North West Coast Clinical Networks

Best Practice Service Model for Parent Infant and Early Years Relationship Services

North West Coast Clinical Network for Perinatal and Early Years Mental Health

July 2023

Cover document

North West Coast Clinical Network

Purpose

The North West Coast Clinical Networks operate across two Integrated Care System areas: Lancashire & South Cumbria and Cheshire & Merseyside.

The Perinatal Mental Health Clinical Network was established in 2016 with Early Years Mental Health formally made part of the network's remit from 2019.

aim

Provide leadership and project management support through clinical consensus to reduce unnecessary variation in services, and to improve health outcomes for service users.

objectives

Co-ordinating the expertise of stakeholders from both commissioning and provider organisations we endeavour to overcome challenges facing services and support the development of service provision in line with the NHS Long Term Plan.

Approach:
"Relationships are the currency for systemic change"
(Bruce Berry)

- **Critical friend**
- **Share best practice across NWC**
- **Support quality improvement**
- **Connect and enable**
- **Co-produce**

Early Years Mental Health

NHS North West Coast Clinical Networks

The NWC Clinical Network story so far

Network group established

September 2019 – under the name Parent Infant Relationship Partnership, part of the *Maternity Clinical Network.* Close working with LMS supporting relationships from conception to age 2.

PIRP Launch Event

January 2020 - in person NWC launch event attended by over 100 people from a range of background including experts by experience.

NWC Parent Infant Pathway

September 2021 – relationship-focused pathway developed by a multi-disciplinary team over 12 months.

Expanded to 0-5

November 2021 – scope of the work expanded up to age 5 in line with national agenda. Name changed to PIER.. *Moved to MH Clinical Network*.

Understanding best practice

October 2022 – T&F group established. PIER Network groups continued to meet for oversight of work.

Scoping reports

May 2022 – reports published to describe the provision of relationship support available in C&M and L&SC .
Two key recommendations made from the summit and scoping.

PIER Summit Event

February 2022 – online event to launch the PIER Network attended by 200 people. Engagement and views re systems priorities

Service model document

July 2023 - best practice service model published and shared widely.

Best practice service model

Development process

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One of the two recommendation made in the scoping reports published May 2022 was:

Develop model of best practice for joint working and service delivery to support relationships and mental health from conception to age 5. This model should provide a reference framework that will build a system to better support joint working.

A three-pronged approach was taken to writing and developing the model document in response to this recommendation:

Task & Finish Group

Met regularly between October 2022 –June 2023.

Membership included:

- Parent Infant Mental Health
- CYP Mental Health
- Perinatal Mental Health
- Health Visiting
- Integrated Care Systems / Commissioning

Engagement Approach

Lived Experience Lead appointed.

Engagement activities included an online survey completed by 225 parents and online focus groups with parents.

Standalone summary report of engagement findings as well as shaping the main report.

PIER Network

Bimonthly meetings.

Individual groups for C&M and L&SC.

Draft versions of the model document shared in January, March and June 2023 for discussion, scrutiny and development.

Total 189 members.

Best practice service model

Summary

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- **A theoretical and aspirational** service model to consider: *how could we best meet the relationship needs of young families?*
- Provides a springboard for system level partners to consider how PIER services could be delivered:
  a) At place
  b) At scale
- Designed to **support system thinking**
- Co-produced with families and professionals. Young children held central.
- **Trusting relationships** as a key principle.
- Describes an approach and an ethos for delivering services that can support parent-child relationships from conception to age 5 across an ICS area.
- Considers how new services could be developed to reduce variation across the NWC area and close the gaps in provision identified by the 2022 scoping reports.

Developed around a key set of guiding principles.

Includes discussion on best practice interventions, outcome measures, workforce, joint working and digital offers.

Considers how a best practice service would be experienced by both parents and young children.

Presents two potential options for how services could be structured:

a. A single service that could operate across an ICS area, with teams working at Place.

b. Partnership model with services commissioned and delivered at Place to agreed standards with ICS level partnership.

Scope of the document:

- Not a service development proposal
- Does not consider funding or commissioning
- Not specific to local Places
- Presents some options, but not all the options

Next steps for the PIER Network

Developing ICS wide approaches to early years mental health

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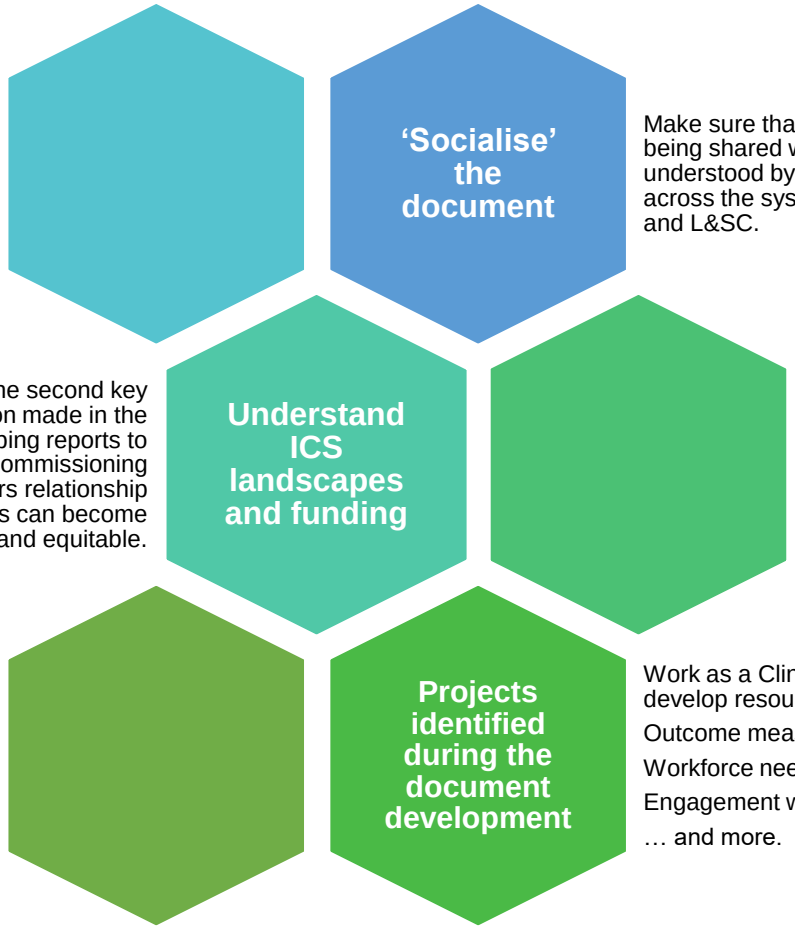

Make sure that the document is being shared widely and is understood by stakeholders across the system for both C&M and L&SC.

Address the second key recommendation made in the May 2022 scoping reports to understand how commissioning of early years relationship support services can become more integrated and equitable.

Work as a Clinical Network to develop resources to address:

Outcome measures

Workforce needs

Engagement with minority groups

… and more.

This document is one step in a programme of work that will continue across the NWC.

Conversations are now needed across ICSs and at Place to understand what this model could offer to our local populations and how it might be used to inform transformation programmes.

Community powered co-production will be essential, where parents and leaders at Place can centre their focus on local neighbourhood assets, structures and unique population needs.

Co-production needs to be a continuous and iterative activity that continues with every step in this process.

