptoms and pain

Separately we asked participants whether they

- Understood the benefit of vaccinations for them, their child(ren) and their family
- Had (or plan to have) a Covid-19 or Flu vaccination
- Knew if their child(ren) had their childhood immunisation vaccinations
- Understood what a healthy diet is
- Understood how their weight can affect them and their child's health
- Knew where to go or who to ask for support or resources that can help you take care of your wellbeing and mental health

Answers to the above helped our trainers to ensure that the programme was tailored to address identified gaps and was relevant to them individually so that they could benefit as much as possible from our programme.

Our community-based ESOL & Digital Skills for Health outreach service aimed at reducing barriers to health engagement by actively engaging with Harrow communities who are disproportionately disadvantaged and are at greater risk of poorer health outcomes due to their lack of English language and digital skills.

The overarching aim of our project was to reduce identified health inequalities by empowering and upskilling some of the most vulnerable families in Harrow through a tailored ESOL and Digital Skills for Health programme.

We created a dedicated network of community-based hubs led by ESOL & IT Health Trainers at specific
ow around the local community within libraries and children's centres where
with and support our target group.

were pregnant women and those with children under 5 years of age. However, our programme was open to other members of the family including fathers and grandparents who also want to attend sessions to develop their English language and IT skills and, in the process, also improve their own knowledge around health and to find out about relevant local health services and agencies.

Harrow Giving

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Project Participant Name: [redacted]

[redacted] is a 45 year old mother living in Harrow. She is married with 3 children under the age of 16 years. There are 5 people in total who live in her household.

She is originally from India and could not speak a word of English when she arrived in May 2010.

Her education level was below primary level and her ESOL level was assessed as Pre-entry level.

[redacted] had a limited understanding of the education system. She lacked confidence, had low digital skills and poor English language skills.

[redacted] found out about our ESOL and IT for Health programme and was very keen to join as really wanted to improve her English language skills so she could speak independently and confidently with her doctor.

[redacted] has an autistic son; he was a main motivator in her joining the programme as she has to speak with several health professionals.

[redacted] joined our programme in October and has already seen improvements in not only her language skills but also her understanding of using the NHS app, speaking to her pharmacy, the importance of vaccinations and being able to describe her child's symptoms to health professionals.

Feedback from [redacted]

"My experience has been great. I am very happy because now I can speak [a] little bit of English and am learning new words. I feel very safe in class. I feel good when I come to learn it helps me gain confidence."

"I have felt a big boost in my speaking power. When we speak in class and do drama activities I enjoy a lot. In future I want to do a simple job."

[redacted] has given her explicit consent for her feedback and photo to be used for this case study.

	☑ ☐
	☐ ☑

Appendix 9f. Best Beginnings

Harrow Giving

Grant Monitoring

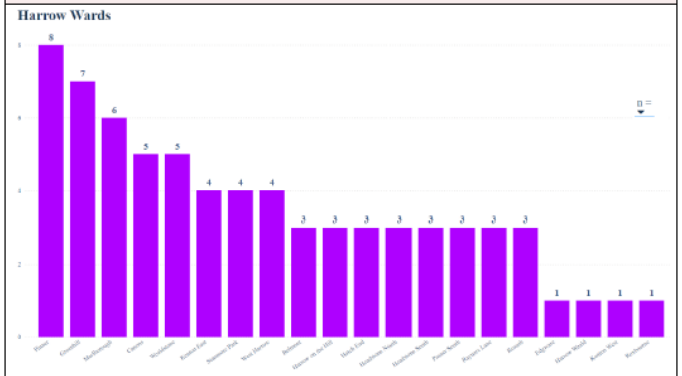
Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	Best Beginnings (Baby Buddy)
Name	Alex Paterson – Head of Impact
Monitoring Period Duration (mm/YY-mm/YY)	May-Oct 2024

What has been achieved through your project?

Please fill out the following information for the monitoring period.

How many Harrow families have engaged with your project?	71
How many individuals have engaged with the project?	124

Where in Harrow are the majority of your families living? If possible please provide the postcodes of the families engaged.



Pinner, Greenhill and Marlborough were the Harrow wards with the highest number of registrations for the Baby Buddy app over the reporting period, with 8, 7 and 6 registrations respectively.

Harrow Giving

Please describe additional characteristics and demographics of the people who have benefited from this grant? (e.g. single parents, people with disabilities, people from black and ethnically diverse backgrounds, people on low incomes etc.)

If you have specific numbers this would be preferable.

Over the reporting period, the Baby Buddy app reached 71 families in Harrow.

