BEST START IN LIFE

Best Start Family Hubs Camden

NIHR | Public Health Intervention Responsive Studies Teams

EVALUATION OF CAMDEN COUNCIL'S BEST START FOR BABY SERVICE

Final Report | October 2026



NHS Central and North West London NHS Foundation Trust

Camden

THE UNIVERSITY of EDINBURGH



Contents

Page No.	Heading	
01	1	EXECUTIVE SUMMARY
05	2	BACKGROUND
10	3	EVALUATION AIM & OBJECTIVES
11	4	EVALUATION APPROACH
13	5	METHODS: HOW WE CONDUCTED THIS EVALUATION
15	6	FINDINGS: TO WHAT EXTENT IS BSFB REACHING FAMILIES?
15	7	FINDINGS: WHAT ARE THE BARRIERS AND FACILITATORS TO SERVICE ENGAGEMENT WITHIN THE BSFB SERVICE?
34	8	RECOMMENDATIONS TO INCREASE REACH AND ENGAGEMENT IN BSFB
38	9	POTENTIAL IMPACT AND WIDER APPLICATION OF FINDINGS
39	10	REFERENCES

1 EXECUTIVE SUMMARY

1.1 Background

Best Start for Baby (BSfB) is an enhanced model of the Healthy Child Programme delivered by Camden Council, in partnership with Central North West London NHS Trust. It offers parents/carers eight health visiting contacts from pregnancy to age 24 months, compared with the five mandated contacts typically offered in many other parts of England. The service includes close collaboration and coordinated support from Health Visitors, Community Nursery Nurses, psychologists and administrative staff and is delivered flexibly through home visits and appointments in Camden's Best Start Family Hubs. In addition to the eight universal health visiting appointments, Best Start for Baby also offers an additional two appointments for families with emerging concerns, as well as signposting to a range of additional support focused on perinatal mental health, parent-infant relationships, and wider family wellbeing. Best Start for Baby was launched in a staged approach in April 2024 and continues to develop.

1.2 Evaluation aim and objectives

The evaluation aim was co-developed with key stakeholders across Early Years services. From the start, the consensus was to better understand equity and reach of the service, and barriers and facilitators to engagement. As such, the objective was to understand the extent to which BSfB is reaching families, assess patterns of attendance across the different BSfB appointments and identify factors which may influence reach and engagement. The evaluation specifically looked at possible variations across certain parent/carer groups and geographic localities.

1.3 Methods

The evaluation analysed existing data from the NHS (using the platform SystmOne) and Camden Council (using the platform EIS) on appointment bookings and attendance. To understand barriers and facilitators to engagement, we undertook focus groups and interviews with service staff as well as specific parent/carer groups (total sample: 50). Recruitment of parent/carer groups was informed by Camden Council's September 2025 'deep dive', the Joint Strategic Needs Assessment of Perinatal Mental Health and Parent-Infant Relationships, and stakeholder discussions, for example, during the evaluability assessment phase of this project. This ensured that participants included groups identified as underrepresented, partially engaged, or disengaged. These groups were as follows: Black African and Caribbean, Bangladeshi, Fathers, those experiencing perinatal mental health difficulties and those living in temporary accommodation or experiencing homelessness.

1.4 Key Findings

1.4.1 Families who engaged with BSfB consistently reported high levels of satisfaction with the empathic approach of the staff and efficient integration with wider support services. However, areas for further improvement were identified, including enhancing engagement through more transparent communication, fostering trust, increasing accessibility, and facilitating more seamless cross-system working.

1.4.2 Engagement levels:

- More than 85% of eligible families took up the following mandated visits: New Baby Visit, 6-8 Week visit, 9 month visit (delivered between 9 and 12 months).
- However, full pathway (visit) completion was less common: approximately 1 in 4 families in the analysis cohort attended all eligible BSfB appointments.
- The additional three health visits introduced by BSfB at 3, 6 and 12 months (offered between 52-55 weeks) have lower levels of engagement than the mandated health visits.
- There are some variations according to ethnicity and locality, however these are not statistically significant.

1.4.3 Facilitators to engagement:

- **Support from staff:** Families expressed positive experiences with compassionate and supportive staff, especially during visits, who facilitated a welcoming and informative environment.
- **Comprehensive services for those who engage:** Those who attended and engaged with BSfB praised the programme's integration with wider support services, such as mental health resources, which met family needs effectively, reinforcing attendance.

Camden

Family Hubs Camden

1.4.4 Barriers to engagement:

- **Communication challenges:** Many families were unaware of the full scope of BSfB services, with insufficient information dissemination occurring at crucial contact points, such as during antenatal visits. This was particularly important for parents/carers who were new migrants and/or unable to communicate in English. Lack of understanding of the service's offer and purpose contributed to lack of consistent participation.

- **Trust and understanding:** Trust issues, particularly among new migrants who fear negative perceptions (e.g., fear of social service involvement or government intervention more broadly), and did not feel the service was relevant to them (e.g., how the visits benefit families), hampered engagement.

- **Accessibility issues:** Families faced barriers due to logistical challenges, such as scheduling difficulties, distant appointment locations, and inconsistent reminders.

- **Capacity and cross-system working:** Limited administrative and workforce capacity was linked to difficulties contacting families and reduced appointment availability. These challenges were compounded by cross-system working issues between the NHS and Camden Council, including separate databases, administrative teams, information-sharing processes, and governance arrangements, which creates barriers to effective collaboration and coordination.

1.5 Recommendations

- The following recommendations are intended to improve the reach of BSfB, ensuring that families across Camden are aware of and trust the service, and that the offer is delivered equitably, particularly to families who may have the greatest potential to benefit.

- **Staff and resourcing:** With the current complete enhanced model reaching 1 in 4 residents, workforce, administrative and system capacity needs to be reviewed to determine feasibility to deliver all eight contacts universally and equitably, and whether a targeted universal offer - with enhanced outreach and flexibility for families facing the greatest barriers - would maximise equity and impact.

- **Enhance information on service offering:** Develop user-friendly information materials that outline the purpose and details of the various BSfB appointments. Examples include an app, a website, a paper booklet or a red book insert. The information materials could include a section to take note of upcoming appointments and take notes during visits. They should be distributed at crucial time point(s) and referred to by all staff involved in delivering BSfB across the 2 years.

- **Consistent communication and coordination from BSfB staff:** Training for all BSfB professionals on when and how to consistently communicate the BSfB purpose and offering in an accessible way to parents/carers. This should include training on a systematic approach to appointment reminders. Such an approach would help reduce confusion and encourage participation for families, while improving collaboration and boosting coordination between staff.

- **Additional support for mental health:** Our findings suggest that for those parents/carers experiencing mental health difficulties, encouraging an addition caregiver (where appropriate) to attend appointments, and increasing awareness of the mental health support offer more broadly could be beneficial.

- **Service changes to promote inclusivity and diversity:** By extending appointment times, offering more home visits, and improving interpretation services (e.g., increasing awareness and offer of interpreting services at booking, improving consistency of the service) and translating information materials, more families, regardless of circumstances, would be supported to attend appointments.

- **Targeted recommendations for specific groups:** Although most barriers and facilitators were experienced across all parent/carer cohorts similarly, some tailored approaches that address specific cultural and language barriers for groups like Black African, Black Caribbean, and Bangladeshi families could improve engagement. To better understand how to identify and address specific language and cultural barriers, we recommend working with parent/carer champions from these groups or establishing other mechanisms for continuous and integrated feedback and engagement. Furthermore, offering flexible and accessible services for families in temporary accommodation, those experiencing mental health difficulties and fathers is crucial.

1.6 Conclusion

BSfB is a highly valued service in Camden for those who are able to access it, providing important support to families during the early years of a child's life. Parents/carers who access the service consistently report positive experiences and speak highly of the support they receive. By continuing to strengthen reach, communication, trust and accessibility through tailored approaches, Camden can maximise the benefits of the service and improve outcomes for all families.



2 BACKGROUND



2.1 Parental engagement with early years services in high-income countries

2.1.1 Experiences in early years of life can have long-term implications. Therefore, provision of quality early years services, specialist programmes designed to support parents and their children with a range of social and health-related needs, is crucial to ensure children have the best start in life (Morrison, Hughes, and Doi, 2022). For these services to have the desired impact on children and families, engagement is critical. A systematic literature review examined international evidence from high-income countries on parental engagement with early childhood, maternal and child health, home visiting and wider family support services. It included 29 sources from Australia, Canada, the UK, Sweden, Norway, New Zealand, Ireland and the USA.

2.1.2 Several cross-cutting themes were identified from the review. First, engagement is relational and strengthened through **continuity of care (ongoing relationship with a clinical team or a member of a clinical team) and early contact.** Parents are more likely to access, trust and remain involved in services when practitioners are warm, respectful, non-judgemental and able to build trusting relationships over time. This relational engagement is strengthened by repeated contact with familiar professionals, early or antenatal contact, proactive and personalised outreach, and coordinated provision, which can help parents build confidence and see support as relevant to their needs. In contrast, fragmented, poorly coordinated or inconsistent provision can weaken trust and contribute to disengagement (Underwood and Killoran, 2012; Rossiter et al., 2019; Cowley et al., 2018). The review also suggested that engagement is shaped by whether services explicitly recognise different caregivers, including fathers, as legitimate recipients of support, rather than continuing to position mothers as the primary service users (Solberg et al., 2022; Singhal et al., 2022; The National Centre for Social Research, 2024).

2.1.3 Second, engagement is strongly shaped by **practical accessibility, effective communication and service navigation.** Parents' ability to access and remain involved in services is affected by practical and informational barriers, including transport difficulties, inconvenient timing, childcare responsibilities, cost pressures, waiting times, difficulty contacting services, confusing referral pathways, poor follow-up, conflicting advice, limited local availability, and uncertainty about how services work (Dougherty et al., 2020; The National Centre for Social Research, 2024; Dunlop et al., 2025; Hesson et al., 2017). Conversely, home visiting, outreach, flexible scheduling, simplified access routes, clear information, culturally and linguistically appropriate communication, and community-based or co-located delivery can make engagement and support more feasible, understandable and acceptable for families (Edwards et al., 2020; Donetto and Maben, 2015; Royal New Zealand Plunket Society Inc., 2015; Singhal et al., 2022).

2.1.4 Third, the review found that **cultural safety** (meaning services being experienced as respectful, non-judgemental and free from discrimination), and **cultural fit**, (meaning the extent to which services align with families' cultural values, languages and everyday practices), together with representation, are especially important for Indigenous, culturally and linguistically diverse (CALD), and migrant families (Austin, Hills and Cruickshank, 2022; Bonakdar Tehrani, Kemp and Baird, 2022a; Dougherty et al., 2020; Litmus, 2020). Engagement was found to be strengthened by service models that are culturally safe, family-centred and community-connected, supported by partnership with these communities, and accessible through interpreters or bilingual communication, and delivered by practitioners who understand the cultural, historical and social contexts shaping family life (Austin, Hills and Cruickshank, 2022; Edwards et al., 2020; Wright et al., 2018; Litmus, 2020).

2.1.5 Finally, engagement must be understood within wider **structural conditions and service arrangements**. Across these studies, parents' participation is shaped not only by motivation or willingness to engage in services, but also by poverty, housing insecurity, stigma, digital exclusion, work and childcare pressures, disability-related access needs, and programme models that can be difficult to access or insufficiently responsive to diverse family circumstances. This also includes immigration status: wider evidence on undocumented migrant families and non-English-speaking migrant families suggests that housing insecurity, poverty, insecure immigration status, fear, distrust of formal systems and difficulty maintaining contact with services can restrict engagement (Kvamme and Voldner, 2022; Dougherty et al., 2020). Thus, rather than placing the burden of adaptation on parents, more flexible, home-based, co-produced and family-responsive models may help reduce some of these pressures and make sustained engagement more feasible (Hackworth et al., 2018; Bäckström et al., 2021; Kvamme and Voldner, 2022; Solberg et al., 2022; The National Centre for Social Research, 2024; Hickey, Leckey and McGilloway, 2024; Lu, West and Daniels, 2025).

2.2 Health visiting as a key early years service

Our review of parental engagement with early years services in high-income countries highlights the importance of awareness, trust, relationships with providers, and service accessibility in shaping engagement. These considerations are highly relevant to health visiting in the UK, a universal early years service delivered by specialist community public health nurses that supports families during pregnancy and the early years through health promotion, prevention, early identification of need, and connection to wider services (Department of Health and Social Care, 2026). As a key component of the Healthy Child Programme, health visiting provides an important platform for reaching families and ensuring that support is accessible to those who may benefit most.

2.3 Health visiting: Best Start for Baby in Camden

2.3.1 Best Start for Baby (BSfB) is an enhanced model of the Healthy Child Programme delivered by Camden Council in partnership with Central North West London NHS Trust (CNWL) and North London NHS Foundation Trust (NLFT). The programme provides parents/carers with eight free health visiting contacts from pregnancy to age 24 months, compared with the five contacts typically offered in many other parts of the UK. It also offers two additional targeted health visiting appointments for families with identified or emerging concerns (see page 8 for further information on appointment schedule). Best Start For Baby contacts give families regular opportunities to ask questions, receive advice, and access the wider Family Hub offer, including both universal and targeted services.