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Best Practice Service Model for Parent Infant and Early Years Relationship Services

North West Coast Clinical Network for Perinatal and Early Years Mental Health

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Contents

1 Executive Summary

This document presents a theoretical service model that aims to support children under the age of 5 and their parents to develop healthy and secure relationships across the North West Coast (NWC) area of England. This model was developed in response to scoping reports produced by the NWC Clinical Network in 2022 that identified the lack of an agreed best practice approach for these services.

The purpose of this document is to present an aspirational vision on how we can best meet the needs of families in developing healthy and secure relationships from conception to age 5, with equity of provision across an ICS area. The document is intended as a springboard to support system thinking and exploration around how such services could be delivered "at Place" and "at Scale".

The model describes an approach to service provision that helps to reduce variation across and within the two Integrated Care System (ICS) areas of Cheshire and Merseyside and Lancashire and South Cumbria to deliver support to all parents and children in their earliest years.

This report was written by a task and finish group of experts from a range of relevant disciplines and backgrounds from across the NWC and in collaboration with families who shared experience of parent-infant relationship challenges in their children's early years.

The Parent Infant and Early Years Relationship (PIER) Service model presented here takes a whole-system, community approach with an explicit focus on strengthening family relationships and the 'village' in which the family lives. PIER services will seek to foster trusting relationships with both the families they support and the villages that surround them. Sitting alongside and working jointly with other specialist services, PIER Services support parents directly through a range of evidence-based interventions as well as providing consultation and training to other providers.

The PIER Service model is founded in trusting relationships. By fostering and valuing feelings of trust between service users and professionals or peer supporters, service users will feel supported into, through and out of the service. This will promote the development of trusting relationships within their families.

The project has worked to understand what this model means in a practical sense in the NWC area and how this service could be delivered at scale across two ICS areas. Two potential options for how services could be structured are presented and discussed, both of which could support a reduction in variation across the NWC area whilst maintaining service quality and addressing local need.

The next stage of this project will seek to share this report across the health and social care systems in the NWC with the intention of engaging leaders and commissioners in conversation about how we can seek to realise the ambitions of this model.

2 Introduction

Parent-infant and early years mental health refers to a young child's capacity to experience, regulate and express emotions and form secure relationships. This underpins the social and emotional wellbeing and development of children in the earliest years with impacts that can affect an individual across their entire life.

The early years are a period of rapid development. Early experiences affect not only a child's wellbeing now but also influences how their bodies and brains develop in the future. Although children's development is not determined by age two, persistent problems in early relationships and emotional development can have lifelong impacts on a range of outcomes.

Promoting infant and early years emotional wellbeing and providing support to families experiencing difficulties in early relationships can help to prevent mental and physical health problems in the future including:

- Learning and behaviour
- Earning potential
- Social and emotional development
- Physical and mental health
- Healthy adult relationships

Sensitive, responsive, and trusted relationships are fundamental to infant and early years mental health. Parents and caregivers help young children to feel safe to explore the world and build the foundations of resilience. However, relationship development may be impacted by a range of factors, such as current adverse circumstances for families or the impact of past adverse and traumatic experiences that can make parenting difficult. It is important to note that parenting does not occur in a vacuum. Research has shown that the accumulation of socioeconomic risks negatively impacts child development and attachment relationships, highlighting that parental behaviour is not the only causal factor. Many families require support through a range of thoughtfully sequenced interventions from health and social care.

Good infant and early years mental health promotes positive outcomes throughout a person's life and influences how they parent their own children. Investing in infant and early years mental health and relationship pays dividends for generations to come. All babies and young children should have sensitive, nurturing relationships to lay the foundations for lifelong health and wellbeing.

In 2019, the NHS Long term plan set the ambition to provide *"a comprehensive offer for 0-25 year olds that reaches across mental health services for Children, Young People and adults"* by 2023/24 and references the consideration of the needs of 0-5 year olds.

References and further reading

The NHS Long Term Plan, NHS England, 2019

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Evidence Briefs Series, First 1001 Days Movement, Parent Infant Foundation

https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/

Understanding and supporting mental health in infancy and early childhood – a toolkit to support local action in the UK, UNICEF UK, 2023

https://www.unicef.org.uk/campaign-with-us/early-moments-matter/early-childhood-mental-health-toolkit/

Rare Jewels – Specialist parent-infant relationship teams in the UK, Parent Infant Foundation, 2019

https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/

2.1 The North West Coast approach

The North West Coast (NWC) Parent Infant and Early Years Relationships (PIER) Network was established in 2022 to support the transformation of provision for children from conception to age 5 through stakeholder engagement and quality improvement initiatives across the two ICS areas of Cheshire and Merseyside and Lancashire and South Cumbria. The Network brought together stakeholders from Perinatal Mental Health and CYP mental health as well as universal service providers from across Health, Maternity, Early Years Education, Social Care, third sector and Local Authority providers and commissioners.

In 2022, a scoping report was produced to describe the current offer of support to this age group across the NWC area (see Appendix A: Conception to age 5 mental health support scoping reports) and recommended the development of a model of best practice for the delivery of services, as described in Text box 1.

Recommendation 2: Model of best practice for joint delivery of services

Develop model of best practice for joint working and service delivery to support relationships and mental health from conception to age 5. This model should provide a reference framework that will build a system to better support joint working. The model should include:

a. *What a 'good enough' system looks like – including leadership and professional relationships.*
b. *What services need to be in place – including staffing models.*
c. *What interventions are needed within services.*
d. *Minimum workforce and training needs for each service.*
e. *Workforce training plan to build capacity and to upskill the universal workforce, to ensure equity across the ICS area.*
f. *How and when services / multi-disciplinary professionals should work together to deliver interventions.*
g. *How families should experience a seamless journey through and between services.*
h. *Consistency in performance / outcome measures between services.*
i. *Joint working between Specialist Perinatal Mental Health Services and Children's and Young Persons Mental Health Services to close the gaps around provision of parent infant mental health interventions, in line with the NHS Long Term Plan objectives.*

Text box 1 - excerpt from the NWC Conception to age 5 relationship and mental health support scoping report, 2022.

In 2022 a task and finish group was established with the aim of developing this best practice model. The task and finish group comprised clinical and non-clinical experts from across the NWC area with a range of disciplines and backgrounds. The voice of families with relevant lived experience is represented in this group by the Lived Experience Lead who was responsible for the delivery of the co-production elements of the project, as described below.

2.1.1 Co-production approach

A Lived Experience Lead was recruited to support the work of the PIER Task and Finish group, funded by the Cheshire and Merseyside ICB Participation fund. This role provided ongoing expertise by experience and assistance with data collection from families, to ensure that lived experience informed the development of the service model.

Feedback was collected from families using an online survey, supported by two online focus groups. The survey was open for responses from January – February 2023 and was widely promoted through PIER Network members and partner organisations. Survey respondents were also invited to join focus groups, which took place in March 2023.

The engagement work to date was completed with the aim of understanding what families want and need from PIER services. Data has been collected with this purpose and to provide a broad overview of the general population across the NWC. It is noted that the scope of this project did not extend to conducting additional outreach activity into marginalised communities. For marginalised citizens to make meaningful contributions, their involvement should extend to strategic and decision-making processes in their local communities, actively shaping neighbourhood assets, pathways and provision. With this in mind, asset-based co-production with families is undertaken as a continuous and iterative process within the NWC Clinical Networks, as described in Figure 1.