Between May and October 2024, around 70% of users were mothers, and almost 21% were co-parents or fathers. Around 6% were healthcare professionals. Around two-thirds of parent users in Harrow were aged between 30-39 years old (66%). 21% of users were aged between 25 and 29 years old. The remainder 13% were over 40 years old. There were no users aged under 24 years old. Less than a fifth of the Baby Buddy app parent users in Harrow identified as White (18%), and more than half identified as Asian (52%). About 6% identified as Black or Mixed. Another 4% identified as Other ethnicities, and 20% chose not to share the ethnicity they identify as. Most users in Harrow spoke English as their first language (82%). The other top languages spoken were Gujarati, Romanian, Polish, German and Tamil.

More than half of users did not disclose their household income (58%). Around 9% of users were earning under £25k. More than 25% earned over £45k. Over half of all users were in a paid job (58%). Around 13% were on parental leave, and 4% did not currently have a job due to being a student or other reasons. Over 25% did not disclose their employment status (withheld or blank responses).

During the reporting period, over half of all parent users in Harrow signed up for Baby Buddy in the first six months immediately after birth (53%). More than 24% signed up for Baby Buddy during pregnancy - of all three trimesters, Trimester 2 was the period with the highest uptake. When parents sign up to the Baby Buddy app, they are asked whether they are on their own, with the dad, with the mum or with their partner (4). During the reporting period, there were 2 single parents who identified as female (responded that they are on their own).

How many volunteers have been involved in your project?	NA

What were the most common types of needs and/or challenges amongst the families you worked with? What rough percentage of visitors experienced these issues?

Harrow families viewed in-app content, including written articles, videos, glossary terms and FAQs at least 453 times over the reporting period. Below are the top 10 Discover articles and videos viewed by users across Harrow during this period, which gives insights into their needs/challenges:

Top 10 Written Articles	Views
Which vaccinations can my child have and when?	5
Should I have the "whooping cough" vaccine when I'm pregnant?	4
What should I do when my baby starts teething?	4

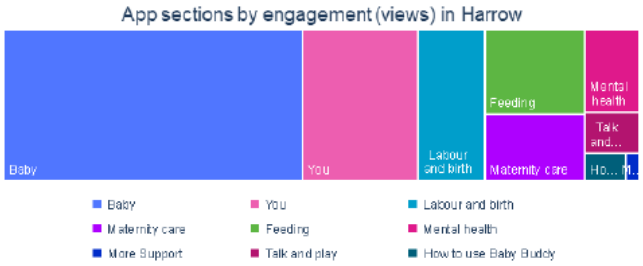
Harrow Giving

What are the best positions for labour and birth?	4
Dads can use Baby Buddy too	4
When should I start my antenatal care?	3
When will my baby start to talk?	3
How do you burp a baby?	3
How do I take care of baby teeth?	3
What are my choices for pain relief in labour?	3

Top 10 Videos	Views
MRI scans at different points during pregnancy	71
Cuddling and movement	7
The "traffic light" system	6
Is my baby growing?	5
What your baby is telling you	5
Is my baby moving enough?	5
Your tummy muscles	4
Chatting with baby	4
What is an active birth?	4
Recognising sleep states	4

What ways has your project made a difference to clients?

The app section most engaged with by users in Harrow over the reporting period was the Baby section with 239 views. This means that parents are most often using the app to track to get support to understand their baby's growth during pregnancy or after birth. A significant number are also looking to the app for support with their own well-being, with infant feeding and birth choices/maternity care also being important topics.



Harrow Giving

Our most recent app-wide analysis of family experiences shows that 99% of parents using Baby Buddy say it is easy to use and has helped them to take care of their children. Baby Buddy increases the confidence of parents (94%) and supports users to get more out of their engagement with Healthcare Professionals (76%); whilst improving breastfeeding, parental self-efficacy, maternal and infant bonding and strengthening multi-disciplinary working amongst healthcare professionals.

Tell us about any wider benefits to the community.

The Baby Buddy app supports timely access to healthcare services, by providing personalised daily information from conception to a child's first birthday and signposting families to relevant services and NHS resources. Both internal and external evaluations have found evidence that Baby Buddy strengthens relationships, improves parental knowledge and confidence, supports breastfeeding and bonding and improves parental mental health.

As part of this project, we have been running/promoting targeted ads for Harrow residents/families. The first was posted 1st October (for 2 weeks) and 25th October (for 2 weeks). These ads have now been seen 112, 951 times with 951 viewers clicking through to download the Baby Buddy app. This means there is now a wider awareness of the Baby Buddy offer across the community in Harrow. In the next phase of the project, we will be running further targeted promotions, as well as distributing print collateral (stickers and posters) across the borough, further building awareness of this support across the community.