2.3.2 The enhanced model was developed in response to a recognised gap in the timing of the mandated Healthy Child Programme developmental reviews, which resulted in no universal contact with families between the 6-8 week review and the 9-12 month review. A mapping exercise of local services for children aged 0-5 years found a range of targeted support available across Camden, but identified a need to improve referrals and access to these services. The additional BSfB contacts were introduced to bridge this gap, with the aim of supporting earlier identification of need, strengthening engagement with families, and increasing access to both universal and targeted Family Hub services.

2.3.3 The service is delivered flexibly through home visits and appointments at Camden's Best Start Family Hubs and is underpinned by close collaboration between Health Visitors, Community Nursery Nurses, psychologists and administrative staff, ensuring coordinated and responsive support for families during the critical early years.



2.3.4 BSfB was developed using national policy guidelines and key frameworks such as the Solihull approach (Douglas, 2016a; Douglas, 2016b; Douglas, 2017), Newborn Behavioural Observation (Nugent et al., 2007), Video Interaction Guidance (Kennedy et al., 2011), Ready to Relate (Dickens & Milne, n.d.), and through co-production with Camden families and professionals. Camden was also one of 75 local authorities taking part in the Start for Life Programme, which aims to join up and enhance services delivered through Best Start Family Hubs in local authority areas across England, ensuring all families can access the support they need.

2.3.5 **The Best Start for Baby appointments are as follows:**

Appointment type	Recruitment plans	Location	Staff
Antenatal visit	Mandated through Healthy Child Programme *This visit was scaled up during the cohort period and was not consistently delivered as a universal contact	Home visit	Health Visitor
New Birth Visit (NBV)	Mandated through Healthy Child Programme	Home visit	Home visit
6–8-week visit	Mandated through Healthy Child Programme	Home visit	Health Visitor
3-month visit	Additional universal BSfB appointment	Family Hub	Health Visitor
6-month visit	Additional universal BSfB appointment	Family Hub	Health Visitor
9-month visit	Mandated through Healthy Child Programme (this is the 8–12-month mandated review)	Family Hub	Community Nursery Nurse
12-month visit	Additional universal BSfB appointment	Family Hub	Health Visitor
15-month visit	Additional targeted BSfB appointment only for families with identified or emerging concerns	Family Hub	Health Visitor
18-month visit	Additional targeted BSfB appointment only for families with identified or emerging concerns	Family Hub	Health Visitor
24-month visit	Mandated through Healthy Child Programme	Family Hub	Community Nursery Nurse



Artwork from Infant Mental Health Awareness Week 2026

2.3.6 BSfB also involves referral and signposting to a range of additional support and interventions focused on perinatal mental health, parent-infant relationships (e.g., baby bonding groups), and wider family wellbeing (e.g., breastfeeding support, Stay and Play).

2.3.7 BSfB aims to ensure that every family in Camden receives timely, evidence-based, and coordinated support for perinatal mental health and parent-infant relationship needs in the first 2 years of a child's life, through an integrated, inclusive and family-centred early years approach.

2.3.8 **Best Start for Baby objectives are as follows:**

- Identify and respond early to perinatal mental health and parent-infant relationship needs through structured screening at eight key contacts from pregnancy to age two.
- Strengthen parent-infant relationships through integrated, evidence-based support.
- Embed whole-family support by involving fathers, partners and other caregivers in assessment and care.
- Promote collaborative and integrated care by aligning the efforts of Camden's Health Visiting and Family Support Services, Best Start Family Hubs, Child and Adolescent Mental Health Services (CAMHS), maternity services, and community partners in delivering seamless care across services/sectors.
- Reduce inequalities and stigma by providing inclusive, accessible and co-produced support.

3 EVALUATION AIM & OBJECTIVES



3.1.1 The aims and objectives of this evaluation were co-developed with BSfB strategic managers, delivery staff and parents/carers in two evaluability assessment workshops. There was a strong consensus to better understand reach and equity of the BSfB service through this evaluation, especially whether the service is reaching those with the greatest capacity to benefit.

3.1.2 **The aim** of this evaluation was to understand the reach of the BSfB service, and barriers and facilitators to service engagement.

3.1.3 **The specific objectives were to:**

1. **Understand the extent to which BSfB is reaching families.**
2. **Identify and understand the barriers and facilitators to service engagement across the eight enhanced appointments.**

3.1.4 This information will help the service managers, public health and early years teams to further develop the service to increase its reach and impact. As such, this evaluation primarily acts as a service improvement tool to ensure all families in Camden can benefit from BSfB equitably, impacting on longer-term health outcomes and reducing health inequalities.

By focusing specifically on equity and reach of the BSfB service, we were able to generate 6 key recommendations (p.39).

4 EVALUATION APPROACH

4.1 Evaluation team

This evaluation was undertaken by the NIHR PHIRST Elevate team, in collaboration with Camden Council.

4.2 Evaluability assessment

An evaluability assessment was conducted to agree evaluation aims, design and methods, and preferred reporting approaches and outputs. This included two in-person workshops in June and July 2025 with key stakeholders from Camden Council and BSfB service users (parents/carers). The process helped develop a shared understanding of the BSfB intervention, and a programme logic model (Appendix 1). The workshops also helped clarify data collection options and timelines.



4.3 Understanding of the BSfB intervention

BSfB is a complex intervention, involving several interconnected parts and activities, whilst relying on choices and actions of both the practitioners delivering the service and families receiving it, which may yield a range of intended and unintended outcomes (Jepson et al., 2021). BSfB involves a local authority and two NHS trusts, all of whom have their own funding, staff and responsibilities associated with the service. Although health visits are delivered by CNWL, clinical, managerial and administrative staff employed by Camden Council and NLFT support the service. As such, the identification of barriers and facilitators to the service was nuanced and multifaceted, reflecting the nature of the intervention and the need for effective coordination, communication and shared priorities across multiple organisations and professional groups. BSfB is an evolving service, and the evaluability assessment provided a snapshot of stakeholder and service user perceptions of the service at the time.

4.4 Public involvement

A group of 10 parents, each with different levels of engagement and experience of the service, formed a "public involvement group" and helped steer this evaluation. Their feedback helped ensure that the evaluation was feasible, acceptable and relevant to the Camden parent/carer community. At the time of writing, PHIRST Elevate had organised four public involvement group meetings throughout the evaluation (August 2025, December 2025, March 2026 and June 2026). The group supported the following activities: developing a PHIRST BSfB webpage, reviewing focus group recruitment materials and topic guides, planning of knowledge mobilisation activities, providing key perspectives and insights on the service, and feeding back on initial evaluation findings, help formulating recommendations.

4.5 Work Package development

Collectively, the consultations described above informed the development of two Work Packages for the evaluation. Work Package 1 (WP1) which involved analysis of data collected by the BSfB service, and Work Package 2 (WP2) which involved focus groups and interviews with BSfB staff and service users.

4.6 Embedded team member model

As per PHIRST Elevate's "Embedded Team Member model," a Data Analyst from Camden Council was seconded to work with PHIRST Elevate two days a week. We also had support from an Information and Engagement Worker and a Clinical Psychologist from the BSfB team. They supported multiple aspects of the evaluation including the development of the Public Involvement Group, co-ordination of data collection and knowledge mobilisation and analysis of quantitative data for WP1 (Data Analyst). Through this approach, the research team benefitted from specialist knowledge and context, a streamlined approach to recruitment leveraging local channels, and additional capacity and expertise in producing engaging knowledge mobilisation outputs.

4.7 Ethics approval

This project received ethics approval from University of Edinburgh (REF: JMAN20102025).



5 METHODS: HOW WE CONDUCTED THIS EVALUATION

5.1 Work Package 1: Secondary analysis of existing data from SystmOne (NHS) and EIS (Camden Council) databases.

The focus of the analysis was to understand attendance and reach across the eight universal BSfB appointments, in line with Objective 1. The analysis focused on children born in 2024 who were known to CNWL. Antenatal visits were excluded as this element of the BSfB model was being scaled up during the cohort period and was not consistently delivered as a universal contact. The 24-month visit was also excluded because most children in the 2024 birth cohort were not yet old enough to have reached this stage during the analysis period. Attendance was therefore analysed for six visits (NBV, 6-8 week, 3 month, 6 month, 9 month [delivered between 8 and 12 months], and 12 month contacts) plus the additional two targeted visits (15 month and 18 month contacts). Information on whether families were offered appointments by email, text or phone was not consistently recorded. The analysis therefore used the best available record for each type of visit.

For the New Baby Visit and 6-8 week contact, there was no separate booking information, so children who were old enough and resident in Camden at the relevant time were counted as due for the visit. From the 3-month contact onwards, booking information was available, so the analysis used children with a recorded booking. This is why the report uses both "due" and "booked". "Due" means the child was eligible for the visit based on age and residency. "Booked" means there was an appointment recorded in the data. Where no booking was recorded, this should not be interpreted as no offer being made. It may reflect families not booking after being invited or no suitable appointment being available at the family's preferred time or venue. *Addition detail on methods for Work Package 1 can be found in Appendix 2.*

5.2 Work Package 2: Focus groups (FGs) and interviews (INTs) with BSfB service users and staff

The focus of this element was to understand barriers and facilitators to engagement with the BSfB service, in line with Objective 2. Regarding service users, a sampling framework was agreed with the Camden Council team, which includes five groups identified as underrepresented, partially engaged, or disengaged (see Table 1 below). Between December 2025 and February 2026, the PHIRST Elevate team conducted 12 focus groups and 5 interviews, which included a total of 50 participants (24 parents and 26 members of staff). See Table 1 below for participant details.

To facilitate recruitment and data collection, the Camden Council team coordinated focus groups recruitment and attendance, including transport (funded by PHIRST Elevate) and translators where required. Participants were provided with a participant information sheet and consent form at least 48 hours before participation and gave informed consent prior to taking part, with electronic or hard-copy materials made available if needed. A topic guide was developed in partnership with the BSfB team and the public involvement group. Participants (staff and parents/carers) were asked about their involvement with and understanding of BSfB, and explored the barriers and facilitators to engagement across the appointments, including structural, cultural and informational factors, as well as whether families felt the service and its appointments were relevant to and needed by them. Participants were also asked about stigma around help-seeking, trust in services, whether families felt valued and safe to seek support, and the perceived helpfulness of the additional three BSfB appointments.

Table 1: Work Package 2 data collection

Participant type	Recruitment plans	Sample included
Total sample		**50**
Service users	Underrepresented, partially engaged, or disengaged groups (~5 of each). Target groups:	**24****
	1. Black African and Black Caribbean families	**6**
	2. Bangladeshi families	**4**
	3. Families who live in temporary accommodation*	**5**
	4. Those who have experienced perinatal mental health (PMH) difficulties	**7**
	5. Fathers	**6**
Health visitors (HVs)	Variety of experiences (e.g., managers, HVs who work with homeless families).	**12**
Other staff	Variety of experiences	**14**

*This included families experiencing homelessness as well as refugee families
**Some participants represented more than one group

6 FINDINGS: TO WHAT EXTENT IS BSFB REACHING FAMILIES?

6.1 What proportion of children attended their BSfB contacts?

To assess BSfB appointment attendance, we used two related engagement measures with different denominators. This is because complete offer data was not consistently available.

1. Primary measure: engagement with contacts due or booked for each child

This measure included children with at least one due or booked BSfB contact in the analysis period (n=2,136). It looked at whether each child attended all contacts that were due or booked for them individually. On this measure, 66.0% of children (n=1,410) had full recorded engagement, meaning they attended all contacts that were due or booked for them. As this measure is based on the contacts due or booked for each child individually, the 66.0% figure should not be interpreted as meaning that two-thirds of children completed the full NBV-12 month pathway.

A further 33.9% (n=725) had partial recorded engagement, meaning they attended at least one, but not all, of their due or booked contacts. One child had a due or booked contact but no recorded attendance (see Table 3 in the appendix). Figure 1 below represent attendance at each contact stage, using the relevant denominator for that stage. It shows the proportion of children eligible/due or booked for each contact who also attended that contact.

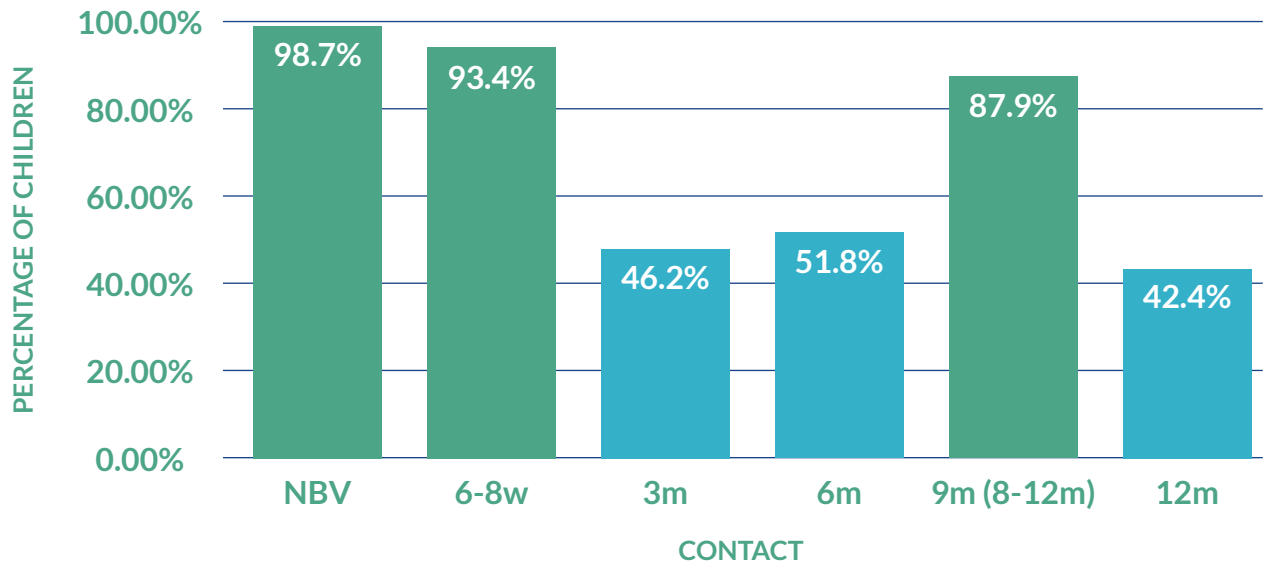
2. Stricter subset measure: completion of the full NBV-12 month pathway

This second measure was a stricter subset analysis. It was limited to children who were eligible for all six NBV–12 month contacts (n=1,639): NBV, 6–8 week contact, 3 month, 6 month, 9 month (delivered between 8–12 months), and 12 month contact. This means it was a smaller group within the wider analysis cohort, rather than a separate unrelated sample.