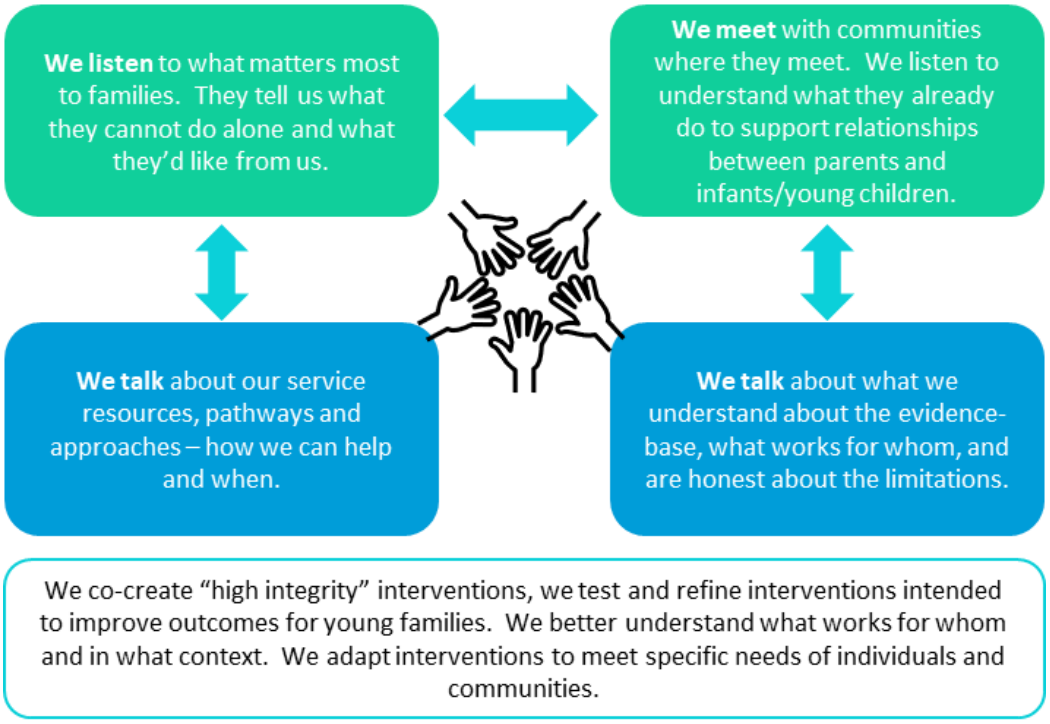

Figure 1 – The North West Coast Clinical Network approach to community engagement for the purpose of designing and developing appropriate and responsive services. Adapted with thanks from the Cheshire & Merseyside Specialist Perinatal Mental Health Service.

It is intended that engagement activity will continue as part of this work programme long beyond the time frame of writing this report. This is especially important in understanding the specific needs of local populations and the barriers to accessing services experienced by marginalised groups at Place. Members of already marginalised populations often face double or triple exclusion owing to their gender, age, ability, ethnicity or other characteristics. This can result in differing priorities and make it difficult for parents to achieve consensus and take collective action. Thus, locally driven approaches are indicated, where parents and leaders at Place can centre their focus on local neighbourhood assets, structures and unique population needs. Community powered coproduction will be essential in the next stages of the PIER work programme, during which the case for commissioning services across all Places of the NWC will be explored in this greater level of detail and specificity in line with the NHS England Core20PLUS5 approach.

The findings of the feedback from families, is presented in full in Appendix B: Family feedback report and have been used throughout this report to direct and inform the service model and as direct quotes.

This approach has resulted in the below guiding principles and the conceptual service model presented in this report.

3 Guiding Principles

The following principles have been identified as key qualities of the service[1] model.

1. The service has a **focus on relationships** between parents and children as opposed to the mental health or behaviour of individuals.

2. The service will provide **dedicated early years relationship support provision**, working with families from conception up to the child's fifth birthday and supporting all parents and carers of young children.

3. The service will be **co-produced at Place with local families** with lived experience of early years relationships and mental health challenges.

4. The model will be based around the **Thrive Model** concept, to describe a whole system approach to change which responds to multiple and different levels of need.

5. The model will describe how the service will **integrate** with the current health and social care system. This will include:

    a. **Outreach and consultation** provided by the service to partner organisations.
    b. Details of **joint working** across sectors and between services including mental and physical health services for both adults and children.
    c. **Collaboration with other relevant services**, including but not limited to perinatal mental health, maternal mental health, neonatal, maternity services, health visiting, general practice, primary care and early years. Including collaborative training plans.
    d. Appropriately flexible **integrated approaches to service commissioning** and monitoring.

6. **Trusting relationships** between parents and professionals will be the facilitator of access to the service: integration of the service within the local system will promote a warm transfer of care in, through and out of the service, taking a **trauma informed care** approach throughout.

7. The service will maintain **flexibility** to meet the needs of service users, allowing staff within the service to have autonomy to exercise best practice approaches. The needs of populations will be met by responsive teams working within a system wide offer that understand their local communities, including marginalised and vulnerable groups.

8. The service will provide a **range of evidence-based interventions** focussed on the child, the parent-baby dyad, couples and families.

[1] The term service here refers to both a single service and a system of services working collaboratively to deliver early years mental health and relationships support to families.

9. The service model will reflect the recognised importance of a **physical presence** in communities for both professionals and service users to foster relationships and improve access for all communities.

10. The model will describe the **workforce needs** of the proposed service in the context of current staffing challenges, including the need for specialised staff.

11. The model will describe **outcome measures** that should be implemented to provide clarity on how the impact of the service is measured. This will include robust audit procedures to support service development and research.

12. The model will consider innovative approaches with the recognition of the need for **new ways of working**. The model will seek to implement current evidence and support seamless integration of services for the service users.

4 Proposed best practice service model

Described in this paper is a model for how parent infant and early years relationship support services could be delivered at scale across an ICS area. This model envisions a cohesive offer of PIER support, in which services that, where they exist, are currently delivered by PIMHS, CYPMHS and third sector providers would be brought together into one offer. The model has been developed to explore how such services could be delivered at scale whilst maintaining flexibility to respond to local need at place.

Two options for how services could be structured to deliver PIER provision equitably across an ICS area are presented in section 4.9. Both service structure options presented share key elements of approach and ethos, as described in sections 4.1 to 4.8.

4.1 PIERS Key Model Elements – Descriptive Narrative

PIERS takes a **whole-system, community approach** with an explicit focus on **strengthening family relationships** and the 'village' in which the family lives. The service will seek to foster trusting relationships with both the families it supports and the villages that surround them. For parents, discussing their relationship with their child can provoke high levels of anxiety and fear of stigma. Being able to develop a trusting relationship with someone within a service, is the key that allows many parents to finally reach out and access the support they and their children deserve and need.

"I had a really good experience this time around compared to when I had my daughter 7 years ago. I feel like my Health Visitor was really good and she saw I was in this time a bit of a not

a great place and kind of ran with it… she really took the lead and just did it and... we talked about trust; she was really good." (Focus Group Participant)

This is not about applying adult mental health concepts to young children and is distinct from traditional or dominant adult mental health language and models (e.g., diagnosis, medication, talking therapies, stepping-up / stepping-down).

A visual representation of the PIERS model concept and how it strengthens and supports the community and individuals around a child and its family is presented in Figure 2 below.