Ad / content:	Location:	Total impressions:	Total reach:	Link clicks:	Total engagement:	Engagement rate:
Baby Buddy Promotion 1	Harrow (+ 10 mile radius)	30,232	19,323	279	279	1.4%
Baby Buddy Promotion 2	Harrow (+ 10 mile radius)	82,719	54,248	645	645	1.2%
Total social media ads performance:		**112,951**	**73,571**	**924**	**924**	**1.3%**

Case Study (MAX 350 words) – Please give a short description of an individual who accessed your project and how your services helped and supported them.

Harrow Giving

Asian British (Bangladeshi) First Time Mum, 27 Years old with a 9-Month-Old Child, Living in London *I am a Mum to my first child who is five weeks old. Being a Mum is so rewarding and these past five weeks have been great. My son is growing really well and although it has been hard adjusting after having a C section, my husband has been fantastic at supporting me. I first discovered Baby Buddy when my husband noticed it on a billboard at the hospital when we went for our twelve week scan. Since then, I have been using it every day and always read the daily article. It is so simple to use and the menu at the bottom makes everything straightforward. It answers all of my pregnancy and baby related questions. For example, when my son had his BCG jabs coming up, I went on the app and it told me exactly what it is and what to expect. I have found the transition between pregnancy and birth within the app to be seamless. I was overdue and found some really helpful information about what to expect with induction, which helped me to feel prepared. I have used lots of the videos and find that I can always find what is relevant to me at the time. When I was pregnant, I was watching videos about pelvic floors and since my baby has arrived, I have been watching the videos about building core strength. I love using 'my space' to save videos and frequently share what I have learnt on the app with my husband as well sharing the updated with my siblings on our group chat!*	
Do you have photos that can be used alongside the case study?	☐Yes X **No**
Can we (Voluntary Action Harrow and Harrow Giving) use this case study and any photos publicly? It will be placed on our public website and communications.	☐**Yes** X No

Please email any photos, along with this form, to grants@harrowgiving.org.uk

Appendix 9g. Harrow And Somali Voluntary Organisation (HASVO)

Harrow Giving

Grant Monitoring

Unique Reference Number	Ref: [OPEYI0224]
Fund	Optivita Parents & Early Years Innovation Fund
Organisation	HASVO
Name	Yusuf Yusuf
Monitoring Period Duration (mm/YY-mm/YY)	07/24 – 10/24

What has been achieved through your project?

Please fill out the following information for the monitoring period.

How many Harrow families have engaged with your project?	86
How many individuals have engaged with the project?	92

Where in Harrow are the majority of your families living? If possible please provide the postcodes of the families engaged.

Area	Number
HA0 1	1
HA1 1	3
HA1 2	8
HA1 4	5
HA2 0	26
HA2 6	2
HA2 8	5
HA2 9	4
Ha3 4	1
HA3 5	14
HA3 7	6
ha3 8	1
HA4 0	1
HA5 5	1
HA6 1	3
HA7 1	2
HA7 2	1
Ha7 3	1
HA7 4	1
HA8 5	1
HA8 6	5
Grand Total	92

Harrow Giving

Please describe additional characteristics and demographics of the people who have benefited from this grant? (e.g. single parents, people with disabilities, people from black and ethnically diverse backgrounds, people on low incomes etc.)

If you have specific numbers this would be preferable.

Gender	Total
Female	75
Male	17
Grand Total	92

Ethnicity	Total
Arab	23
Black - African	69
Grand Total	92

100% of the direct beneficiaries were from low income households

152 were further reached by WhatsApp

How many volunteers have been involved in your project?	7

Harrow Giving

What were the most common types of needs and/or challenges amongst the families you worked with? What rough percentage of visitors experienced these issues?

The most common types of needs and challenges among the families served by the Optivita project included:

1. **Language Barriers**:
   - Families, particularly those from refugee and low-income backgrounds, often struggled with language barriers, impacting their ability to access health services and information.
   - **Estimated Prevalence**: Approximately 60% of participants faced language-related challenges.
2. **Lack of Health Literacy and Information**:
   - Many families lacked essential knowledge about preventive healthcare measures, including oral health, routine immunisations, and the importance of early dental registration.
   - **Estimated Prevalence**: About 70% of participants encountered challenges related to health literacy.
3. **Chronic Health Conditions**:
   - Parents of children with chronic conditions like Type 1 diabetes faced specific challenges, including difficulties managing the transition to self-management for their children.
   - **Estimated Prevalence**: Roughly 20% of participants dealt with issues related to managing chronic conditions.
4. **Limited Access to Preventive Services**:
   - Some families were unfamiliar with available preventive services, such as smoking cessation support and routine immunisations.
   - **Estimated Prevalence**: Approximately 50% of families had limited access to or awareness of preventive services.
5. **Financial Constraints**:
   - Being from low-income households, all families faced financial constraints that affected their ability to prioritise health needs.
   - **Estimated Prevalence**: 100% of visitors faced economic challenges as they were all from low-income households

Harrow Giving

What ways has your project made a difference to clients?