Among children eligible for the full pathway, 26.0% (n=426) attended all six contacts. On average, children in this group attended 4.26 out of six contacts. Nearly two-thirds attended at least four of the six contacts, while around one-quarter attended all six. This suggests that full completion of the NBV–12 month pathway was relatively uncommon, although most children had several contacts. See Table 2 in the appendix.

Figure 1. Percentage of children attending each BSfB contact. Green bars highlight the mandated health visiting appointments, blue bars highlight the additional health visiting appointments.



6.2 Is the offer being taken up consistently across demographic groups and localities?

1. Full engagement was defined as attending all due or booked contacts included in the analysis.
2. Partial engagement was defined as attending at least one, but not all, due or booked contacts.
3. No recorded attendance was defined as having at least one due or booked contact but no recorded attendance.

6.2.1 Partial engagement was recorded in about one-third of children with at least one due or booked contact. Among the full analysis cohort of 2,311 children, 54.6% (n=1,262) attended one or more additional contacts (3m, 6m, 12m, 15m or 18m). As noted in the introduction, these contacts are offered in addition to the five mandated contacts (antenatal, NBV, 6-8wk, 9m [8-12m] and 24m). While the additional 3m, 6m, and 12m contacts are universal (available to all babies in Camden), the 15m and 18m contacts are targeted (offered as required). Among children who attended additional contacts, most attended between one (n=353; 15.3%) and three (n=440; 19.0%). See Table 4 in appendix.

6.2.2 Partial engagement was explored further by dividing children according to the proportion of due or booked contacts attended (four categories): full engagement, partial engagement with 50-99% attendance, partial engagement with 1-49% attendance, and no recorded attendance. This showed that almost all children in the partial engagement group had attended at least half of their due or booked contacts, while only 10 children attended fewer than half. The main report therefore retains the three headline engagement categories (full engagement, partial engagement, no engagement) for clarity and consistency, with the fuller four-category breakdown provided in Table 5 in the appendix.

6.2.3 Engagement was broadly similar across the main ethnic groups (Table 6 in the appendix), but there was more variation when ethnicity was broken down into specific categories. For example, full engagement was lower than the overall average of 66.0% among Bangladeshi children (57.1%), Any Other Black Background children (42.9%), Pakistani children (31.6%) and Mixed White and Black Caribbean children (31.6%), compared with 65.9% among White British children (Table 7 in the appendix). These findings should be interpreted cautiously due to size of some detailed ethnicity groups and statistical testing did not indicate a significant association (see paragraph 6.2.8). However, they reinforce the value of continuing to review engagement by detailed ethnicity as well as broad ethnic group, so that differences for specific communities are not hidden within wider categories.

6.2.4 Engagement was similar by sex (of the child). Full engagement was 67.4% among girls and 64.8% among boys. In adjusted analysis, there was no strong evidence of a sex difference in incomplete engagement (Table 8 in the appendix), suggesting that sex was not a major driver of variation in engagement.

6.2.5 Engagement varied by locality. Full engagement was lowest in Euston at 58.9% and highest in Kilburn Priory (KP) at 71.2%, followed by Kentish Town West (KTW) at 68.7%, King's Cross and Holborn (KCH) at 64.4% and Kentish Town East (KTE) at 62.6% (Table 9 in the appendix). In the adjusted model, compared with Euston, children in KP and KTW had significantly lower odds of incomplete engagement (Table 10 in the appendix).

6.2.6 Ward-level descriptive analysis also showed variation in full engagement, with lower full engagement in St Pancras and Somers Town, Regent's Park, Camden Square and Holborn and Covent Garden, and higher full engagement in Fortune Green, Hampstead Town, West Hampstead, Kilburn and Kentish Town North (Table 12 in the appendix). These ward-level findings should be interpreted cautiously because some ward denominators are relatively small and may reflect recording or delivery capacity and appointments availability, as well as family engagement.



6.2.7 There was no clear deprivation gradient by the Income Deprivation Affecting Children Index (IDACI). Full engagement ranged from 61.5% to 72.8% across IDACI groups, but the pattern was inconsistent (Table 13 in the appendix). The adjusted model similarly did not show a consistent deprivation gradient, although some individual IDACI categories differed from the reference group (Table 10 in the appendix).

6.2.8 Overall, the adjusted analysis supports the descriptive finding that geographic variation was more apparent than broad differences by sex, ethnicity or deprivation (Table 10 in the appendix). Chi-square tests comparing full and incomplete engagement showed no strong evidence of differences by sex, broad ethnic group or IDACI (Table 11 in the appendix). Although this evaluation was not designed to examine the reasons or sources of these variations, it is possible they could reflect variations in implementation, administrative or appointment capacity, accessibility of provision, or how consistently families are contacted and booked across localities. This could be an area for further exploration.

6.3 What are the characteristics of those who partially engage or do not engage in BSfB appointments? How do these compare to the population characteristics within the Borough of Camden?

6.3.1 This analysis uses the full 2024 analysis cohort of 2,311 children and compares those who did and did not attend at least one additional BSfB contact. Children who attended at least one additional BSfB contact (3m, 6m, 12m, 15m or 18m) were also more likely than children who did not attend any additional BSfB contacts to have recorded contact with wider Early Years and family support services. For example, 54.0% of children who attended an additional BSfB contact had Infant and Early Development session contact recorded, compared with 16.7% of children who did not attend any additional BSfB contacts. They were also more likely to have Stay and Play attendance, vitamin collection, Parenting Support, Special Educational Needs and Disabilities/additional needs contact, Family Early Help and IEYS Welfare Rights Team (IEYS WR) involvement (Table 14 in the appendix). Children who attended additional contacts typically had higher engagement with wider Early Years and Family Support Services, such as Infant and Early Development sessions and Stay and Play, highlighting a pattern of increased service contact. This may indicate that BSfB is helping connect families into wider support, or that families already more connected to services are more likely to attend additional BSfB contacts. However, this is not true in context of statutory social care indicators, including Children Looked After (CLA) or Child Protection (CP) status. These children did not show notable differences in BSfB contact (Table 15 in appendix). There was less variation in children with partial engagement versus full engagement in BSfB appointments (Table 16 in the appendix). Table 17 in the appendix provides a detailed breakdown of the service offering.

6.3.2 Comparing the BSfB cohort with the Camden Under-5 population snapshot reveals similarities across ethnic, sex, and deprivation indices. Table 18 in the appendix outlines slight over-representation of Asian, Black, and Mixed children within the partial engagement group. Sex differences were minimal, with a slight male predominance in BSfB compared to Camden's wider population (Table 19 in the appendix). Locality differences were more apparent; Euston was over-represented in the partial engagement group, while KP and KTW were under-represented, aligning with findings in the adjusted model (Table 20 in the appendix). No clear deprivation gradient was observed by IDACI (Table 21 in the appendix), indicating similar engagement patterns across socioeconomic groups.

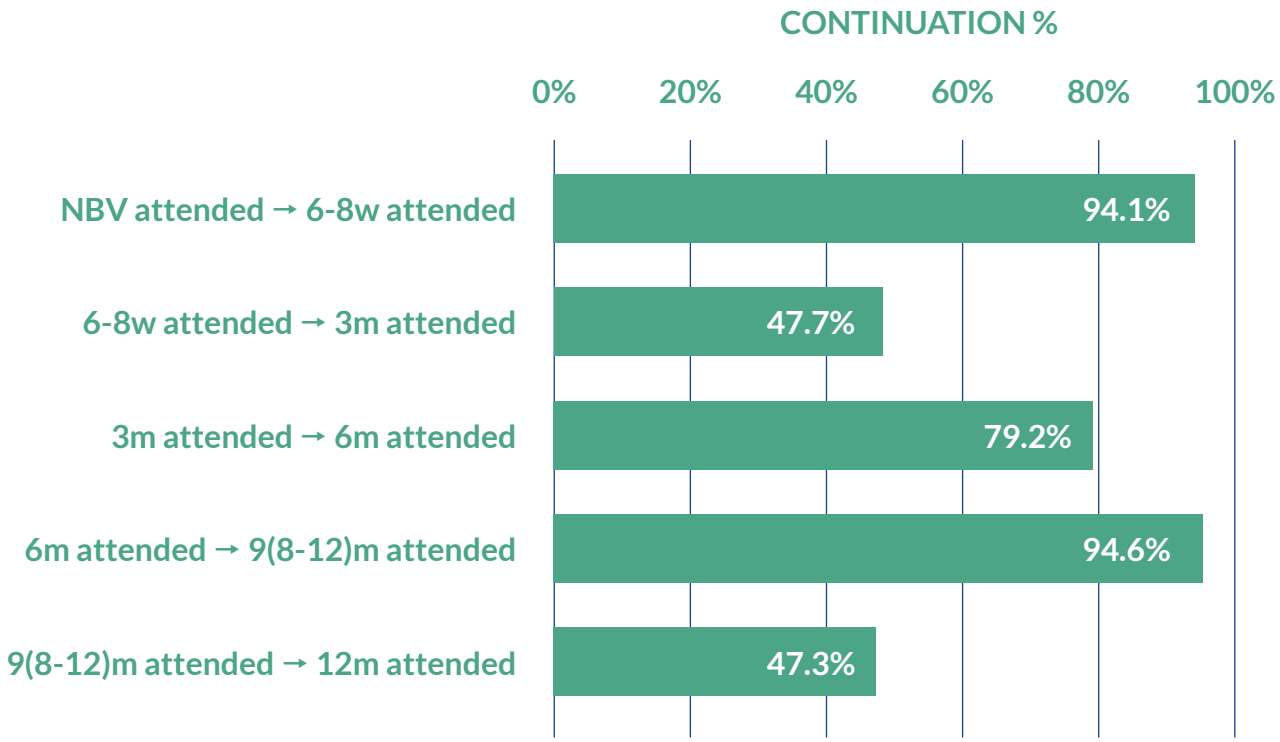
6.4 Are there drop-offs at specific stages?

6.4.1 Among children eligible for each contact stage (NBV-12m), attendance data showed marked drop-offs between specific contact points. Early universal contacts had high attendance among eligible children: 98.7% attended the NBV (1,906 of 1,931 eligible children) and 93.4% attended the 6-8 week contact (1,834 of 1,963 eligible children). Attendance was lower at the additional BSfB contacts, with 46.2% attending the 3-month contact (888 of 1,922 eligible children) and 51.8% attending the 6-month contact (946 of 1,826 eligible children). Attendance then increased at the 9 (8-12) month contact, with 87.9% attending (1,653 of 1,880 eligible children), before falling again at the 12-month additional contact, where 42.3% attended (772 of 1,826 eligible children). This suggests that there is higher uptake in the mandated contacts. A contributing reason may be that the NBV and 6-8 week contacts are booked directly by Health Visitors. Other mandated contacts are booked by a dedicated CNWL admin team. The additional contacts are booked by the BSfB administrative teams, in addition to their main role.

6.4.2 For the additional 3-month, 6-month and 12-month contacts, attendance among children with a recorded booking was higher: 78.2% at 3 months (888 of 1,135 booked children), 83.6% at 6 months (946 of 1,131 booked children) and 80.2% at 12 months (772 of 963 booked children). This suggests that, where an additional BSfB contact was booked, most families attended. The larger gap appears to be between eligibility and recorded booking/contact, rather than attendance after booking. However, a missing booking should not be interpreted as evidence that no offer was made, as this may also reflect recording practice, appointment availability or other contact routes outside the BSfB pathway.

6.4.3 Table 22 (in the appendix), Figure 2 (below) and Figure 3 (in the appendix) highlight that the largest drop-offs occurred between the 6-8 week and 3-month contacts (52.3% drop-off) and between the 9-month and 12-month contacts (52.7% drop-off). In contrast, transition from 3-month to 6-month contacts showed stronger continuation at 79.2%. This indicates that while attendance was generally high when a booking was recorded, substantial gaps existed in transitioning from eligibility to booking, particularly at certain stages.

Figure 2. Stage-to-stage continuation across the NBV-12m pathway. Percentages show the proportion of children who attended the previous contact, were eligible for the next contact and then attended the next contact.