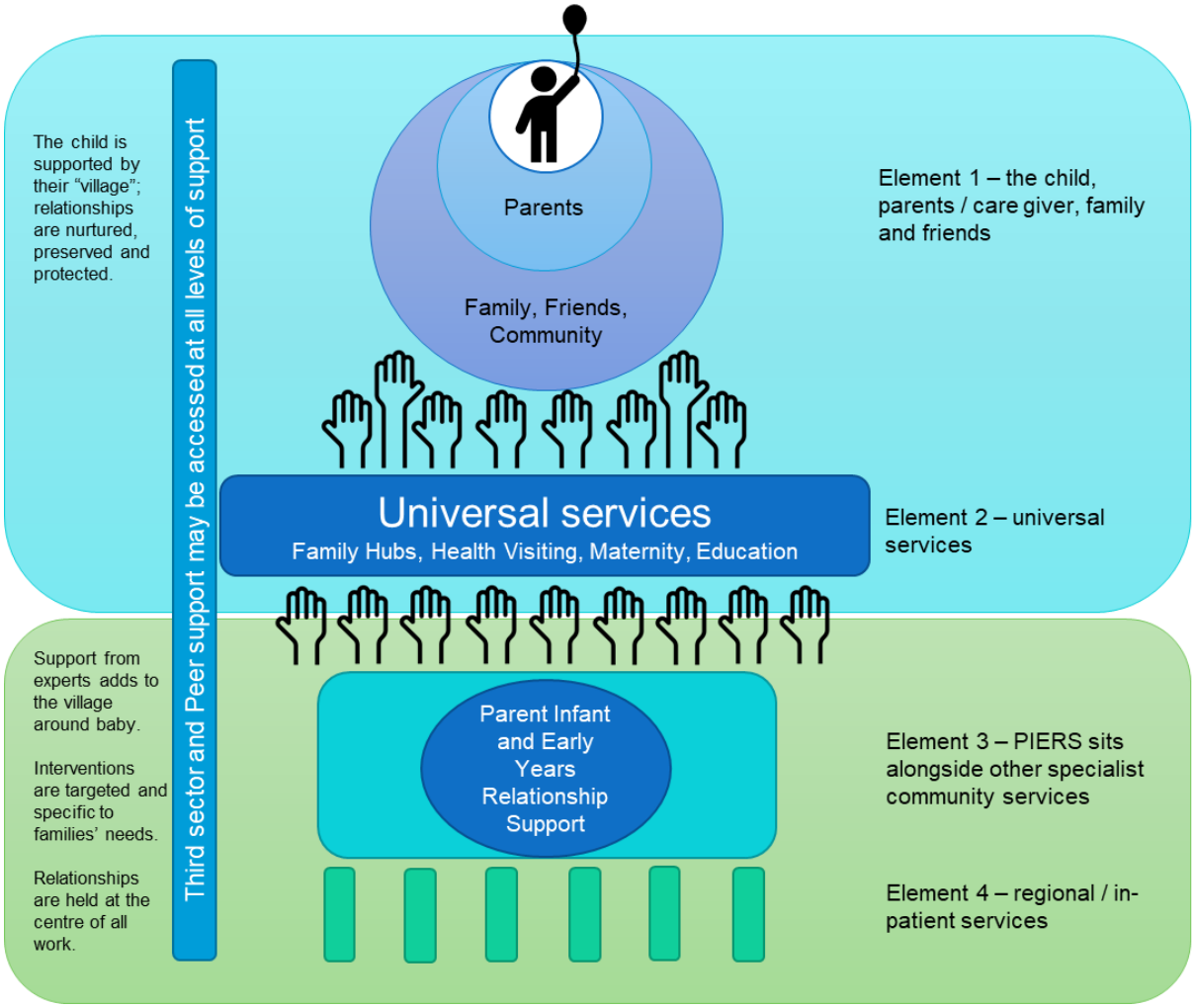

Figure 2 – a visual representation of how the PIER Service is part of the wider system of care surrounding a child.

Element 1 = The child, parents or caregiver, family, and friends

The child is at the top. They are supported by all the layers below them and the closeness of the layers to the top tier represents how close those people are to the child – parents or caregivers next, then family and friends (who may live close-by or further afield or perhaps in a different country all together). This is the kinship village that is helping to raise this child.

This may also include faith and community groups. The value of this support is recognised and nurtured by the whole system.

Element 2 = universal services

As families expand, with the arrival of their first or subsequent child, they will be supported by universal services, such as midwifery and health visiting. These services will 'lean in' to families at this time because it is such a momentous event that every family needs some support.

Families will also link with their local Family Hub, to supplement the support from health care and to connect with other parents in their area. Family Hubs facilitate a "one stop shop" that can provide for all needs of the new family without separating service types or need such as mental and physical health, behaviour, relationships, finances, education etc.

Families will feel mentally and emotionally 'held' by the services in element 2; they will feel heard, understood and given time to work out how they want to do things. This is the professional village and may also include GPs, nurseries, primary schools, community organisations etc.

Element 3 = Parent Infant and Early Years Relationships Services (PIERS)

Some families may have questions or feelings or be doing things in a way that the professionals they are linking with at the universal level feel unable to answer or manage or feel uncomfortable about. These universal professionals would ask parents' permission to talk to staff / teams who are more specialised in infant mental health. Parents would feel respected and included in the process of getting additional expertise.

We want to promote increased access into relationship-based services and enable parents to seek support. Therefore, **multiple points of entry** (self-referral, universal services, GP, specialist services, children's centres etc) are needed into the service where the referral criteria use the language of relationships.

Staff in element 2 (universal) and 3 (specialist) would meet and discuss the concerns, understandings, connected emotions and plans for the family [**consultation model**]. These conversations would be made easier by the training and shared learning that they do together, having shared frameworks, models and language. This might result in the universal staff continuing to support the family, maybe in the way they were doing before but with more confidence, maybe in new ways. Families would experience continuity and useful developments in the relationships and work they are completing with these staff. Or staff in elements 2 and 3 might agree to see the family together [**joint working model**]. The family would experience this as an open and less formal enlargement of their 'village of support'; a 'warm inclusion' rather than a referral to a strange person and service (which they may or may not understand or which may or may not have been explained fully).

If the family and PIER Service agree to undertake a piece of work together **[direct work or assessment / intervention**] there will also be an agreement about how this fits with the support from universal services, and what information will be shared by whom and when, to keep things co-ordinated. This would include practicalities like which days which people meet the family, as well as more conceptual concerns like not pushing the parent to put the child in nursery if their relationship with baby is taking some time to strengthen and they don't want to be separated from baby. Parents will experience coherence in the support they receive between universal and more specialist services.

At some point in the family's journey, they may want and benefit from support from a parent that has walked the path they are on previously or walked a similar path. These peer supporters would be connected to element 3; they would give and receive 'inter-vision' (mutual supervision) with other staff, putting things into psychological models and frameworks and sharing their lived experience expertise. Families would experience 'peer supporters' as knowledgeable friends with clear boundaries; people who are very relatable, reliable and inspiring. Parents who work with a peer support may want to be one themselves in the future.

The families we consulted felt strongly that peer supporters, especially those working in a voluntary capacity, provide a different and at times more accessible alternative to clinical support.

"I would see them [the volunteer] as more able to give because they are obviously doing it for a reason. You usually find volunteers who are helping in specific areas they've been there, done that, they needed the support and that's why they are doing it because they know how beneficial and how helpful it can be. So, for me volunteers would be the main driver and the most beneficial." (Focus Group Participant)

The peer support element of the PIER model should be prioritised and invested in as a sustainable and integral component of the service offer. Peer to peer support should also be provided through the running of group activities that facilitate social connections between families.

Element 4 = regional / inpatient / tertiary services

Tertiary services are available if needed, as an out of village retreat that can provide a temporary solution to a period of acute distress. Families can't stay for long as it's expensive and it's not 'real life'.