The Optivita project has made a significant impact on clients in the following ways:

1. **Increased Access to Health Services**:
   - The project assisted parents in registering with NHS dentists, overcoming language and informational barriers. This proactive approach has enabled families to prioritize preventive care, reducing future health complications.
2. **Improved Health Literacy**:
   - Through workshops on oral health, diabetes awareness sessions, and leaflets on routine immunizations, the project has raised awareness among families about essential health practices. This knowledge has empowered parents to make informed decisions and take preventive actions for their children's health.
3. **Support for Chronic Condition Management**:
   - The diabetes awareness sessions provided a platform for parents to share experiences and learn from others managing Type 1 diabetes in their children. This support has helped ease the transition to self-management, preparing parents for future challenges and improving the care quality for children with chronic health conditions.
4. **Promotion of Healthier Lifestyles**:
   - By providing information on smoking cessation resources, the project encouraged healthier behaviors among parents, benefiting both them and their families. Many parents expressed gratitude for this support, noting it as an invaluable resource for themselves or their partners.
5. **Enhanced Awareness of Immunizations**:
   - Reminding parents about routine childhood immunizations ensured that essential vaccines were not missed. This has helped maintain high immunization rates among young children, reducing the risk of preventable diseases within the community.
6. **Tailored Support for Refugee and Low-Income Families**:
   - Recognizing the unique needs of refugee families and those from low-income backgrounds, the project provided culturally sensitive and accessible support. This focus on inclusivity has fostered a supportive environment, making it easier for these families to navigate health challenges despite language and financial barriers.

Harrow Giving is a trading name of Harrow Together (registered charity no. 1167770) and is administered by Voluntary Action Harrow Co-operative

Harrow Giving

Tell us about any wider benefits to the community.

The Optivita project, though still in progress, has already delivered significant benefits to the community by increasing health awareness, promoting preventive care, and fostering social connections. Workshops and digital outreach have so-far helped boost health literacy on essential topics like oral hygiene, immunisations, and chronic disease management, enabling families to make more informed health choices. The project is gradually building a culture of preventive care, with families beginning to prioritise health maintenance to reduce future risks. Peer support networks, particularly for parents managing Type 1 diabetes in children, are strengthening as the project continues. Targeting low-income and refugee families has started to bridge health access gaps, empowering disadvantaged households with critical information and resources. By encouraging healthier lifestyles, such as smoking cessation, the project is contributing to a healthier environment. While ongoing, our project is already helping create a more resilient, connected, and health-aware community

Harrow Giving

Case Study (MAX 350 words) – Please give a short description of an individual who accessed your project and how your services helped and supported them.

Case Study: Oral Health Workshop

Background:
Mother Z attended an Oral Health workshop organized by HASVO, aimed at providing parents and caregivers with practical knowledge and resources for children's oral health care. During the workshop, Mother Z received an urgent phone call from her son's school, informing her that her son had a fall and lost his two front teeth. Distressed and unsure of the next steps, she shared her concern with the on-site oral health professional.

Intervention:
Upon hearing about the incident, the oral health professional immediately offered guidance to Mother Z. She explained the recommended steps for handling the loss of a child's teeth in an emergency, including:

- **Immediate Dental Care:** Advising Mother Z to contact a dentist immediately to assess her son's oral health.
- **Preserving Lost Teeth:** Educating her on the importance of placing lost teeth in milk to preserve them, as well as promptly transporting them to a dentist for potential reattachment.
- **Further Medical Attention:** Suggesting an x-ray to check for any additional trauma, such as damage to the gums or underlying adult teeth, to prevent future complications.
- **Follow-up Support:** Offering reassurance that if Mother Z's regular dentist was unable to see her son that day, HASVO would provide additional support to secure an appointment with a dentist urgently.

Outcome:
Mother Z expressed immense gratitude for the support and practical advice she received at the workshop. In her feedback, she shared:

"I benefited greatly from the workshop. I was able to seek advice on whether my child needed to see a dentist after his fall. I was advised on how to care for the lost teeth by placing them in milk, to see a dentist immediately, and that he might need an x-ray to check for any trauma to his gums or underlying adult teeth. The oral health professional even assured me that if my dentist couldn't see my son that day, she would follow up through HASVO to assist in getting a dentist. I was very grateful. Her advice meant I knew what to do to help my child, what to expect at the dentist, and what to do if I couldn't find a dentist."