7 FINDINGS: WHAT ARE THE BARRIERS AND FACILITATORS TO SERVICE ENGAGEMENT WITHIN THE BSFB SERVICE?

7.1 What are the facilitators to engagement in the universal BSfB appointments?

7.1.1 Positive feedback and supportive staff

Families who engaged with the service provided very positive feedback, which motivated their continued attendance. Health Visitors and Community Nursery Nurses were described as knowledgeable and kind, fostering a safe environment where many parents felt comfortable asking questions and requesting help. Appointments provided comfort, helped new parents learn how to care for their first baby, and offered reminders for those with more than one child. The staff at the hubs, including Health Visitors, were particularly praised, and families felt supported and encouraged by the BSfB staff.

> *"I just want to personally say thank you to everyone from the Best Start team. It helped me feel very secure in my early motherhood and I really appreciate the time and effort that the workers gave to me and just made me feel like I was a good person, doing great, supporting well, and gave me the motivation to move forward in so many different aspects of motherhood that we in general doubt."* (Black African/Black Caribbean FG, Mother 2)

> *"I would encourage people to have children in Camden because of the services, which includes this, where research and money is being put in for the betterment, so our children are very well taken care of in Camden."* (Bangladeshi FG, Mother 2)

7.1.2 Comprehensive appointments and wider service offering

Families valued the content and breadth of appointments, appreciating the focus on both physical and mental health. The visits boosted parents' confidence, ensuring they were doing the right things, and were described as helpful and straightforward. They provided reassurance about their baby's development and offered referrals to specialist services if needed, allowing for early intervention. The connections to wider services, such as Stay and Play sessions, were well-received, providing great opportunities for socialising and meeting other families. This included Camden Dads, aligning with research highlighting the importance of involving fathers in early years services. The appointments also effectively bridged to mental health support and were particularly valuable given the difficulty in accessing other healthcare services (e.g., GPs).

> *"One of the things we've noticed since the Best Start for Baby has started is that it's actually a very good bridge into the Family Hubs [and associated teams] I think Best Start for Baby has actually added an extra layer of something that's more accessible."* (Staff FG3, F2)
>
> *"I would say this [Family Hub] is my second home here more than anything else. We started from Baby Bonding to Under Ones, now we're Under Twos. So, we are here, we're like a family here."* (Black African/Black Caribbean FG, Mother 3)

7.1.3 Accessibility and language support

The number and location of hubs were beneficial, making it easier for families to access services, and the fact that these services were free and offered across the borough was highly appreciated, especially as other boroughs had fewer offerings. Interpreting services were valued, providing essential support despite language barriers (discussed below). For those in WhatsApp groups, the responsiveness was appreciated. Having a health visiting team focused on families in temporary accommodation was also a key strength of the service.

> *"[We attend] Quite a few [Best Start Family Hubs], so Agar Grove, Harmood, Regents Park .....I think compared to other boroughs, there's a lot more facilities which I'm happy with." (Fathers Focus Group 1, Father 2)*

7.1.4 Communication and trust

Some families reported positive experiences with appointment booking and communication, which made them feel valued. Appointments were a good way to link families to both BSfB services and external assistance, such as housing help. Many felt reassured by occasionally having the same Health Visitor. Most parents expressed trust in the service, recognising its importance and impact. Staff believed the service was effective, meeting people's needs, helping them reach families earlier, and increasing referrals, particularly beneficial for those needing specialist support.

> *"For me personally I had really good experiences. It almost felt like your mum coaching you, very delicate advice delivered in a very calm way."* (Black African/Black Caribbean FG, Mother 2)

7.2 What are the barriers to engagement in the universal BSfB appointments?

Alongside the facilitators that enhance engagement, several barriers have also been identified.

> *"On one side, I am astounded by the service I did receive. And on the other side, I am very disappointed at the lack of communication between the services."* (Bangladeshi FG, Mother 2)

7.2.1 Awareness of and communication about the universal offer

7.2.1.1 Many participants we spoke to (families and BSfB staff) felt there was an overall lack of awareness of the universal health visiting offer (i.e., the eight appointments), and specific health visits within the offer (e.g., 3, 6 and 9-month appointments). This is supported by the quantitative findings showing drop-offs in attendance at additional health visits.

> *"There are loads of mums that don't go to Best Start for Baby and haven't heard of it actually."* (Bangladeshi INT1, Mother)

7.2.1.2 These gaps in awareness occurred at various stages of the health visiting pathway. For example, most families did not have (or remember having) an antenatal visit, which may be because this initial visit was not consistently delivered as a universal contact at the time of the evaluation. This presents a missed opportunity for initial contact with the programme. Other families were unaware of some of the appointments that occur when the child is older (e.g., at 24 months).

> *"…it's quite confusing…like, it's only once you have the baby, then you start getting access. So, it's not really clear as to how to reach out for that support when you're pregnant."* (Mothers who experienced PMH difficulties FG1, Mother 2)

7.2.1.2 This lack of awareness was particularly challenging for families who were new to the UK and therefore unfamiliar with health and social care services in general and where to access support.

7.2.1.4 Families felt that the lack of awareness was due to an absence of proactive communication from frontline healthcare workers and BSfB staff which occurred throughout the health visiting pathway. For example, BSfB information was often not shared during pregnancy (e.g., midwife appointments, antenatal classes) which resulted in families missing out on their initial appointments. Families felt that the period immediately after birth, while still in the hospital, was an ideal time for frontline healthcare workers to inform them about the universal health visits. However, this opportunity was often missed.

> *"...I don't know how much that information is shared, how much people have an understanding of how many times you'll be expected to see your Health Visitor and why."* (Staff FG1, M1)

7.2.1.5 Additionally, many families were not contacted by BSfB staff to schedule the initial visits, while others attended the initial visits but were not informed or contacted about scheduling subsequent ones. This led to non-engagement or partial engagement with the eight visits.

> *"…talking to other mothers, and they were telling me, like, oh your child's coming up to 12 months, have you had the appointment yet. And that's how I hear [about the appointments], not by people reaching out to me, but by just listening to other mothers. If I wasn't in those children's centres, I probably wouldn't have gone to any appointment, because I just wouldn't have heard of it."* (Mothers who experienced PMH difficulties FG1, Mother 1)

7.2.1.6 Families also noted that the information on the website and in the provided materials was often insufficient and unclear, adding to their confusion about the BSfB programme and the universal health visiting appointments.

> *"I feel like the Camden website…you have to just click, click, click, to find what you're looking for. Unless someone tells you. And I know now they have WhatsApp groups, like you can join the children's centre WhatsApp groups, which is really good. But if someone who doesn't know it, they can't go on the WhatsApp group till they add you to it."*
> (Bangladeshi INT2, Mother)

7.2.1.7 Families sometimes struggled to fully grasp the purpose and benefits of health visiting appointments, making it challenging to understand how these visits support both them and their babies. Families also experienced confusion about what the BSfB programme entails and how it differs from other services, such as those offered by GPs and midwives. This uncertainty made it harder for them to understand the unique benefits of each service.

> *"Best Start for Baby is still quite new to families, and I wonder if families have got to grips around what it is and what it means and what they're going to get out of it?"*
> (Staff FG2, F2)



7.2.2 Trust in the service and asking for help

While trust was high in some parents, and reported to facilitate ongoing engagement, in other communities in Camden a lack of trust was a barrier to initial service uptake. For example, families new to the UK and those who lacked understanding around the purpose and benefits of the health visits. Some families fear that participation implies issues within the family, due to concerns about safeguarding. Others may have had a negative experience at some point in the pathway (e.g., a traumatic birth or not felt listened to during an appointment) which eroded their trust and discouraged them from further engagement in the pathway. Discomfort with perceived 'government' intervention and the assignment of different Health Visitors for each appointment further complicate this, making it difficult to establish consistent, trusting relationships. These factors can make families hesitant to mention mental health concerns during visits, as fears about safeguarding and a lack of trust may lead them to feel unsafe or uncomfortable openly discussing their needs.

> *"…I felt at the time, like they tick you off, are you comfortable, are you safe, you don't have any domestic, they kind of, go through these questions, are you feeling mentally supported… I cannot speak for every mother, but I think you do definitely, soft wash it [underplay mental health challenges], because you're too intimidated by the questions, in terms of like, I don't want to look vulnerable, because I don't want any problems with my child, and myself right now…I probably didn't tell them I felt really stressed, and I needed support, I probably just said, no I'm fine. I could probably picture myself doing that."*
> (Mothers who experienced PMH difficulties FG1, Mother 1)

7.2.3 Language and cultural barriers

Language barriers exist despite available interpreting services, preventing non-English speaking families from fully engaging with the service. For some families, there is a lack of awareness of the interpreting services on offer.

> *"When I think about them [other Afghan women] they face barriers if they don't know about the appointments or the Best Start for Baby or that they could get an interpreter."*
> (Temporary accommodation INT1, Mother)

Staff felt there were several possible reasons for this. For example, that most communication was in English, and that families are not always asked if they need an interpreter.

"I think we are contacting them, calling them and sending them texts in English. Many of the families don't read or understand English. And even if it says they need an interpreter, we're still sending a reminder text the day before in English. And so, I think that is a barrier. (Staff FG5, F3)

For those families who are able to access interpreting services, they sometimes encountered challenges such as interpreters not showing up or cancelling last minute, delays or issues with the phone-based service (often used as a back-up). Furthermore, appointments were often too short to accommodate the additional time interpreting the discussions required.

"Very often, we will book an interpreter, ask for an interpreter and the interpreter doesn't turn up. And if I was a parent, that would make me not want to come back. That is a very, very big issue, I think." (Staff FG5, F3)

7.2.4 Appointment booking and logistics

Families encountered some logistical challenges with appointment scheduling. They often needed to book far in advance, and appointments could be located at a distance, which was less convenient. Additionally, the timing of appointments was not always ideal for busy and working parents. While families appreciated the effort, they sometimes experienced difficulties with the booking process and follow-up communications. Additionally, reminders to schedule and attend appointments were inconsistent, and it was sometimes difficult to get in touch to book, cancel or reschedule. A few mothers noted that this was particularly challenging as it was difficult to manage everything while being overwhelmed with all the responsibilities of caring for a baby. The complexity of navigating the BSFB service, as indicated in the quantitative analysis by partial path completions, underscores the need for clearer communication, particularly regarding appointment scheduling and service offerings.

"So, I think there is an issue with people not being offered the appointments, but there is also an issue of people not attending…some of the reasons I think are pretty simple, so, for example, people are being offered appointments three months in advance without reminders…you've got a young baby, you've been offered an appointment three months in advance, you're not going to remember unless someone prompts you." (Staff FG1, F5)

7.2.5 Staff capacity

Staff observed that inconsistencies in contacting families about health visits were partly due to capacity challenges faced by both administrative and health visiting teams. They noted that administrative staff often lacked sufficient time to reach out to every family after a new birth and to schedule follow-up appointments. Even when contact was made, they were often limited by the number of available appointments, as health visiting staff themselves were unable to accommodate every parent. These issues were highlighted in a conversation from one of the staff focus groups (Staff FG1):

F6: *We've not gone more than 25 per cent [of eligible families being contacted], and that's just calling them to offer. So, usually we can only ever manage to call that much.*

I: *And that's less to do with the availability of the appointments and more to do with the time of the admin staff to call them?*

F4: *It's the availability of the appointments as well…We haven't got capacity to deliver it to 100 per cent [of eligible families] even if they had the capacity admin-wise to make the appointments and they'd probably need five times more admin and we'd need five times more staff.*

7.2.6 Complexities of working across systems

Another challenge involves cross-system collaboration, particularly stemming from the use of two different databases and administrative teams across the NHS and the local authority. Achieving consistent communication and language in scheduling and messaging has proven difficult. For example, health visits are done through the NHS but interpreters are arranged by Camden Council.

Additionally, Health Visitor vacancies over the past year in Camden, despite being atypical, have contributed to these challenges. The complexity of partnerships across the local authority, two NHS trusts (CNWL who offer the health visits and NLFT who offer BSfB Psychology), and various practitioners also adds to the intricacy of the situation.



> *"There are fundamental issues maybe to do with the local authority and the NHS being two different organisations, which are trying to offer a very good service and well-designed and everything, with good outcomes. But there's something about the power wrangles of ownership of the programme, the issues of trust and the issues of resource capacity. So, those I think are three things I can see as maybe influencing the direction of how the programme is delivered and also how everybody shares in a transparent way in real-time issues about, you know, if it's the NHS having a glitch or a difficulty, i.e., capacity, because of sickness or the local authority, these things were reached at after a time of acknowledging that there was definite pressures on each of our services."* (Staff FG1, F7)

7.3 Why are families with certain characteristics not engaging or partially engaging?

The barriers described above were not experienced equally; most had a disproportionate effect on the five target groups. Similar barriers and facilitators were discussed across the target groups (e.g., language barriers and cultural differences more broadly). This is an important finding as it implies that consideration of the broader barriers and facilitators (mentioned above) will have a positive impact on the target groups. Additional barriers and facilitators that are specific to each of the target groups are presented below.

7.3.1 Specific ethnic groups

Some staff felt that language and communication challenges were greatest among Bengali (including many people of Bangladeshi heritage) and Black African groups, who staff identified as being less likely to access available support services.

> *"It was the Bengali and the Black African groups that had the highest proportion of language and communication need, and they were also the least likely to have engaged in any services around Camden, whether that be Best Start for Baby or attending a Stay and Play et cetera."* (Staff FG3, F1)

Although there were very few comments made explicitly regarding barriers specific to Black Caribbean and Black African families, staff identified challenges that may affect their experiences of accessing support.