Key points of the model:

- Baby or child is supported by their village – PIERS model explicitly serves to support, preserve and nurture relationships.
- When specialist services are needed to offer support, advice or therapy to a family they should not do this in isolation. Specialist knowledge and skill is '**added into'** the system around a baby or child, not separate from.

- The PIER Service temporarily joins the child's village when needed, as such it's vital that these specialist teams are physically located in communities.

4.1.1 How the service will be experienced by families

Below are three fictional accounts from the perspective of a parent, a baby and a young child, based on what we learned through engaging with families through this project's co-production workstream. These accounts imagine what families would say if they experienced a best practice service offer of PIERS.

Parent's perspective

When my baby was born, it was confusing for me that I didn't immediately experience the rush of love that I'd been told to expect. What I felt towards him was much more complicated than that and it made me doubt my abilities as a parent and the relationship that we had with each other. It was difficult to know who I could talk to about this, or how to bring it up, as I didn't know who I could trust and how I would be judged by professionals. I was also feeling ashamed that I wasn't coping well with becoming a mum.

I learned about our local PIER Service online and it was reassuring to know that there was support available to me and that what I was experiencing happens to other mums too. Despite knowing this, it was still a relief to be asked by my Health Visitor how I felt about our relationship and about being a mum.

I trusted my Health Visitor when they suggested a referral into the PIER Service. My Health Visitor was able to come to my first appointment with PIERS and it meant a lot to have them there to support me in talking about difficult things. I felt listened to and I felt like the best interests of my family were always being considered.

The service offered me a couple of options for how they could help me and helped me to think about what might work best for our family, such as who might be involved in the appointments and what we wanted to get out of the work.

Some of our appointments were done at home, which was helpful at times when it was difficult to get out of the house with the baby, but it was also nice to have the option to go to the family hub or to talk on the phone or via video call when it was difficult to fit appointments around what was going on in my life.

It made a big difference to know that the people who were supporting me through PIERS knew what it was like to be a parent and had struggled with some of the same things that I was going through. This was the same for when I met other parents at the PIERS group, we helped each other through the tough times and continued to support each other outside of the group too.

I never felt judged by the people who supported me, so I always felt safe to tell them what was really going on for us all as a family. I trusted the people that I worked with and connected

with them on a human level. When it came to the end of my time with PIERS, my team made sure that I had support around me and that I felt happy and confident to leave the service.

I've learned so much about my baby and how I can be a great parent to him. I really enjoy spending time with him now and I feel like we have a really special bond and connection.

Baby's perspective

My parents are the most important thing to me in the world. I rely on them for everything; for making sense of the world and for my security and safety.

I need them to communicate with me and show me kindness, love and understanding. When they are not present with me and can't connect with my ways of communicating, it makes me feel scared, lonely, and incomplete. When they are stressed and angry, it makes me feel stressed too.

When my parents had help to think about how they can engage with me and communicate with me, it made me feel more connected to them. I am now learning more about the world and people around me, and their support and love make me feel confident to explore.

Young child's perspective

My emotions can feel really big and overwhelming to me, I don't know what to do with them, so I end up making a lot of noise and break things or hit my baby sister. My parents used to get angry when I this happened and would shout at me or leave me alone. This made me feel abandoned and ashamed.

After my parents had help to understand what I was experiencing in these moments, they changed how they reacted in these situations. They seem much calmer, and I have started feeling calmer too. We are playing more together - our favourite game is playing shop. I love being the shopkeeper the best! When my big feelings come, I don't feel like I am doing something wrong, and I know that my parents love me no matter what.

I am getting used to being away from my parents and my home. Now that I feel safer with my parents at home, I have found it easier being at nursery and I like being able to meet new people and explore this new place.

When I come home to my parents, I know that it is ok to let out my feelings and that my parents are there to help me to feel better again. I am excited to start school next year, I am feeling ready to learn and explore more of the world.

4.1.2 Thrive Framework

The Thrive Framework for Systems Change (see Figure 3) was developed by the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre. This can be used to conceptualise the differing needs of the parent-baby/child relationship and different support and interventions to meet their specific needs. In this model, the Thrive Framework is presented as a method of conceptualising levels of need and mapping these to the types of support and interventions that might be offered by the PIER Service or other organisations that the service would link with.

Different frameworks were considered in the development of this model, with the Thrive framework proposed for the following reasons:

- It is a needs-led approach, which means parent-baby/-child relationship and mental health needs are defined by families alongside professionals, through shared-decision-making. Needs are not based on severity, diagnosis or care pathways.
- It moves away from a stepped or tiered model of delivering services, to focusing on matching support and intervention to need.
- It relates to all families. It places emphasis on the prevention and promotion of wellbeing and mental health, with a view to all Thriving.
- It uses language about wellbeing and mental health which everyone can understand.
- It looks to identify and build on family and community strengths and resources.
- It was developed for all families of children and young people aged 0-25 and has been adopted by perinatal and infant mental health models of service conceptualisation and delivery [Manchester and Cwm Taf Morgannwg, Wales (PIF report, 2021)].
- It has been highlighted as a model of good practice in: Understanding and supporting mental health in infancy and early childhood – a toolkit to support local action in the UK, UNICEF UK (2023).

Figure 3 - The Thrive Framework for Systems Change as presented by the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre.

The Thrive framework conceptualises five different needs-based groupings:

1. *Thriving* – this represents parent-baby/ child relationships that are thriving and whose current need is support in maintaining the wellbeing of their relationship. This is met through effective *Prevention and Promotion* strategies. Communities and services working together should consider how to support such initiatives at a system-wide level. Particular care may be needed to focus on vulnerable groups and those systematically at greater risk, through targeted outreach and interventions and tailored support that meets specific needs.

2. *Getting Advice* – this represents those who experience mild or temporary difficulties, distress or concern about the parent-baby/child relationship. They may be managing and not wanting or needing goals-based specialist input. They identify needing *Advice and/or Signposting*. The best intervention fitting their needs is usually within the community and can include signposting to access self-support. Advice may include a range of topics which impact on the relationship and may be offered by a range of people around the family (element 2). These people may lean into PIERS for consultation, to strengthen this offer. Information, advice, and signposting is to be shared in a way that empowers families to make choices.

3. *Getting Help* – this represents those who need specific, evidence-based interventions which are focused on agreed aims and outcomes for the parent-baby/-child

relationship. An intervention can be any form of help targeted to the relationship needs, which is offered directly by a specific individual, team, or service whose role and responsibility is to provide such interventions. The intervention is characterised by a shared understanding about what a successful outcome looks like, how likely it is to occur by a specific date, and what would happen if not achieved. Emphasis is placed on ending the intervention if it is felt it is not working or if gains do not outweigh costs or potential harm.

4. *Getting More help* – this represents parents and babies/children who need help with their relationship and would benefit from more extensive and specialist interventions. What this looks like may vary, but generally it is recognised that more resource is needed. This could relate to the length and/ or type of intervention, and degree of specialist skills required. Families in this grouping may have overlapping needs which means there is likely need for clear coordination between different agencies. Interventions also need to be focused and evidence-based, with clear goals and means of evaluating outcomes and progress.