Do you have photos that can be used alongside the case study?	Yes
Can we (Voluntary Action Harrow and Harrow Giving) use this case study and any photos publicly? It will be placed on our public website and communications.	Yes

Please email any photos, along with this form, to grants@harrowgiving.org.uk

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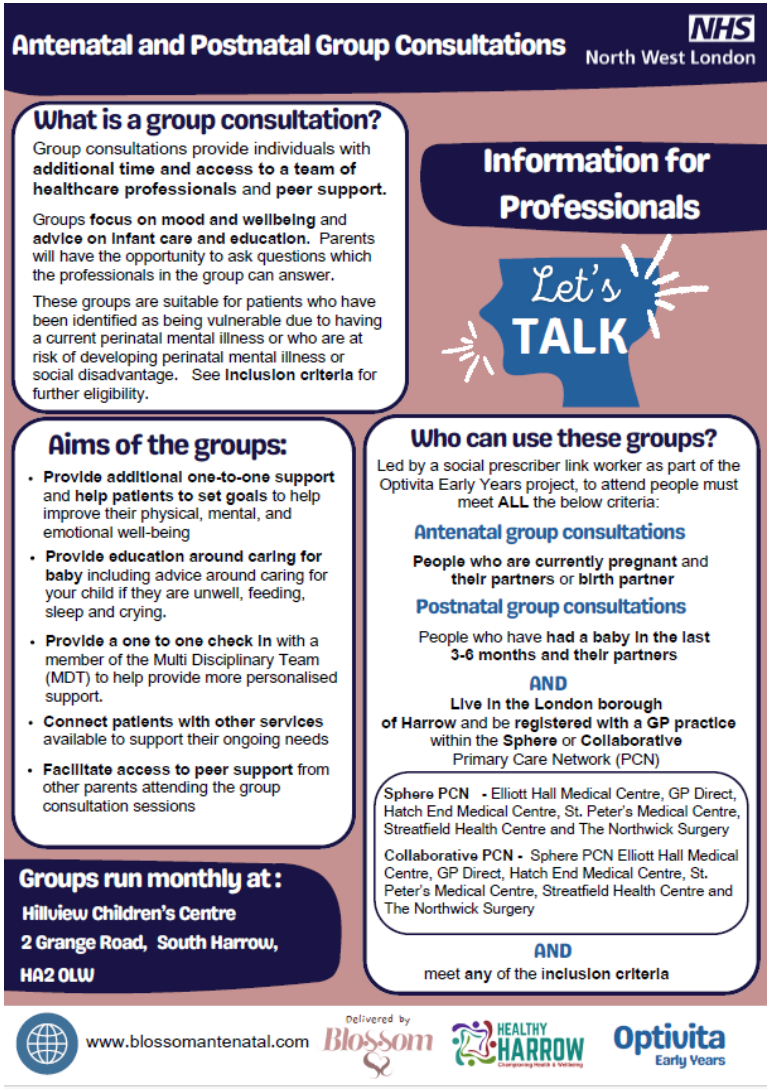
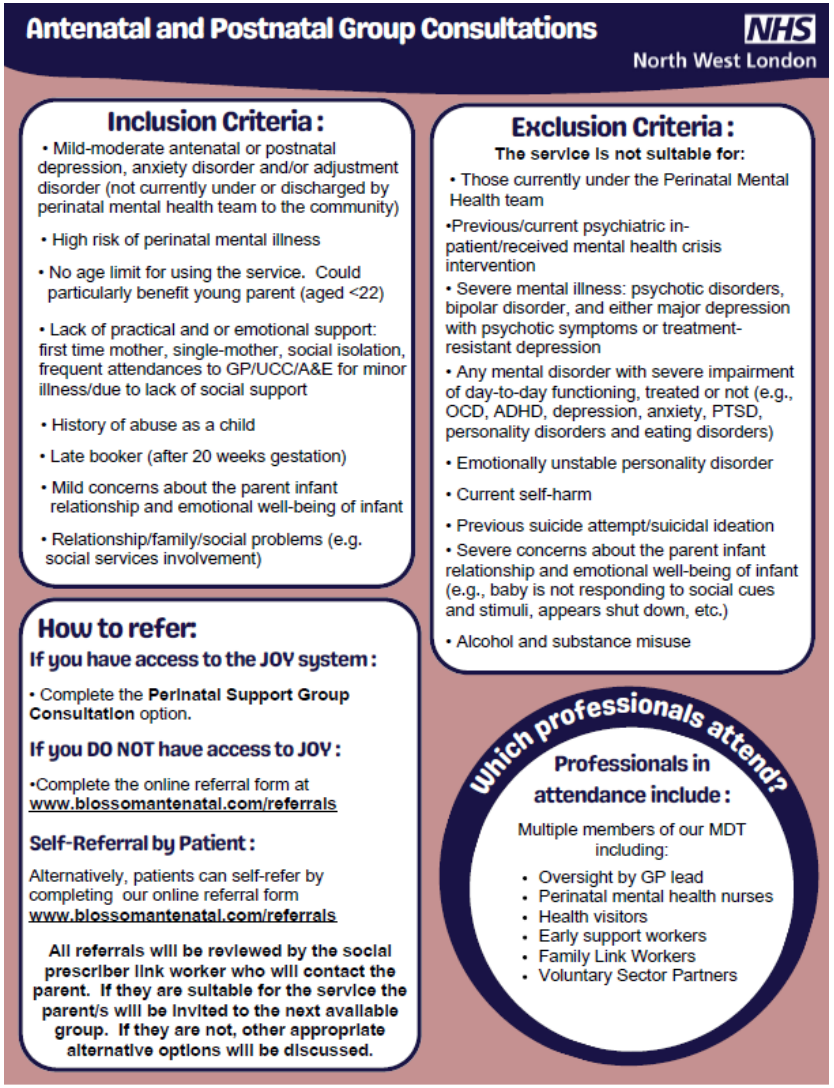
Appendix 10. Postnatal Group Consultations invitation