"She [M1's mother] had very bad treatment through hospitals and things like that around the time I was born…there are countless studies that basically say that a lot of black women…are more likely to be medically neglected in situations like that. And I think as a result of that, my mother, as a Black Caribbean woman, has a bit of a distrust towards any medical or authority service. And I imagine that would be quite a similar barrier for a lot of people, especially Black Caribbean people who just feel as though, since they haven't got good medical treatment in the past, that in terms going forward, felt either... not necessarily be given the wrong information but simply not given as much information or as much support as their white or other ethnic counterparts. I would say that for the Black Caribbean experience in particular." (Staff FG4, M1)

Another staff member mentioned barriers specific to Black fathers:

"I think from the work that that group have done there are perceptions by black fathers where they have had negative experiences and they haven't felt like they're being invited. So, we know about that, that people need very explicit invitations to show that they're included and that they're part of what's being offered." (Staff FG3, M1)



Mothers and staff noted several barriers to engagement faced by Bangladeshi families. Cultural differences in child-rearing, such as preferences for eating habits, often created misunderstandings. In multigenerational households, family members frequently weighed in, but language barriers sometimes prevented them from fully understanding the Health Visitors' advice. Families were occasionally hesitant to open up to healthcare providers not from their community. This was compounded by partners born outside the UK, who had differing views on raising children, such as traditional feeding practices like handfeeding instead of baby-led weaning. Language barriers further hindered communication, leading to non-attendance and delayed identification of infant developmental issues. Additionally, there was stigma around discussing mental health, and the level of clinic intervention sometimes felt unfamiliar, as many women were used to relying solely on family support for maternal and infant care. This sometimes created barriers to disclosing mental health and other challenges, particularly if family members (e.g., grandparents) were home and within earshot during the appointments.

> *"I'm from the Bangladeshi community and I feel like it's also, like, a lot of stigma, like, that they think if they're going to say something like, for example, if they're not feeling themselves, or something, that either they're going to be watched upon, if that makes sense?"* (Bangladeshi INT2, Mother)

7.3.2 Families who live in temporary accommodation

Families in temporary accommodation faced several challenges in engaging with health visiting appointments. Frequent relocations, often between boroughs and/or multiple hotels, made it difficult to maintain consistent contact and led to communication issues. This sometimes resulted in missed appointments, particularly when service transitions and updates in contact information were delayed. Families moving into Camden with babies born elsewhere were not registered as new births in the system, delaying outreach by Health Visitors. Language barriers further complicated these challenges for many refugees and others in temporary housing.

> *"It was really frustrating because when we came back [moved back to Camden] I had an appointment in Camden for my son's eight month check and they ended up cancelling it and rescheduling it for the old borough because there was a mix up…so it's a bit of a nightmare."* (Temporary accommodation INT3, Mother)

Being in temporary accommodation, often for short periods, placed families in a state of limbo, with borough responsibilities sometimes unclear. Health Visitors struggled to keep track of relocations, as appointments were booked in advance and families moved on short notice. These logistical issues were exacerbated by the complex circumstances many families faced, such as financial concerns and meeting basic needs, in addition to caring for their children. A history of negative experiences with government systems also made some families uncomfortable with seeking help. Moreover, the location and accessibility of appointments were problematic if families were not placed near Best Start Family Hubs. Confusion due to multiple databases across services and Boroughs added to the challenge, making it difficult for providers to track movements and ensure continuous care.



> *"[Some] people are just not comfortable with government intervention in general, so people who have had bad experiences with housing for example, people who've been evicted, people who haven't been supported by homelessness prevention, anything like that where the service is attached to the local government. That could definitely cause a barrier."* (Staff FG4, M1)

8.3.3 Families experiencing perinatal mental health difficulties

Families experiencing perinatal mental health difficulties faced several barriers in engaging with health visiting appointments. Many mothers were not aware of the mental health support available, often due to missing appointments or not being informed. Some felt uncomfortable bringing up mental health concerns, which meant support was not always offered. There was feedback that more explicit offers from Health Visitors could be beneficial, although it was important to balance between asking too much and too little, as some families found these inquiries too personal.

Mental health challenges also made it less likely for families to attend Best Start Family Hubs, with appointment forgetfulness being common. Some mothers found tick-box assessments challenging without explanation, fearing negative judgments on their parenting. Many became aware of mental health support through BSfB too late, wishing they had known about it sooner. Concerns about appearing vulnerable and safeguarding also made families hesitant to admit struggles.

For some, mental health was not a priority due to other responsibilities like caring for multiple children. Mothers sometimes became more distressed when their children did not meet developmental expectations, exacerbating feelings of inadequacy. Staff noted that appointment durations were insufficient to adequately address mental health, given other necessary checks. Inconsistencies in psychologist appointments added uncertainty, and sensitive communication was crucial to ensure comfort and understanding.





"I don't think there's enough time allowed [for discussion]...if there's any [mental health] issues, we'll book them for a review, refer them to the psychologist, refer them somewhere else. But as a Health Visitor and a Community Nursery Nurse, to me we have a duty of care for someone in that appointment...[Gives example] She [a mother] was my very last appointment. It was 11:45, it was meant to finish at 12:30. We had a team meeting booked at like, 1:30. I literally got to the team meeting with, like, a minute to spare because I couldn't leave her in the state that she was in. And that's not a one-off, that happens quite a lot. And it's, you know, how are we supposed to deal with that when we don't have the time?" (Staff FG5, F3)

8.3.4 Fathers

Fathers faced several barriers in engaging with health visiting appointments. There was a stigma attached to their attendance, with societal expectations often viewing health visits as the mother's responsibility. Some fathers felt judged by their employers for wanting to attend and requesting time off work. Fathers were not always explicitly invited to appointments, though efforts were being made to change this by including fathers in the language around appointments and offering video call options. Appointment times, often scheduled during weekdays, were inconvenient for working fathers, and it was primarily the mothers who were contacted by the service. Fathers occasionally felt excluded from conversations with Health Visitors, who tended to focus on the mother and baby, even when fathers were primary caregivers. This posed a greater challenge for families with limited time.

"From our experience of developing our fathers' work we know there's a system issue about a, kind of, default thinking of mother being the carer who's providing care. And so, we've done work, a lot of work around that to shift that perception; but that perception still stands." (Staff FG3, M1)

8 RECOMMENDATIONS TO INCREASE REACH AND ENGAGEMENT IN BSFB

The recommendations are based on a rigorous 12-month investigation combing over 40 interviews and focus groups, with analysis of existing service level data. All six recommendations represent the views of evaluation participants and members of the Public Involvement Group, evidence from the literature on early years services (Section 2.1), and the expert consensus from the PHIRST Elevate team (4.1 only).

8.1 Investing into staff, systems and resourcing

The evaluation found that the inconsistencies in contacting families about health visits were partly due to capacity challenges faced by both administrative and health visiting teams (e.g., lack of available appointments, lack of capacity for proactively contacting parents). This is further exacerbated by challenges of working across two different systems operated by the NHS and Camden Council. Given that the current complete enhanced model is reaching only 1 in 4 families in Camden, we recommend that further work is undertaken to understand the workforce, administrative and system capacity and feasibility to deliver all eight contacts universally and equitably, and whether a targeted universalism approach would maximise equity and impact. A targeted universal offer could provide the same core services to all families, while directing additional outreach towards those who are hardest to reach. This would ensure everyone is aware of the service and able to access it, regardless of the barriers they face. This would further strengthen a key asset of the service, as coordinated provision and continuity of care are central to building trust and sustaining engagement (Cowley et al., 2018; Rossiter et al., 2019). Whilst it will be difficult to overcome the logistical issues of working across systems, providing specific training and peer support on how to navigate between different systems could help support staff in this matter. In the long-term, we recommend an integrated/shared recording and information solution, which could then be used as the primary BSfB system.

8.2 Providing a key information resource on what BSfB offers to aid parents' understanding of the service

Many families were not aware of the BSfB offer. If they were, several families did not understand the purpose and content of appointments. The information found online and in the current materials was seen as insufficient and unclear. We recommend creating a centralised information resource which all staff signpost to and encourage use of. Examples include: an app, an easy-to-navigate website, and/or a physical booklet (either in addition to or as a part of the existing 'red book' parents receive). This builds on evidence that clear information and simplified access routes make engagement more feasible, understandable and acceptable for families, with culturally and linguistically appropriate formats being particularly valuable (Dougherty et al., 2020; Edwards et al., 2020). This resource would include an overview of appointments, their purpose and what families should expect. The resource could also include the ability to view upcoming appointments and instructions for rescheduling. Creating one key resource to help communicate the BSfB offer, the advantages it offers to parents and scheduling support could improve how families understand the concept of health visiting and their subsequent engagement with the service.

8.3 More consistent communication from and coordination between BSfB and NHS staff to increase awareness of service

Families felt there is absence of proactive communication from frontline healthcare workers (e.g., GPs, midwives, hospital staff) and BSfB staff, contributing to the lack of awareness on what BSfB has to offer. More consistent, timely communication and reminders about appointments would help support attendance. This is especially relevant for the additional 3-, 6-and 12-month contacts, where there is a larger gap between eligibility and recorded booking compared to the mandated appointments. Families felt that the period immediately after birth, while still in the hospital, was an ideal time for frontline healthcare workers to inform them about the universal health visits. Early or antenatal contact and proactive, personalised outreach are key facilitators of engagement, helping families build confidence and see support as relevant to their needs (Rossiter et al., 2019; Cowley et al., 2018). Providing comprehensive staff training on what BSfB is and how/when it should be communicated to families could help enhance communication and encourage family participation. The staff training should include frontline delivery staff, GPs, and administrators. In addition to helping attendance/engagement from families, such training may also strengthen collaboration between BSfB staff, and help prevent families from being overlooked – especially important in safeguarding situations. Other opportunities to increase awareness of the service that were suggested by parents include: adapting to the ways that parents already communicate (e.g., utilising platforms like WhatsApp more), hosting birthday parties for baby cohorts, offering freebies like books, having a BSfB 'bus' for outreach.

8.4 Enhancing mental health support for parents

In some cases, families experiencing mental health difficulties reported they may face additional barriers to engaging with BSFB and the wider BSfB offer. Barriers such as trouble remembering or getting to appointments and lack of awareness of mental health support services were mentioned by parents who had experienced or were experiencing mental health difficulties as well as health visiting and admin staff. We recommend enhancing communication about available BSfB mental health offers. This could include a specific section in a core BSfB resource (see recommendation 8.2), as well as multilingual leaflets. In addition, we recommend changing the appointment structure where possible to give more time to discuss mental health. This could include incorporating specific questions relating to mental wellbeing into appointments, although parents felt it was important to find a balance between asking too much and too little. Particularly when post-natal depression is a concern, we recommend offering an optional invite to additional caregivers, such as fathers/co-parents or grandparents, to join appointments (where appropriate, while ensuring mothers have opportunities to speak privately with practitioners). This aligns with evidence that engagement is strengthened when services explicitly recognise fathers, partners and other caregivers as valued recipients of support alongside mothers (Solberg et al., 2022; Singhal et al., 2022). Finally, we found that those with mental health difficulties are less likely to take up the wider BSfB offer. Thus, encouraging attendance at Stay and Play groups or similar community activities is important for parents experiencing perinatal mental health difficulties, and could offer additional contact and more informal check-in opportunities. Furthermore, removing barriers to accessing existing mental health support could strengthen identification and responses to emerging perinatal mental health difficulties and parent–infant relationship difficulties.

8.5 Promoting access, inclusivity and diversity

Offering a wider schedule of appointments (e.g., earlier or later in the day and on weekends) could ease participation (e.g., for parents who live far, work or have other responsibilities that make it challenging to attend existing time slots). Offering targeted home visits to families who may struggle to get to Best Start Family Hubs (e.g., due to distance, finances, mental health concerns) could reduce barriers to attendance and reduce drop-off for in-person visits (i.e., after the new baby visit). These approaches build on established strengths of the service and are well supported by evidence identifying home visiting, outreach, flexible scheduling, community-based delivery and interpreter or bilingual communication as key facilitators of accessible and acceptable engagement (Edwards et al., 2020; Donetto and Maben, 2015; Singhal et al., 2022). Additionally, a booking system that allows information for multiple caregivers could make scheduling easier and more flexible, ensuring that the needs of the entire family are considered.



More reliable interpretation services and earlier identification of translation and interpretation needs (e.g., in the hospital and/or at the time of booking) could also support accessibility. We also recommend ensuring health visiting rooms were warm and comfortable for babies and parents, to ensure a warm, welcoming and inclusive space.

8.6 Targeted recommendations for specific parent/carer groups

A lot of barriers were similar across all groups of parents, and there were only very few specific barriers that were mentioned for Black African, Black Caribbean and Bangladeshi families. Thus, we recommend focusing on general increased awareness, communication and accessibility of the service (see recommendations above). Moreover, to further understand possible cultural and language barriers for specific groups like Black African, Black Caribbean, and Bangladeshi families we recommend deeper, longer-term, coordinated and integrated engagement with these groups. This could include co-producing informational materials with these groups, reaching out through trusted community networks, regular feedback sessions with parent champions from these groups. Engagement with culturally and linguistically diverse and migrant families is strengthened by culturally safe, community-connected and co-produced approaches delivered in partnership with these communities (Austin, Hills and Cruickshank, 2022; Litmus, 2020).