5. *Getting Risk Support* – this represents the needs of parent-baby/-child relationships that have not benefited from or are unable to use help at that current time, but where there are high concerns about the relationship and identified risk within that relationship. Families will still be in contact with services due to the concerns and risk, but what is provided is focused on managing risk only. It may be that despite extensive input, the family are currently unable to make use of the advice, help, or more help offered. For example, the family may be in crisis in other areas of need(s), and this may be getting in the way of them accessing the focused, evidence-based intervention for the parent-baby/child relationship. It may include families where there is statutory involvement from Social Care and Child Protection Plans or Child Proceedings are in place, as an example. There is likely to be contact with multiple agencies. As such, effective coordination for risk support is needed. To promote, develop and maintain effective relationships with the family, relational-focused models may be useful to draw on. One example includes AMBIT model *(see references below)*.

To facilitate effective implementation of the Thrive framework, the relationships between the family and others in their village of support are prioritised in developing a shared understanding of the family's needs and collaborative plans for support and intervention. PIERS will work in partnership with the family and their village of support. Consultation can facilitate understanding of a family's needs and joint working may be helpful.

Each person, agency and service in the community may offer support and interventions which cut across the needs-based groupings. The framework can help understand the support and interventions offered by services and how these meet different needs of families. Specific offers will vary according to local need and commissioning; however, a broad conceptualisation is represented below:

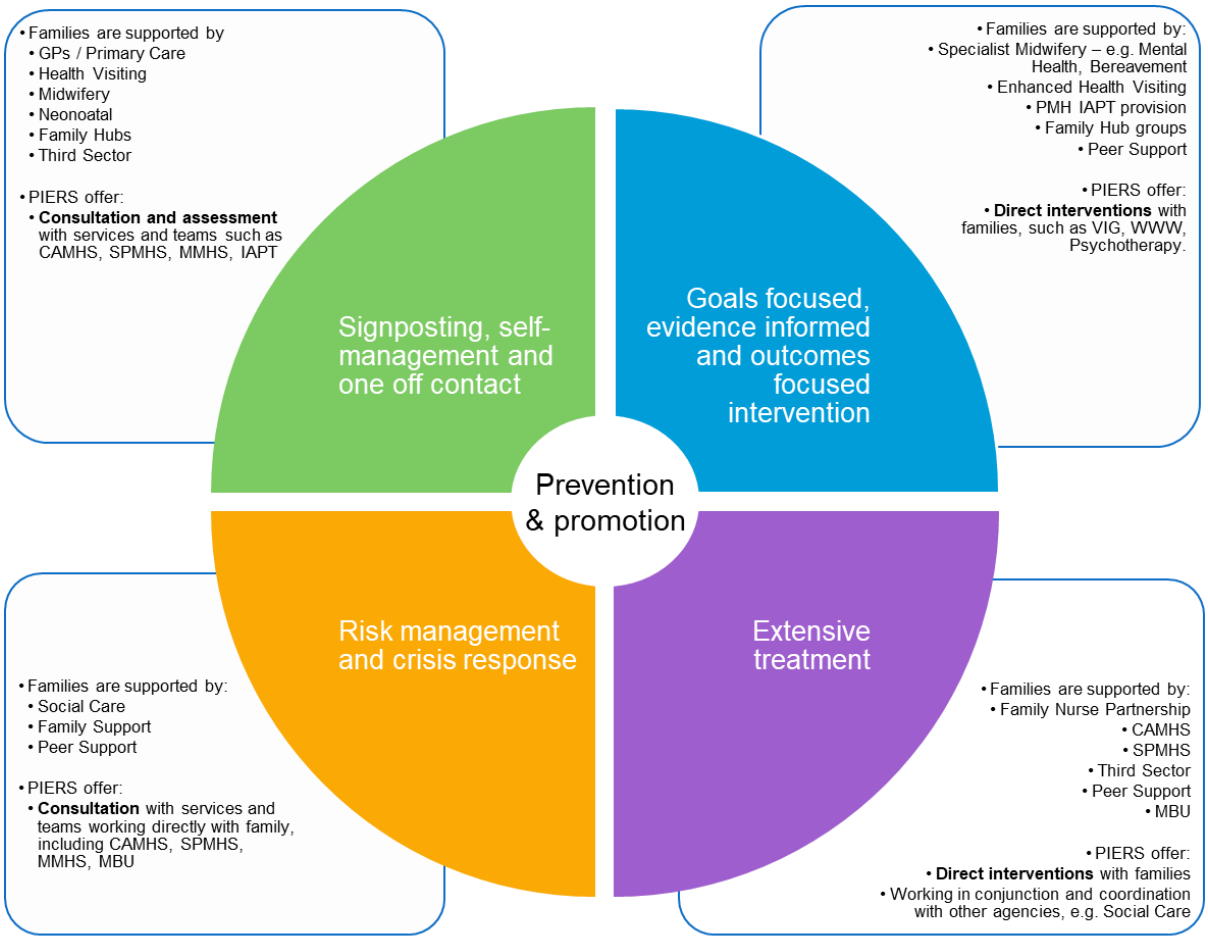

Figure 4 - The Thrive model presented in relation to the proposed PIER service model.

References and further reading

THRIVE – The AFC-Tavistock Model for CAMHS

https://www.annafreud.org/media/2552/thrive-booklet_march-15.pdf

Innovations in Practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT), Bevington, Fuggle, Fonagy, Target, & Asen, 2013

https://pubmed.ncbi.nlm.nih.gov/32847259/

Voice of the Infant Best Practice Guidelines (2023)

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2023/03/voice-infant-best-practice-guidelines-infant-pledge/documents/voice-infant-best-practice-guidelines-infant-pledge/voice-infant-best-practice-guidelines-infant-pledge/govscot%3Adocument/voice-infant-best-practice-guidelines-infant-pledge.pdf

4.2 Interventions

The findings of the family survey and focus groups indicated, through thematic analysis, that families would like the service to deliver support in the following key areas:

- Education on child development
- Reassurance on typical behaviours
- Opportunity to meet other parents
- Mental health support for parents
- Advice
- Practical parenting skills (e.g., sleeping, weaning, feeding, first aid)
- Group activities
- Self-help resources
- Signposting to other services
- Peer Support
- Activities for parents, both alone and with their child

And there should be a high level of emphasis on empowering parents as the experts in their own families.

"whatever you set up has to really focus around the Mum and the Dad or the parents, that family, as the experts and just having that recognition because that gives you confidence in yourself if you think, oh someone else thinks that about me, then it gives you a bit of a boost and a bit of confidence and then building on that as to all the other things, the practical elements and what you do with a baby, how to play with a baby" (Focus Group Participant)

For many parents who responded to our survey and focus groups, there is a strong link between the practicalities of parenting and bonding.

"You are just expected to know what to do. And I feel like people, especially kind of the younger ones, they don't dare say, do you know what can I have a little bit of help? How do you bath your baby? 'Cos you are just sent home and you are just expected to know." (Focus Group Participant)

"He [my boyfriend] could have benefited from something around relationship with a baby and bonding… he didn't feed him for the first three days because he didn't dare because he was too dainty" (Focus Group Participant)

Interventions that can offer support around the practicalities of parenting, especially for first time parents could help to increase confidence in parents and reduce barriers to bonding.

This underscores that identifying support and interventions begins with forming a relationship with parents and understanding their views, areas of concern, hopes and goals. Explicit attention is given to the voice of the baby/child, for example considering *'What is the baby/ child telling us? If they could talk, what might they say?'* Through developing a shared understanding about the strengths and needs in the parent-baby/-child relationship, support and intervention options can then be explained and discussed. Interventions are agreed in full collaboration with parents, led by their needs and change which they hope for.