What can you expect?

- Develop goals and strategies to help you look after your physical and mental health
- Help you improve your confidence around how to care for your baby
- Give you advice about and connect you with other services available for ongoing support for your specific needs e.g. referral to Home-Start volunteer family support or access to children's centre classes.

How can I be referred?

Please speak to your **GP, health visitor or children's centre** about being referred to us.

Alternatively, **you can self-refer** by completing our self referral form. Visit **www.blossomantenatal.com/referrals**

What happens after I have been referred?

All referrals will be **reviewed by the social prescriber link worker (SPLW)**, and if this service is suitable for your needs, you will be contacted with appointment details.

If there are more appropriate alternative services for you, we will let your GP/you know so that this can be discussed with you.

You will be contacted by our SPLW inviting you for an appointment and asking you to complete a consent & confidentiality form and questionnaire which must be returned before you can attend.

NHS North West London

Antenatal and postnatal support

Let's TALK

Pregnant or new parents?

It's important to talk about how you feel

Antenatal and postnatal group consultation support in the London Borough of Harrow

How to access urgent help

Please be aware that our support group is not an urgent or emergency healthcare service. If you require help urgently, please contact your GP if within their working hours or 111. In an emergency dial 999.

Delivered by Blossom

HEALTHY HARROW Championing Health & Wellbeing

Optivita Early Years

How are you feeling ?

Whether you are pregnant or have just had your baby we are here to listen and offer support if you feel you need it.

We know that when you are pregnant, or when you become new parents, especially first-time parents, there can be pressure to feel like you must be happy all the time. It can become really difficult to talk about any negative feelings you may have.

Adjusting to life with a new baby can be tough, and it is very common and normal for parents to feel anxious and overwhelmed at times. **It is important to talk about how you feel and to get the support you need.**

How can we help ?

To help if you are having difficult feelings, we are running **antenatal and postnatal group consultations** at the Hillview children's centre. We aim to provide you with some extra support for your physical and mental health and well-being.

We are a team of mental health practitioners, early support children's centre staff, link workers and charity partners, with GP input, who are here to support you.

- ✓ You will be able to attend one group consultation with other parents and a team of healthcare practitioners.
- ✓ Together, we will discuss topics and answer your questions around caring for your new baby and how to look after your wellbeing and mood.
- ✓ You will also get a one-to-one check in with one of our team for more personalised support.

Who can use these groups?

Antenatal groups

People who are currently pregnant and **their partners** or **birth partner**

Postnatal groups

People who have **had a baby in the last 3-6 months and their partners**

Open to anyone :

Living in the London borough of Harrow who is **registered with a GP practice** within the **Sphere** or **Collaborative** Primary Care Network (PCN). See the below list of surgeries.

Sphere PCN - Elliott Hall Medical Centre, GP Direct, Hatch End Medical Centre, St. Peter's Medical Centre, Streatfield Health Centre and The Northwick Surgery

Collaborative PCN - Sphere PCN Elliott Hall Medical Centre, GP Direct, Hatch End Medical Centre, St. Peter's Medical Centre, Streatfield Health Centre and The Northwick Surgery

AND - If any of the following applies :

- Struggling with feelings of anxiety or depression
- Have a diagnosis of mild to moderate anxiety or depression
- Feel isolated and/or don't have much access to support from their community, family or friends and feel like some extra support about parenting and caring for your child could be beneficial.
- Experienced traumatic events or life experiences that are negatively impacting your experience of parenting

Unfortunately, this service is unable to provide care for parents who are under the perinatal mental health team.