Furthermore, ensuring that families who do not engage with other early years support services (e.g., Stay and Play) are reached should be a priority, as these families may benefit most from the BSfB enhanced offer. Offering flexible and accessible services for families in temporary accommodation, ensuring they receive BSfB information and support during frequent relocation periods, is crucial. Additionally, focusing on strategies to support those who have experienced perinatal mental health difficulties (see recommendation 8.4) and ensuring fathers feel included in the health visiting process could lead to better outcomes for these groups and strengthening parent-infant relationships.

9 POTENTIAL IMPACT AND WIDER APPLICATION OF FINDINGS

This evaluation aims to support the service improvement of Best Start for Baby, so that those parent/carer groups who are most likely to benefit from the service can access it. We have made several recommendations for this to happen. Some visits have higher uptake than others, but overall, the service is having a positive impact on many families across the Borough. With only 1 in 4 families completing the enhanced universal pathway, we recommend deeper integrated engagement with specific parent/carer groups, more awareness raising and coordinated communication of the service through staff, awareness raising campaigns, communication assets and written information. Given the resources required to implement these recommendations, and the resources required to then deliver full service to all Camden residents, we advise reviewing workforce, administrative and system capacity necessary to deliver all eight contacts universally and equitably.



This evaluation contributes to the NIHR PHIRST aim of providing evidence to support local councils and NHS services. Beyond Camden, the Best Start for Baby evaluation and other enhanced health visiting evaluation such as the one in Rotherham, where they added an additional 3-month visit, can help other local councils and NHS services shape their local health visiting offers. They will help councils decide when additional appointments might be beneficial and how to enable the widest access and engagement, especially for diverse and disadvantage groups.

In the long-term, with more services introducing enhanced health visiting offers, and with more evaluations of these offers, national frameworks such as the Best Start Family Hubs and Healthy Babies programme and Healthy Child Programme may be adapted to incorporate the evidence of local contexts.

10 REFERENCES

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E. and Randel, P. (2015) 'The power of relationships: Exploring how public health nurses support mothers and families during postpartum home visits', *Journal of Family Nursing*, 21(1), pp. 11–34. doi: 10.1177/1074840714561524.

Austin, C., Hills, D. and Cruickshank, M. (2022) 'Models and interventions to promote and support engagement of First Nations women with maternal and child health services: An integrative literature review', *Children*, 9(5), article 636. doi: 10.3390/children9050636.

Bäckström, C., Thorstensson, S., Pihlblad, J., Forsman, A.C. and Larsson, M. (2021) 'Parents' experiences of receiving professional support through extended home visits during pregnancy and early childhood: A phenomenographic study', *Frontiers in Public Health*, 9, article 578917. doi: 10.3389/fpubh.2021.578917.

Bonakdar Tehrani, M., Kemp, L. and Baird, K. (2022a) 'Culturally and linguistically diverse mothers accessing public health nursing: A narrative review', *Public Health Nursing*, 39(1), pp. 82–88. doi: 10.1111/phn.13015.

Bonakdar Tehrani, M., Kemp, L. and Baird, K. (2022b) 'Sustained nurse home-visiting with culturally and linguistically diverse families: Australian nurses' perspectives', *Public Health Nursing*, 39(1), pp. 40–47. doi: 10.1111/phn.12996.

Brook, J. and Salmon, D. (2017) 'A qualitative study exploring parental perspectives and involvement in health visiting services during the Health Visitor Implementation Plan in the South West of England', *Health and Social Care in the Community*, 25(2), pp. 349–356. doi: 10.1111/hsc.12308.

Cowley, S., Malone, M., Whittaker, K., Donetto, S., Grigulis, A. and Maben, J. (2018) 'What makes health visiting successful—or not? 2. The service journey', *Journal of Health Visiting*, 6(8), pp. 404–412. doi: 10.12968/johv.2018.6.8.404.

Department of Health and Social Care. (2026). *Delivery of the Healthy Child Programme: Part 2: Health visiting (ages 0 to 5)*. GOV.UK. https://www.gov.uk/government/publications/delivery-of-the-healthy-child-programme/part-2-health-visiting-ages-0-to-5

Dickens, J., & Milne, E. (n.d.). *Ready to relate: Parent–infant relationship resource cards*. Bradford District Care NHS Foundation Trust.Donetto, S. and Maben, J. (2015) '"These places are like a godsend": A qualitative analysis of parents' experiences of health visiting outside the home and of children's centres services', *Health Expectations*, 18(6), pp. 2559–2569. doi: 10.1111/hex.12226.

Dougherty, L., Lloyd, J., Harris, E., Caffrey, P. and Harris, M. (2020) 'Access to appropriate health care for non-English speaking migrant families with a newborn/young child: A systematic scoping literature review', *BMC Health Services Research*, 20, article 309. doi: 10.1186/s12913-020-05157-x.

Douglas, H. (2016a). *The Solihull Approach antenatal parenting group: Understanding pregnancy, labour, birth and your baby: Facilitators' manual*. Solihull Approach.

Douglas, H. (2017). *The Solihull Approach postnatal parenting group: Understanding your baby: Facilitators' manual*. Solihull Approach.

Douglas H. (2016b). *Understanding your child's behaviour. Facilitators' manual*. Cambridge: Jill Rogers Associates Dunlop, K., Fulton, M., Hamilton, V. and Llewellyn, C. (2025) 'What are the barriers to parents using child and family health nursing services during the first year of their child's life in NSW?', *Australian Journal of Primary Health*, 31, article PY24190. doi: 10.1071/PY24190.

Edwards, K., Rimes, T., Smith, R., Fernandez, R., Stephenson, L., Son, J., Sarkozy, V., Perkins, D., Eapen, V. and Woolfenden, S. (2020) 'Improving access to early childhood developmental surveillance for children from culturally and linguistically diverse (CALD) background', *International Journal of Integrated Care*, 20(2), article 3, pp. 1–7. doi: 10.5334/ijic.4696.

Graham, K. and Underwood, K. (2012) 'The reality of rurality: Rural parents' experiences of early years services', *Health & Place*, 18(6), pp. 1231–1239. doi: 10.1016/j.healthplace.2012.09.006.

Hackworth, N.J., Matthews, J., Westrupp, E.M., Nguyen, C., Phan, T., Scicluna, A., Cann, W., Bethelsen, D., Bennetts, S.K. and Nicholson, J.M. (2018) 'What influences parental engagement in early intervention? Parent, program and community predictors of enrolment, retention and involvement', *Prevention Science*, 19, pp. 880–893. doi: 10.1007/s11121-018-0897-2.

Hesson, A., Fowler, C., Rossiter, C. and Schmied, V. (2017) '"Lost and confused": Parent representative groups' perspectives on child and family health services in Australia', *Australian Journal of Primary Health*, 23(6), pp. 560–566. doi: 10.1071/PY17072.

Hickey, G., Leckey, Y. and McGilloway, S. (2024) 'Exploring participation and engagement in a multi-component, universal early parenting programme', *Journal of Children's Services*, 19(1), pp. 54–73. doi: 10.1108/JCS-06-2023-0038.

Jepson, R., Williams, A. J., Doi, L., & Buelo, A. (2021). D*eveloping Public Health Interventions: A Step-by-Step Guide*. SAGE.

Johnson, J. (2014) 'Understanding why parents disengage in child health surveillance reviews: A health visitor's perspective', *Journal of Health Visiting*, 2(4), pp. 214–220. doi: 10.12968/johv.2014.2.4.214.

Kennedy, H., Landor, M., & Todd, L. (Eds.). (2011). *Video interaction guidance: A relationship-based intervention to promote attunement, empathy and wellbeing*. Jessica Kingsley Publishers.

Kristiansson, S.O., Wijk, S. and Alsén, P. (2018) 'Participation in parental group support offered by the Child Health Service in Sweden: A qualitative study', *Journal of Health Visiting*, 6(3), pp. 142–150. doi: 10.12968/johv.2018.6.3.142.

Kvamme, E. and Voldner, N. (2022) 'Public health nurses' encounters with undocumented migrant mothers and children', *Public Health Nursing*, 39(2), pp. 286–295. doi: 10.1111/phn.13019.

Litmus (2020) *The qualitative research report to inform the Well Child Tamariki Ora review on whanau Maori moemoea for their pepi/tamariki health and wellbeing*. Wellington: Ministry of Health/Te Manatu Hauora.

Lu, S.V., West, A.L. and Daniels, J.D. (2025) 'Experiences of parents with learning differences in early childhood home visiting: A qualitative descriptive study', Health Promotion Practice. Advance online publication. doi: 10.1177/15248399251350631.

Mangrio, E. and Persson, K. (2017) 'Immigrant parents' experience with the Swedish child health care system: A qualitative study', *BMC Family Practice*, 18, article 32. doi: 10.1186/s12875-017-0604-6.

Morrison, K., Hughes, T., & Doi, L. (2022). Understanding the use of telehealth in the context of the Family Nurse Partnership and other early years home visiting programmes: A rapid review. *Digital health*, 8, 20552076221123711. https://doi.org/10.1177/20552076221123711

Nugent, J. K., Keefer, C. H., Minear, S., Johnson, L. C., & Blanchard, Y. (2007). *Understanding newborn behavior and early relationships: The newborn behavioral observations (NBO) system handbook*. Paul H. Brookes Publishing.

Rossiter, C., Fowler, C., Hesson, A., Kruske, S., Homer, C.S.E., Kemp, L. and Schmied, V. (2019) 'Australian parents' experiences with universal child and family health services', *Collegian*, 26(3), pp. 321–328. doi: 10.1016/j.colegn.2018.09.002.

Royal New Zealand Plunket Society Inc. (2015) *Improving support for Pacific families in New Zealand: Project report*. Wellington: Royal New Zealand Plunket Society Inc.

Singhal, N., Fauth, R., Greenstone, J., Goldberg, J. and Easterbrooks, M.A. (2022) *Father engagement in home visiting: Lessons from Massachusetts*. Medford, MA: Tufts Interdisciplinary Evaluation Research, Tufts University.

Solberg, B., Glavin, K., Berg, R.C. and Olsvold, N. (2022) 'Norwegian fathers' experiences with a home visiting program', *Public Health Nursing*, 39(1), pp. 126–134. doi: 10.1111/phn.12995.

The National Centre for Social Research (2024) *A Better Start National Evaluation Themed Annual Report: Parental Engagement*. London: The National Centre for Social Research.

Underwood, K. and Killoran, I. (2012) 'Parent and family perception of engagement: Lessons from early years programs and supports', *Canadian Journal of Education*, 35(4), pp. 376–414.

Wright, A., Wahoush, O., Ballantyne, M., Gabel, C. and Jack, S.M. (2018) 'Selection and use of health services for infants' needs by Indigenous mothers in Canada: Integrative literature review', *Canadian Journal of Nursing Research*, 50(2), pp. 89–102. doi: 10.1177/0844562118757096.

Wright, A.L., Jack, S.M., Ballantyne, M., Gabel, C., Bomberry, R. and Wahoush, O. (2019) 'How Indigenous mothers experience selecting and using early childhood development services to care for their infants', *International Journal of Qualitative Studies on Health and Well-being*, 14(1), article 1601486. doi: 10.1080/17482631.2019.1601486.

All pictures and quotes are unrelated.

CONTACT

This report was prepared by PHIRST Elevate (NIHR160288). For any questions, please contact: Phirst@ed.ac.uk

REPORT AUTHORS

Dr J. Manner, Dr S. Janac, Dr A. Boath, Ms Z. Roskova, Ms H. Zhang, Dr F. Thompson, Dr P. Kelly, Prof M. Murphy, Dr L. Doi

ACKNOWLEDGEMENTS

We would like to thank everyone who came to the Evaluability Assessment workshops, as well as Rosemary Russell and Sara Roberts for their support throughout this evaluation. We would also like to thank Charlie Churchill, Dr Yan Ting Choong, Hatice Moran Ekmekcioglu, Polly Summerbell and other members of the Public Involvement Group for their input.