The survey findings also point to the need for interventions across the groupings of needs in the Thrive Framework and the PIER Service can have a role across all.

Approaches focusing on **Prevention and Promotion** to support families to **thrive** may include:

- Feeding into public health and whole community initiatives
- Awareness raising
- Training
- Selective prevention initiatives targeted towards groups who are facing health and social inequalities.

For families who need **Advice and Signposting**, the PIER Service may join universal staff in supporting the family through offering consultation and/ or joint working with them (see section below). Outcomes may include providing information, increasing access to self-help resources, and signposting and navigating families to resources and support in the local community. The emphasis is on building on families' own strengths, resources and sources of support around them.

For families identifying as needing to be 'Getting help' and 'Getting more help', the PIER Service could deliver direct interventions jointly or in collaboration with universal services. The ideal is for there to be a range of evidence-informed interventions, so that families can make informed choices and receive interventions which are tailored to their circumstances. They include individual and group approaches to provide opportunities to meet and connect with other parents and families with the primary focus of these interventions on the parent-baby/-child relationship(s). Examples may include:

- Parent-Infant Psychotherapy
- Watch Wait and Wonder
- Video feedback approaches, including Video Interaction Guidance (VIG) and Video-feedback Intervention to Promote Positive Parenting (VIPP) and Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)
- Family Therapy
- Mellow Groups, which include Mellow Bumps, Mellow Babies and Mellow Parenting
- Circle of Security, including the original 20 session group programme, and Circle of Security Parenting 8-10 session group. The approach can also be delivered with individual families.
- Mentalization-Based Therapy approaches, which focus on increasing mentalizing and reflective functioning skills
- Play based approaches, such as Watch Me Play
- Empowering Parents, Empowering Communities

Central to all interventions will be the importance of assessment by observation. This is vital to ensure that the voice of the baby or child is held central in the intervention and to make sure that their needs are well understood as an individual, not solely through the parent's reporting.

As highlighted by the parent survey and focus groups, other interventions to help parents experiencing mental health needs may also be provided or signposted to for joint working, for example with Specialist Perinatal Mental Health Services or NHS Talking Therapies.

"I saw a psychotherapist, and this did help me to understand the impact of my own childhood abuse and to understand how it could impact on my own parenting. It gave me time to reflect and act." (Survey Respondent)

Peer support is highlighted as a valued intervention across all levels of need. The role of Peer Supporters will be prioritised within the service. The families we consulted reported that peer supporters provide a different and at times more accessible alternative to clinical support and may also be able to reach those less inclined to access traditional methods of service delivery.

"I feel like men might be, hmm, this healthcare professional or this whoever is showing me how to change a baby and they're going to then watch me. And then they feel on edge. But, if it was delivered by a peer support, another dad who felt that exact same way, I feel like there would be moments when I would prefer not to be there, and he would benefit from me not being there not looking over his shoulder." (Focus Group Participant)

"Zoning into the people that could potentially be at the same groups as you... there in that moment with you, they are at the same stage as you, so those sorts of peer-to-peer support would obviously be worthwhile 'cos they know exactly what you are going through, sleep deprivation, a whingy baby, teething baby, all those different milestones they'll kind of be doing the same thing." (Focus Group Participant)

Peer support should be available throughout a family's journey through the service and may be initiated at any time point.

If families need **Getting Risk Support,** then the PIER Service may contribute to a plan to manage risk or response to crisis. A family may be in the position where there is concern about risk to the parent-baby/-child relationship, but they are not, at that point, able to benefit from interventions available. They may be in a time of crisis or for other reasons, not able to make use of the help offered. The key services around a family may include Social Care, Family Support and Peer Support, and they may ask the PIER Service to join in thinking about supporting a family through consultation. Given the need for close collaboration between families and different professional groups who may be around supporting the family, approaches that focus on relationships can be drawn upon, for example AMBIT (Bevington, Fuggle, Fonagy, Target, & Asen, 2013). Crucially, families continue to have support from someone whom they know, have confidence in, and trust. This may be a Peer Supporter though could be anyone who they have formed that relationship with.

When considering training needs of the workforce to deliver the interventions outlined in this report, the sustainability of skills and the capacity to deliver high quality interventions should be considered. Some interventions require significant investment of time and resources to ensure that the skills are maintained within teams and safely supervised. Some benefits will come from delivering these interventions across a wider geographical area, however arrangements for staff support should be considered.

References and further reading

Parent Infant Foundation Toolkit:

https://parentinfantfoundation.org.uk/tools/implementation-toolkit/

Foundations for life: What works to support parent-child interventions in the early years, Early Intervention Foundation:

https://www.eif.org.uk/report/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years

4.3 Outcome measures

The use of outcome measures is essential to understand the effectiveness of a service or intervention to all stakeholders, including service users, professionals working in the service and commissioners.

The following principles have been agreed around outcome measures for use in the PIER Service model:

1. **As a relationships-based service, only measures that relate to the relationship between parent and child will be core to the PIER Service model.**

   This will be consistent for all service users, regardless of the age of the child from conception to age 5. Other measures that look at parental mood (EPDS, GAD-7, PHQ-9) may be useful for describing mood but will not be considered as part of the core outcome measure set.

2. **All measures used must add value to interventions as experienced by service users and should not be seen as additional work for either service user or practitioner.**
   The service users' experience of outcome measures will be central to their use in this model. Measures that are already familiar to professionals are preferable, to make best use of existing skills. Successful implementation of outcome measures will support both the service user and the professional to understand progress made during an intervention.

3. **Outcome measures used must be proportionate to and appropriate for the intervention being delivered.**
   This relates to the service users' experience of the outcome measures and the amount of time and resource required to effectively implement outcome measures, as well as ensuring that the measure captures an aspect of the parent-infant relationship that is relevant to the intervention (e.g., attachment).

4. **Outcome measures used should be suitable for mapping against the Thrive framework.**

5. **Outcome measures should be consistent across the service to enable data collation, validation and analysis that will support service development.**

All outcome measures that could be adopted come with strengths, weaknesses and challenges and are often the focus of research and development, so current best practices should be considered.

It is recognised that multiple outcome measures may be used by a single service to meet the objectives listed above and to meet the varying aspects of care offered by the service.

The tools adopted for use will vary depending on the unique circumstances and preferences of each family. For example, some families may find a structured approach to outcome measurement reassuring, whereas for others it could trigger feelings of judgement and surveillance. Communication between practitioner and service user to establish a common understanding of the purpose of outcome measurement, as guided by the agreed principles in this document, is key to success and will allow the flexibility required.

References and further reading

Measuring What Matters, Centre for Early Childhood Development, 2023

https://blackpoolbetterstart.org.uk/wp-content/uploads/MWM-Report.pdf

Managing Data and Measuring Outcomes, Chapter 8, Implementation Toolkit, Parent Infant Foundation

https://parentinfantfoundation.org.uk/tools/implementation-toolkit/chapter-8/

4.4 Workforce

The PIER Service workforce will be comprised of a group of specialised individual professionals who will work to support the village that surrounds a child. This will include work with other professionals from across the health and social care system as well as a child's informal support systems and community. These PIER team members will be highly trained in specific skills, all with the intention of holding the baby in mind throughout the service and will operate across all four quadrants of the THRIVE model.

The team would comprise people from a diverse backgrounds, including individuals with relevant lived experience and a range of complementary skill sets. Members of the team will come from a range of disciplines. This mixed skillset is key to support a joint working approach. Establishing a team of individuals from across a range of backgrounds and disciplines could also support recruitment processes given the early stages of the development of this area of healthcare. Some suggested role groups and skills are discussed in the context of service structure options in sections 4.9.1 and 4.9.2.