Appendix 11. Optivita Postnatal Group Consultation

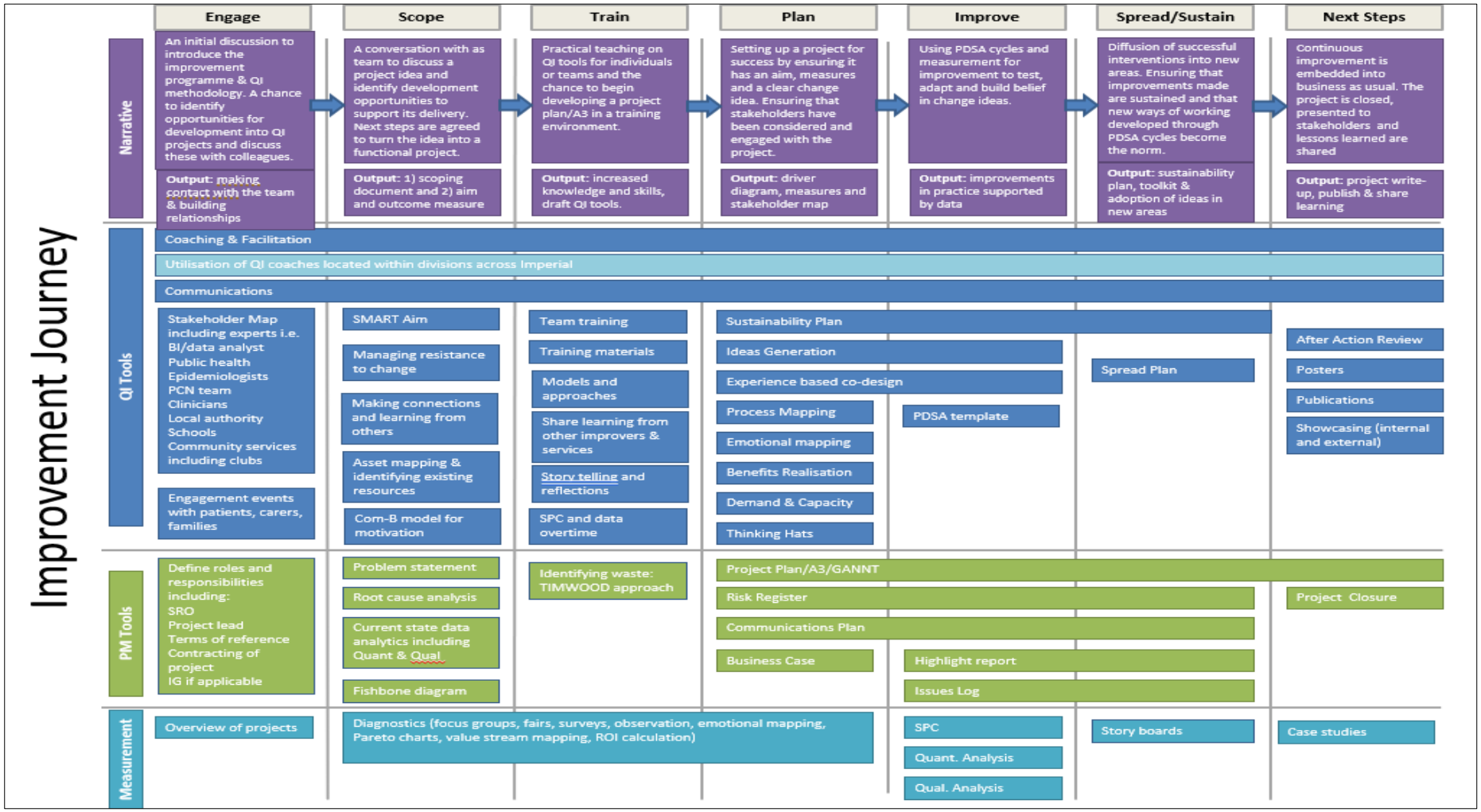
Time	Activity	Rationale
9.10am	**Set up room:** - Chairs in a circle, playmat or similar on the ground in the centre of the chairs with a few toys. - Refreshments laid out. - iPad charged with forms loaded. - Flipchart with the word 'Welcome!' and a second sheet prepared as a table for names of participants, their needs and goals. - Optional: Relaxation music - Ensure everything needed is laid out in advance. This helps the session to flow and maximises time with parents.	- Creates an informal and welcoming atmosphere that feels safe, to make it easier for parents to be vulnerable and reveal their needs in front of strangers. - The presence of a playmat and toys calms new parents fears of their baby crying as they can see this is a baby friendly space. - The circle of chairs signifies that everyone is equally important. - Refreshments are important as parents often forget to eat and drink in the rush to get to an appointment. It also further relaxes parents by reassuring them that this is a safe, comfortable environment.
9.30am	**Parents begin to arrive.** Staff help them get settled and comfortable with informal introductions and drinks. They are assisted to fill in pre session evaluation and it's explained to them why we do this.	- Continues to enable parents to relax and feel safe in the session. - Ensures health and safety with prams to one side. - Ensures all documentation is completed.
9.50am	**Social Prescriber**: - Welcome everyone to the group - Explain the purpose of the group and the goals that will be set. - Go over the ground rules - Ask everyone to say theirs and baby's name and age (include staff). Write parents' names on the flipchart.	- Helps parents understand why they are in the group and what they can expect so they can share appropriately. - Important aspects such as confidentiality are understood to increase a sense of safety. - Writing the parents' names on the flipcharts (and later their needs and goals) helps to keep everyone focussed.
9.55am	**Perinatal Group Facilitator**: - Ask everyone (staff included) to share something they're enjoying (or that is good) about being a parent - Ask everyone (staff included) to share current parenting challenges Social Prescriber: Writes the challenges on the flip chart as parent shares them Group facilitator observes the parents carefully throughout the session to look for signs of distress/depression/trauma; and how they're responding to and caring for their baby in the session to help to plan the services that might be useful.	- Research shows that if people in a group speak at the beginning of a session they are more likely to share throughout the session. - Sharing good things about parenting keeps the session balanced and starts positively. - Sharing challenges for everyone helps to normalise common difficulties - Depressed parents may have times of staring blankly, for example. Traumatised parents may appear to zone out when talking about their births or become pale and tearful. Therefore, careful observation can assist in working out how best to help. Parents may bottle feed the baby lying flat, which could explain reported difficulties like apparent reflux in the baby which may be helped with paced bottle feeding.
10.15am	**Perinatal Group Facilitator** then works through the challenges that have been shared – grouping together similar challenges while also answering questions and providing information as needed. Parents are invited to share more detail, encouraging group discussion of the challenges and for others	A discursive approach empowers parents to practice tackling challenges by: - Demonstrating respect by thanking them for their contributions. - Sharing evidenced based information for them to consider and comment on. - Sharing resources and services that can be helpful.