FUNDING STATEMENT

This project was funded by the NIHR [Public Health Research programme (NIHR 166241)/PHIRST Elevate (NIHR160288)]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

HOW TO CITE THIS REPORT

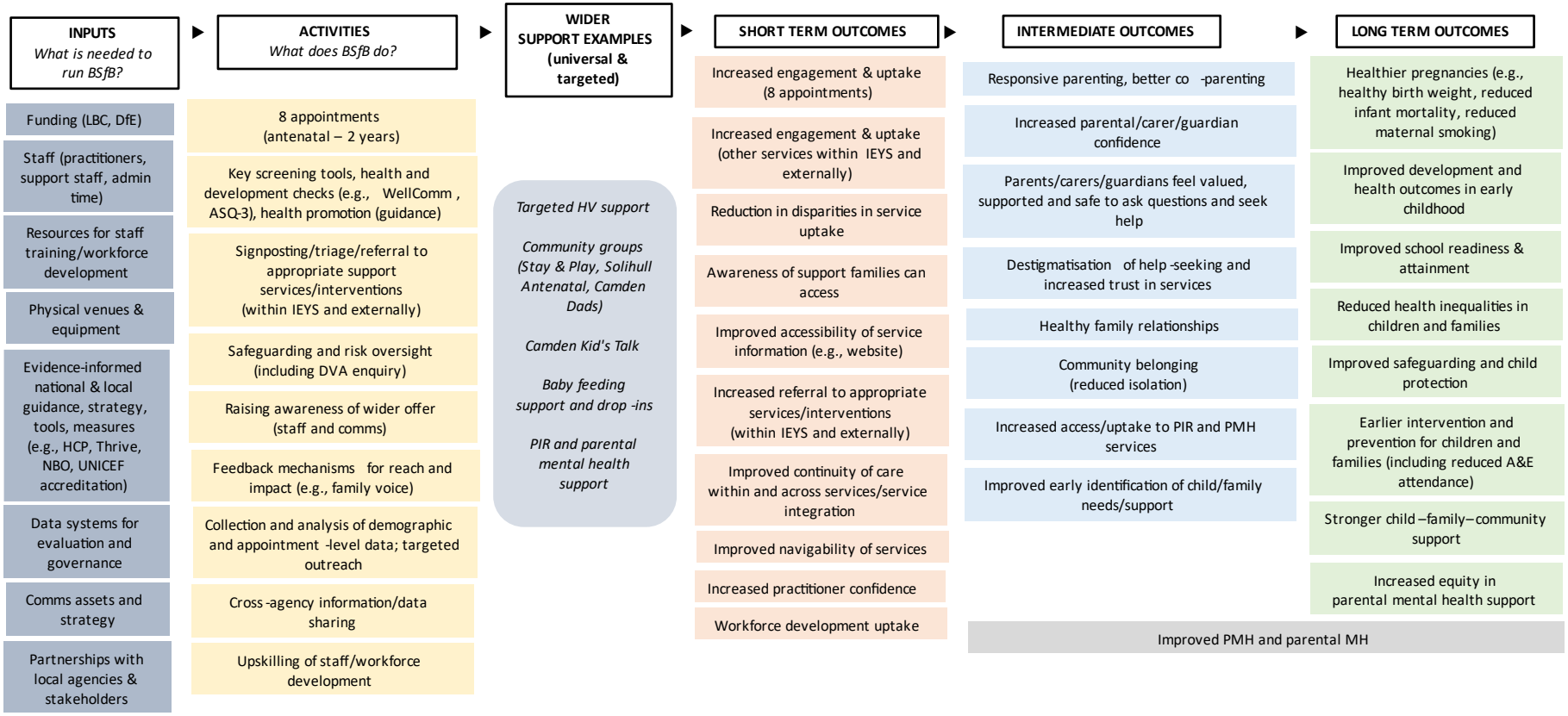
Manner, J., Janac, S., Boath, A., Roskova, Z. Zhang, H., Thompson, F., Kelly, P., Murphy, M., Doi, L. (2026). Evaluation of Camden's Best Start for Baby Service. University of Edinburgh. https://doi.org/10.7488/era/7851

APPENDICES

Appendix 1: BSfB Logic Model

Legend
LBC = London Borough of Camden
DfE = Department for Education
HCP = Healthy Child Programme
NBO = NewbornBehavioural Observations
IEYS = Integrated Early Years Service
DVA = Domestic Violence and Abuse
PIR = Parentinfant relationship
PMH = Perinatal mental health
MH = Mental health

Best Start for Baby
PHIRST Elevate Evaluation Logic Model



Guiding principles: *Parent/carer/guardian/baby -led/father -inclusive - Co-production approach - Holistic approach - Aims to reach diverse/underserved communities*

Appendix 2: Full detail of Work Package 1 methods

WP1 used existing anonymised data from SystmOne and EIS to examine attendance and reach across BSfB contacts. The analysis cohort included children born in 2024 who were known to the Camden health visiting service, CNWL, either through a New Birth record or a Transfer In / Movers In route. Children identified in the wider council cohort but not identifiable in SystmOne were excluded from the main uptake analysis, because contacts could not reasonably be expected to be delivered or recorded for children not visible to the health visiting service.

Antenatal and 24-month contacts were excluded from the main analysis. Antenatal visits were excluded as this element of the BSfB model was still being implemented during the cohort period and was not consistently delivered or recorded as a universal contact. The 24-month contact was excluded because most children in the 2024 birth cohort were not yet old enough to have reached this stage during the analysis period. The analysis therefore focused on the NBV, 6-8 week, 3 month, 6 month, 9 [8-12] month, 12 month, 15 month and 18 month contacts.

Eligibility was defined separately for each contact stage. For the NBV and 6-8 week contact, children were counted as due where they were eligible for the contact. From 3 months onwards, recorded bookings were used where available, restricted to children who were eligible for that contact. This was because complete data on every invitation or offer, such as email, text or phone contact, were not consistently available. A missing booking should therefore not be interpreted as evidence that no offer was made.

Engagement was assessed using due or booked contacts. Full engagement meant that a child attended all due or booked contacts included for them. Partial engagement meant that a child attended at least one, but not all, due or booked contacts. No recorded attendance meant that a child had at least one due or booked contact but no recorded attendance at any of those contacts.

Descriptive analysis was used to summarise attendance by contact stage, engagement group, demographic characteristics and geography. Statistical testing was exploratory. Chi-square tests were used to assess whether full versus incomplete engagement differed by sex, broad ethnic group, locality, ward and IDACI 2025. Adjusted logistic regression was used to examine factors associated with incomplete engagement while accounting for sex, grouped ethnicity, locality, deprivation and the number of due or booked contacts. Fisher’s exact tests were used where numbers were small, including for CLA, CP and Camden Council Children's Social Care and Safeguarding (CSSW) indicators. Results should be interpreted as associations only, not evidence that one factor caused another.

Appendix 3: Additional tables and figures for Work Package 1 findings

Table 2: Number of NBV-12m contacts attended

Number of NBV-12m contacts attended	Children	%
1	20	1.2%
2	164	10%
3	409	25%
4	256	15.6%
5	364	22.2%
6	426	26%

Table 3: Attendance by contact

Contact	Eligible	Booked/due	Attended	Attended %	Attended from booked/due %
NBV	1,931	1,931	1,906	**98.7%**	98.7%
6-8w	1,963	1,963	1,834	**93.4%**	93.4%
3m	1,922	1,135	888	**46.2%**	78.2%
6m	1,826	1,131	946	**51.8%**	83.6%
9m (8-12m)	1,880	1,701	1,653	**87.9%**	97.2%
12m	1,822	962	772	**42.4%**	80.2%
15m	148	148	96	**64.9%**	64.9%
18m	30	30	14	**46.7%**	46.7%

Table 4: Engagement summary (three categories)

Engagement group	Children	%
Full engagement	1,410	66.0%
Partial engagement	725	33.9%
No recorded attendance*	1	<0.1%
Total	**2,136**	

*The "no recorded attendance" group includes only children who had at least one due/booked contact but no recorded attendance at any due/booked contact. Children who attended at least one contact but missed others were counted as partially engaged. As attendance at NBV and 6-8w was high, almost all children with a due/booked contact had at least one recorded attendance, which is why only one child fell into the "no recorded attendance" group.

Table 5: Detailed engagement summary (four categories)

Characteristic	Category	Total in category	Full engagement	Partial engagement: 50-99% attended	Partial engagement: 1-49% attended	No recorded attendance
Sex	Female	1002	675 (67.4%)	324 (32.3%)	3 (0.3%)	0 (0%)
Sex	Male	1134	735 (64.8%)	391 (34.5%)	7 (0.6%)	1 (0.1%)
Broad ethnic group	Asian	414	256 (61.8%)	156 (37.7%)	2 (0.5%)	0 (0%)
Broad ethnic group	Black	231	146 (63.2%)	83 (35.9%)	2 (0.9%)	0 (0%)
Broad ethnic group	Mixed	379	246 (64.9%)	130 (34.3%)	2 (0.5%)	1 (0.3%)
Broad ethnic group	Not recorded	121	83 (68.6%)	35 (28.9%)	3 (2.5%)	0 (0%)
Broad ethnic group	Other	56	43 (76.8%)	13 (23.2%)	0 (0%)	0 (0%)
Broad ethnic group	White	935	636 (68%)	298 (31.9%)	1 (0.1%)	0 (0%)
Specific ethnicity	Any Other Asian Background	84	62 (73.8%)	21 (25%)	1 (1.2%)	0 (0%)
Specific ethnicity	Any Other Black Background	35	15 (42.9%)	20 (57.1%)	0 (0%)	0 (0%)
Specific ethnicity	Any Other Ethnic Group	56	43 (76.8%)	13 (23.2%)	0 (0%)	0 (0%)
Specific ethnicity	Any Other Mixed Background	248	168 (67.7%)	78 (31.5%)	1 (0.4%)	1 (0.4%)
Specific ethnicity	Any Other White Background	585	405 (69.2%)	180 (30.8%)	0 (0%)	0 (0%)
Specific ethnicity	Bangladeshi	210	120 (57.1%)	90 (42.9%)	0 (0%)	0 (0%)
Specific ethnicity	Black - African	162	110 (67.9%)	50 (30.9%)	2 (1.2%)	0 (0%)
Specific ethnicity	Black - Caribbean	17	9 (52.9%)	8 (47.1%)	0 (0%)	0 (0%)
Specific ethnicity	Black - Somali	17	12 (70.6%)	5 (29.4%)	0 (0%)	0 (0%)
Specific ethnicity	Chinese	21	13 (61.9%)	8 (38.1%)	0 (0%)	0 (0%)
Specific ethnicity	Indian	80	55 (68.8%)	24 (30%)	1 (1.2%)	0 (0%)
Specific ethnicity	Mixed - White and Asian	73	44 (60.3%)	29 (39.7%)	0 (0%)	0 (0%)
Specific ethnicity	Mixed - White and Black African	20	13 (65%)	7 (35%)	0 (0%)	0 (0%)
Specific ethnicity	Mixed - White and Black Caribbean	19	6 (31.6%)	12 (63.2%)	1 (5.3%)	0 (0%)
Specific ethnicity	Not recorded	121	83 (68.6%)	35 (28.9%)	3 (2.5%)	0 (0%)
Specific ethnicity	Pakistani	19	6 (31.6%)	13 (68.4%)	0 (0%)	0 (0%)
Specific ethnicity	White - British	337	222 (65.9%)	114 (33.8%)	1 (0.3%)	0 (0%)
Specific ethnicity	White - Irish	13	9 (69.2%)	4 (30.8%)	0 (0%)	0 (0%)
Specific ethnicity	White and Asian	17	15 (88.2%)	2 (11.8%)	0 (0%)	0 (0%)
Specific ethnicity	White and Black African	1	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Specific ethnicity	White and Black Caribbean	1	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Locality	Euston	404	238 (58.9%)	162 (40.1%)	4 (1%)	0 (0%)
Locality	KCH	264	170 (64.4%)	94 (35.6%)	0 (0%)	0 (0%)
Locality	KP	622	443 (71.2%)	174 (28%)	5 (0.8%)	0 (0%)
Locality	KTE	364	228 (62.6%)	134 (36.8%)	1 (0.3%)	1 (0.3%)
Locality	KTW	482	331 (68.7%)	151 (31.3%)	0 (0%)	0 (0%)

Ward	Belsize	180	125 (69.4%)	55 (30.6%)	0 (0%)	0 (0%)
Ward	Bloomsbury	58	39 (67.2%)	19 (32.8%)	0 (0%)	0 (0%)
Ward	Camden Square	88	49 (55.7%)	39 (44.3%)	0 (0%)	0 (0%)
Ward	Camden Town	62	40 (64.5%)	22 (35.5%)	0 (0%)	0 (0%)
Ward	Fortune Green	123	92 (74.8%)	31 (25.2%)	0 (0%)	0 (0%)
Ward	Frognal	91	62 (68.1%)	27 (29.7%)	2 (2.2%)	0 (0%)
Ward	Gospel Oak	118	80 (67.8%)	38 (32.2%)	0 (0%)	0 (0%)
Ward	Hampstead Town	74	55 (74.3%)	19 (25.7%)	0 (0%)	0 (0%)
Ward	Haverstock	110	71 (64.5%)	39 (35.5%)	0 (0%)	0 (0%)
Ward	Highgate	98	65 (66.3%)	32 (32.7%)	0 (0%)	1 (1%)
Ward	Holborn and Covent Garden	116	68 (58.6%)	48 (41.4%)	0 (0%)	0 (0%)
Ward	Kentish Town North	67	47 (70.1%)	20 (29.9%)	0 (0%)	0 (0%)
Ward	Kentish Town South	111	67 (60.4%)	43 (38.7%)	1 (0.9%)	0 (0%)
Ward	Kilburn	130	93 (71.5%)	36 (27.7%)	1 (0.8%)	0 (0%)
Ward	King's Cross	90	63 (70%)	27 (30%)	0 (0%)	0 (0%)
Ward	Primrose Hill	129	81 (62.8%)	46 (35.7%)	2 (1.6%)	0 (0%)
Ward	Regent's Park	103	58 (56.3%)	45 (43.7%)	0 (0%)	0 (0%)
Ward	South Hampstead	147	102 (69.4%)	44 (29.9%)	1 (0.7%)	0 (0%)
Ward	St Pancras and Somers Town	110	59 (53.6%)	49 (44.5%)	2 (1.8%)	0 (0%)
Ward	West Hampstead	131	94 (71.8%)	36 (27.5%)	1 (0.8%)	0 (0%)
IDACI group	0.1	579	356 (61.5%)	220 (38%)	2 (0.3%)	1 (0.2%)
IDACI group	0.2	325	213 (65.5%)	111 (34.2%)	1 (0.3%)	0 (0%)
IDACI group	0.3	171	113 (66.1%)	57 (33.3%)	1 (0.6%)	0 (0%)
IDACI group	0.4	194	133 (68.6%)	60 (30.9%)	1 (0.5%)	0 (0%)
IDACI group	0.5	101	72 (71.3%)	29 (28.7%)	0 (0%)	0 (0%)
IDACI group	0.6	84	53 (63.1%)	31 (36.9%)	0 (0%)	0 (0%)
IDACI group	0.7	81	59 (72.8%)	22 (27.2%)	0 (0%)	0 (0%)
IDACI group	0.8	136	97 (71.3%)	39 (28.7%)	0 (0%)	0 (0%)
IDACI group	0.9	162	117 (72.2%)	43 (26.5%)	2 (1.2%)	0 (0%)
IDACI group	1	303	197 (65%)	103 (34%)	3 (1%)	0 (0%)

Table 6: Engagement by broad ethnic group

Ethnic Group	Full engagement	% Full engagement	Partial engagement	% Partial engagement	No recorded attendance	% No recorded attendance	Total
Asian	256	61.8%	158	38.2%	0	0.0%	414
Black	146	63.2%	85	36.8%	0	0.0%	231
Mixed	246	64.9%	132	34.8%	1	0.3%	379
Not recorded	83	68.6%	38	31.4%	0	0.0%	121
Other	43	76.8%	13	23.2%	0	0.0%	56
White	636	68.0%	299	32.0%	0	0.0%	935
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**<0.1%**	**2136**

Table 7: Engagement by detailed ethnic group

Ethnicity	Full engagement	Full engagement %	Partial engagement	Partial engagement %	No recorded attendance	No recorded attendance %	Total	
Any Other White Background	405	69.2%	180	30.8%	0	0.0%	**585**	**100.0%**
White - British	222	65.9%	115	34.1%	0	0.0%	**337**	**100.0%**
Any Other Mixed Background	168	67.7%	79	31.9%	1	0.4%	**248**	**100.0%**
Bangladeshi	120	57.1%	90	42.9%	0	0.0%	**210**	**100.0%**
Black - African	110	67.9%	52	32.1%	0	0.0%	**162**	**100.0%**
Not recorded	83	68.6%	38	31.4%	0	0.0%	**121**	**100.0%**
Any Other Asian Background	62	73.8%	22	26.2%	0	0.0%	**84**	**100.0%**
Indian	55	68.8%	25	31.3%	0	0.0%	**80**	**100.0%**
Mixed - White and Asian	44	60.3%	29	39.7%	0	0.0%	**73**	**100.0%**
Any Other Ethnic Group	43	76.8%	13	23.2%	0	0.0%	**56**	**100.0%**
Any Other Black Background	15	42.9%	20	57.1%	0	0.0%	**35**	**100.0%**
Chinese	13	61.9%	8	38.1%	0	0.0%	**21**	**100.0%**
Mixed - White and Black African	13	65.0%	7	35.0%	0	0.0%	**20**	**100.0%**
Mixed - White and Black Caribbean	6	31.6%	13	68.4%	0	0.0%	**19**	**100.0%**
Pakistani	6	31.6%	13	68.4%	0	0.0%	**19**	**100.0%**
White and Asian	15	88.2%	2	11.8%	0	0.0%	**17**	**100.0%**
Black - Somali	12	70.6%	5	29.4%	0	0.0%	**17**	**100.0%**
Black - Caribbean	9	52.9%	8	47.1%	0	0.0%	**17**	**100.0%**
White - Irish	9	69.2%	4	30.8%	0	0.0%	**13**	**100.0%**
White and Black Caribbean	0	0.0%	1	100.0%	0	0.0%	**1**	**100.0%**
White and Black African	0	0.0%	1	100.0%	0	0.0%	**1**	**100.0%**
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**0.0%**	**2136**	**100.0%**

Table 8: Engagement by sex

Sex	Full engagement	% Full engagement	Partial engagement	% Partial engagement	No recorded attendance	% No recorded attendance	Total
Female	675	67.4%	327	32.6%	0	0.0%	1,002
Male	735	64.8%	398	35.1%	1	<0.1%	1,134
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**<0.1%**	**2136**

Table 9: Engagement by locality

Locality	Full engagement	% Full engagement	Partial engagement	% Partial engagement	No recorded attendance	% No recorded attendance	Total
Euston	238	58.9%	166	41.1%	0	0.0%	404
KCH	170	64.4%	94	35.6%	0	0.0%	264
KP	443	71.2%	179	28.8%	0	0.0%	622
KTE	228	62.6%	135	37.1%	1	0.3%	364
KTW	331	68.7%	151	31.3%	0	0.0%	482
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**<0.1%**	**2136**

Table 10: Exploratory adjusted odds ratio for incomplete engagement

Factor	Comparison	Adjusted OR	95% CI	p-value
Sex	Male vs female	1.12	0.93–1.35	0.250
Ethnic group	Black vs Asian	0.99	0.69–1.40	0.946
Ethnic group	Mixed vs Asian	0.84	0.62–1.13	0.250
Ethnic group	Not recorded vs Asian	1.37	0.86–2.17	0.185
Ethnic group	Other vs Asian	0.55	0.28–1.08	0.084
Ethnic group	White vs Asian	0.79	0.61–1.02	0.074
Locality	KCH vs Euston	0.76	0.54–1.07	0.116
Locality	KP vs Euston	0.53	0.39–0.70	**<0.001**
Locality	KTE vs Euston	0.77	0.56–1.06	0.107
Locality	KTW vs Euston	0.63	0.46–0.87	**0.005**
IDACI 2025	0.2 vs 0.1	0.91	0.67–1.23	0.526
IDACI 2025	0.3 vs 0.1	0.77	0.53–1.12	0.174
IDACI 2025	0.4 vs 0.1	0.85	0.58–1.23	0.377
IDACI 2025	0.5 vs 0.1	0.60	0.37–0.99	**0.047**
IDACI 2025	0.6 vs 0.1	1.00	0.61–1.64	0.999
IDACI 2025	0.7 vs 0.1	0.75	0.43–1.29	0.296
IDACI 2025	0.8 vs 0.1	0.80	0.52–1.24	0.320
IDACI 2025	0.9 vs 0.1	0.66	0.44–0.99	**0.045**
IDACI 2025	1.0 vs 0.1	1.24	0.89–1.73	0.200
Due/booked contacts	Per additional contact	1.37	1.30–1.46	**<0.001**

Table 11: Chi-square test comparing full and incomplete engagement

Variable	p-value	Result
Sex	0.2317	No evidence of difference
Ethnic group	0.1022	No strong evidence of difference
Locality	0.0004	Evidence of difference by locality
Ward	0.0063	Evidence of difference by ward, but caution
IDACI	0.131	No clear evidence of difference

Table 12: Engagement by ward

Ward	Full engagement	% Full engagement	Partial engagement	% Partial engagement	No recorded attendance	% No recorded attendance	Total
Belsize	125	**69.4%**	55	30.6%	0	0.0%	**180**
Bloomsbury	39	**67.2%**	19	32.8%	0	0.0%	**58**
Camden Square	49	**55.7%**	39	44.3%	0	0.0%	**88**
Camden Town	40	**64.5%**	22	35.5%	0	0.0%	**62**
Fortune Green	92	**74.8%**	31	25.2%	0	0.0%	**123**
Frognal	62	**68.1%**	29	31.9%	0	0.0%	**91**
Gospel Oak	80	**67.8%**	38	32.2%	0	0.0%	**118**
Hampstead Town	55	**74.3%**	19	25.7%	0	0.0%	**74**
Haverstock	71	**64.5%**	39	35.5%	0	0.0%	**110**
Highgate	65	**66.3%**	32	32.7%	1	1.0%	**98**
Holborn and Covent Garden	68	**58.6%**	48	41.4%	0	0.0%	**116**
Kentish Town North	47	**70.1%**	20	29.9%	0	0.0%	**67**
Kentish Town South	67	**60.4%**	44	39.6%	0	0.0%	**111**
Kilburn	93	**71.5%**	37	28.5%	0	0.0%	**130**
King's Cross	63	**70.0%**	27	30.0%	0	0.0%	**90**
Primrose Hill	81	**62.8%**	48	37.2%	0	0.0%	**129**
Regent's Park	58	**56.3%**	45	43.7%	0	0.0%	**103**
South Hampstead	102	**69.4%**	45	30.6%	0	0.0%	**147**
St Pancras and Somers Town	59	**53.6%**	51	46.4%	0	0.0%	**110**
West Hampstead	94	**71.8%**	37	28.2%	0	0.0%	**131**
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**<0.1%**	**2136**

Table 13: Engagement by IDACI

IDACI	Full engagement	% Full engagement	Partial engagement	% Partial engagement	No recorded attendance	% No recorded attendance	Total
0.1 (most deprived)	356	61.5%	222	38.3%	1	0.2%	579
0.2	213	65.5%	112	34.5%	0	0.0%	325
0.3	113	66.1%	58	33.9%	0	0.0%	171
0.4	133	68.6%	61	31.4%	0	0.0%	194
0.5	72	71.3%	29	28.7%	0	0.0%	101
0.6	53	63.1%	31	36.9%	0	0.0%	84
0.7	59	72.8%	22	27.2%	0	0.0%	81
0.8	97	71.3%	39	28.7%	0	0.0%	136
0.9	117	72.2%	45	27.8%	0	0.0%	162
1 (least deprived)	197	65.0%	106	35.0%	0	0.0%	303
Total	**1410**	**66.0%**	**725**	**33.9%**	**1**	**<0.1%**	**2136**

Table 14: Wider service engagement amongst children with and without additional BSfB contact

Service engagement	No additional BSfB attendance	Any additional BSfB attendance
Infant & Early Development	16.7%	54.0%
Stay and Play	19.9%	42.7%
Vitamins collected	41.6%	89.1%
Parenting Support	2.0%	8.7%
SEND/additional needs	2.2%	6.6%
Family/Early Help	7.4%	12.2%
IEYS WR	2.0%	5.2%

Table 15: Statutory social care indicators by additional BSfB attendance

Indicator	Without additional BSfB n/N (%)	With additional BSfB n/N (%)	p-value
CLA	8/1,049 (0.8%)	8/1,262 (0.6%)	0.803
CP	17/1,049 (1.6%)	22/1,262 (1.7%)	0.872
CSSW	68/1,049 (6.5%)	77/1,262 (6.1%)	0.731

P-values are from Fisher's exact tests comparing children with and without additional BSfB attendance. No differences were statistically significant at $p < 0.05$.

Table 16: Wider service engagement amongst children with full and partial engagement with the BSfB offer

Service engagement*	Full engagement	Partial engagement
Parenting Support	5.7%	6.6%
SEND/additional needs	4.9%	5.0%
Stay and Play	33.5%	33.9%
Vitamins collected	72.1%	71.9%
CLA	0.6%	1.0%
CP	1.2%	2.6%
CSSW	5.3%	8.6%
Family / Early Help	9.3%	12.3%
IEYS WR	3.8%	4.1%

Table 17: Early Years Service offer

Service	Session
Infant & Early Development	Baby Bonding
	Baby Feeding
	Baby Massage
	Baby Play
	Books Together
	Save a Baby's Life
	Starting Solids/Next Steps
	Tiny Talkers
	Together Time
Parenting Support	Bump to Baby
	Camden Kids Talk
	Dads Sessions
	Parenting sessions
	Togetherness
	Triple P (Positive Parenting Program)
	Video Interaction Guidance
	Young parents
SEND/Additional Needs	KIDS
	Quiet Stay and Play Session
	Sensory Room
Stay and Play	Fun For All
	Play session
	Saturday Drop-in
	Soft Play
	Step in and Play
	Toddler Time

Table 18: Ethnic group comparison

Ethnic group	Camden U5 population %	BSfB due/booked cohort %	Partial engagement group %
Asian	19.40%	19.40%	21.80%
Black	10.00%	10.80%	11.70%
Mixed	17.40%	17.70%	18.20%
Other	3.00%	2.60%	1.80%
Not recorded	7.30%	5.70%	5.20%
White	43.00%	43.80%	41.20%

Table 19: Sex comparison

Sex	Camden U5 population %	BSfB due/booked cohort %	Partial engagement group %
Female	48.8	46.9%	45.1%
Male	51.2	53.1%	54.9%

Table 20: Locality comparison

Locality	Camden U5 population %	BSfB due/booked cohort %	Partial engagement group %
Euston	19.40%	18.90%	22.90%
KCH	12.30%	12.40%	13.00%
KP	28.00%	29.10%	24.70%
KTE	16.10%	17.00%	18.60%
KTW	24.10%	22.60%	20.80%

Table 21: IDACI comparison

IDACI 2025	Camden U5 population %	BSfB due/booked cohort %	Partial engagement group %
0.1	27.6%	27.1%	30.6%
0.2	15.1%	15.2%	15.4%
0.3	8.5%	8%	8%
0.4	9.1%	9.1%	8.4%
0.5	4.4%	4.7%	4%
0.6	4.1%	3.9%	4.3%
0.7	3.9%	3.8%	3%
0.8	5.7%	6.4%	5.4%
0.9	7.3%	7.6%	6.2%
1	14.2%	14.2%	14.6%

Table 22: Contact to contact continuation

Transition	From	To	Continuation %	Drop-off %
NBV attended → 6-8w attended	1,889	1,777	94.1%	**5.9%**
6-8w attended → 3m attended	1,790	854	47.7%	**52.3%**
3m attended → 6m attended	852	675	79.2%	**20.8%**
6m attended → 9m (8-12m) attended	911	862	94.6%	**5.4%**
9m (8-12m) attended → 12m attended	1,599	757	47.3%	**52.7%**

Figure 3. Drop-offs throughout NBV-12 month pathway (alternative figure)