	(both staff and parents) to share what has helped them or they've seen help others before. If appropriate, the group will be split up to have someone to one time with staff, especially if some challenges don't apply to all parents – for example if there are newborn feeding issues for one parent but other parents need to discuss teething worries. **NB: A break for refreshments may be taken halfway through if needed.**	- Overcoming barriers (such as easing fear of attending a parent and baby group by talking through what happens there, how to get there and what to do when you get there).
11.10am	**Social Prescriber** takes responsibility for noting down goals for individual parents on the flipchart and on their 'goal postcards' to take home. (She also enters these on the parent's NHS records later).	- Keeps the session solution focussed. - Models the approach to parents for future issues they may face. - Further empowers parents as they meet their goals. - Allows for evaluation of the session.
11.15am	**To close the session**, the facilitator leads everyone in an appropriate 5 minute activity which might be: - Blowing bubbles for the babies but using this as deep breathing for parents. - Sharing some simple, useful and fun Baby Yoga techniques for everyone to enjoy. - Sharing some baby massage strokes with simple songs. - Sharing some simple postnatal exercises that can be done with baby.	- Enables parents to calm and self-regulate if difficult topics like Birth Trauma were discussed - Brings the parents back to everyday life after concentrating on challenges. - Prepares the parents to leave the session feeling positive. - Shares play ideas and general ways to enjoy being with their baby which may be missing where there have been early challenges. - Shares ideas to support babies' development.
11.20am	Everyone assists parents to **fill in post session evaluation forms.** Drinks and snacks are offered.	- Ensures appropriate data is collected for evaluation. - Ensures parents leave the session feeling good - Gives a few moments for any final one to one support. - Supports parents as many use this time to talk to each other and even swap phone numbers for ongoing support.
11.30am	**Session ends.**	

It is essential to note that timings are approximate. New parents find it very difficult to attend on time due to the unpredictable nature of babies. They may also be attending the group consultation because of additional difficulties like postnatal depression, a very unsettled baby or difficult home life. This creates additional barriers to attending. Therefore it is common for parents to arrive late, sometimes through the duration of the session. This requires staff leading the session to use considerable skill to proactively adapt timings and activities in order to maintain a cohesive feel and flow to the group consultation, ensuring that important realisations and lightbulb moments already reached are not lost. Techniques used to achieve this can include: scheduling a break earlier or later to enable welcoming of new arrivals, one staff member welcoming a new arrival while the facilitator continues with the other parents and splitting the group into 2 or 3 to allow parents with similar challenges to talk together.

Appendix 12. Toolkit 'improvement journey' for BYCP programmes

Process for setting-up and monitoring feasibility, implementation, sustainability of early years child health integrated care



Evaluation of the Early Years GP Child Health Hubs Pilots for the NHS North West London Integrated Care Board
FINAL REPORT
March 2025

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North West London Integrated Care System