In addition to the key team members outlined above, joint working with partner services will be a key element of the model and could be further strengthened by the recruitment of workers for sessional hours per week. This might include colleagues from CYP Mental Health, Health Visiting, Maternity, Social Care, Neonatal services, Education and others.

4.5 Joint working, consultation and training

This is part of the process of expanding the network (or village) around a child – universal staff asking for another and different perspective to join them in supporting a family to thrive. The objective of this joint working approach is to provide a smooth and seamless experience for families, so that they are not at risk of falling between services. This may be particularly pertinent when supporting families with more complex needs. Communication channels should be established and agreed between services when working together to make sure that information is shared efficiently and considerately.

An agreed consultation model with professional groups within universal services would support a joint working approach with key partners such as Health Visiting, Midwifery, Primary Care, General Practice, Education, Specialist Perinatal Mental Health Services (SPMHS), Maternal Mental Health Services (MMHS) and Children and Young Peoples Mental Health Services (CYPMHS). Joint clinics may also be offered where there are overlap in service outcomes and interventions.

Joint working will look different across an ICS area due to variations in services provided between Places. These may include both statutory and third sector providers. There is a wide variation in in support models on offer by voluntary, community, faith and social enterprise organisations. Each local offer should consider “how do we best meet the needs of local families” in the context of their collaborators.

A coherent, agreed, shared training programme for the region would be delivered by PIERS in collaboration with SPCMHS, MMHS, CYPHS and the Neonatal Network, covering all key aspects of parent-infant mental health and linking in with other relevant training needs such as Perinatal Mental Health, Education, Public Health, etc.

Topics to include, but not limited to:

- Attachment and bonding
- Antecedents to attachment security (Sensitive Responsiveness, Mentalization)
- Ghosts in the nursery
- Perinatal mental health - opportunities and impacts
- Complex trauma, relationships – opportunities and impacts
- Couple and family life cycle changes in perinatal period
- Neonatal journeys
- Working with families in distress (containment and reciprocity)

4.6 Addressing health and social inequalities

It is important to acknowledge and consciously address the health inequalities that exist for the populations that the service will work for.

NHS England's Core20PLUS5 approach describes how health leaders should be working towards addressing health inequalities through working with the 20% most deprived of the national population (Core20) as well as population groups known locally to be disadvantaged (PLUS), including ethnic minority communities, inclusion health groups and learning disabilities amongst others. The strategy for Children and Young People includes access to mental health services from age 0 as one of the five clinical areas of focus, highlighting the need for development in this arena.

Research estimates (PIF) that 34% of infants born into low-income families experience disorganised attachments styles, whereas this decreases to only 15% for middle-class families.

The service will work to actively address these health inequalities through targeted engagement with at-risk communities and the development of trusting relationships with these populations and the groups and leaders working amongst them. It is acknowledged that marginalised and more vulnerable families will need additional support to access services.

The experience of mental health and relationships in this period may appear different for some families based on many factors, including but not limited to, culture, heritage, experience, additional needs and income. These should all be considered thoughtfully during the development of service provision at Place and the support offered to families.

To accurately monitor and consider equity of access, the service will routinely record quality ethnicity and social deprivation data for service users. In turn, data will inform how to best target resource and outreach activity to particular communities or neighbourhoods.

References and further reading

Disorganized attachment in early childhood: meta-analysis of precursors, concomitants, and sequelae, Van IJzendoorn, M., Schuengel, C. & Bakermans-Kranenburg, M. (1999)

https://pubmed.ncbi.nlm.nih.gov/16506532/

Chapter 3: Funding and Commissioning a Specialised Parent-Infant Relationship team, Implementation Toolkit, Parent Infant Foundation

https://parentinfantfoundation.org.uk/tools/implementation-toolkit/chapter-3/

Core20PLUS5 – An approach to reducing health inequalities for children and young people, NHS England, 2022

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

4.7 Best start for Life agenda and Family Hub development

The UK Government's Family Hubs and Start for Life programme has set out funding for selected Local Authorities to develop system-wide models of providing high-quality, joined-up, whole -family support services from conception to age 19. Several LA areas in the NWC that have not been awarded funding are self-funding the development of family hubs in line with the government programme. Parent-infant relationship and perinatal mental health support has been identified as one of the priority areas of the Family Hub and Start for Life programme with the goal being to promote and support positive early relationships and good mental wellbeing for babies and their families.

PIER Services should be fully integrated with local Family Hubs. This approach could provide access to a physical base and therefore a presence within the local community, as well as facilitating better integration of services and joint working between professionals supporting families. Several areas in the NWC are already including mental health services for parents and young children within their family hubs. The PIER model would look to build upon this best practice and ensure consistency in this approach across the NWC.

4.8 Digital offer

Feedback from families showed that a hybrid approach that utilises new technology, but does not entirely rely on it, was seen as the gold standard. It is recognised that there are benefits from being able to offer appointments remotely, via video and telephone calls, especially for families with young children, when it is not always easy to get to appointments and venues. However, virtual appointments should be offered in combination with in-person interactions that support the development of trust and personal connections between service provider and user as well as reducing the impact of digital exclusion for those groups without easy access to technology required.

"The dynamics of all three [WhatsApp, Zoom and face to face group] settings, the dynamics of all three are completely different and cater to completely different types of people and situations" (Focus Group Participant)

"I'm pregnant now and I can't get to things in the week because my husband works away, and my little boy is in bed. So being able to access stuff like yoga and things on zoom that's like a gamechanger" (Focus Group Participant)

There is a growing evidence base for online forms of help for children under the age of five. It is important to acknowledge that for many parents, when searching for information and support, looking online is usually the first step to finding this. Over two thirds of respondents in our parents' survey said that they would first turn to the internet for support. With this in mind, it is important that the service has a strong presence online to reach parents and families at an early stage. High quality, NHS approved, and locally relevant information has been suggested as wanted and missing by the parents that we engaged with:

"It surprised me how much I had to learn about parenting approaches, breastfeeding and normal infant sleep from Instagram accounts and Facebook pages rather than NHS pages" (Survey Respondent)

References and further reading

Moving from exclusion to inclusion in digital health and care:

https://www.kingsfund.org.uk/publications/exclusion-inclusion-digital-health-care?utm_source=twitter&utm_medium=social&utm_term=thekingsfund&s=03

4.9 Service structure options

Within the NWC area there are some services that are already offering exemplar approaches to support parent-infant and early years relationships and mental health. These include Specialist Parent-Infant relationship services delivered by NHS and third sector organisations, as well as offers within Specialist Perinatal Mental Health and Children and Young Persons Mental Health Services, as presented in the 2022 Scoping Reports by the NWC Clinical Network (see appendices). However, these scoping reports also highlighted the significant variation in the availability of services across the geographical area, and the lack of specific provision for children between the ages of two and five years old.

Presented below are two options for how an ICS wide PIER offer could be structured to overcome the inequity in service provision across the NWC. Both models look to incorporate existing services and extend the current offer across the whole population.

Two options are presented here with the aim of supporting whole-system thinking and planning. It is acknowledged that there may be other potential alternative solutions.

4.9.1 Option A: Single ICS wide PIER service

In this model, the PIER Service would operate across an ICS area with teams operating at "Place" level. PIER teams would enhance and build-on existing provision, not take away or be distinct from, illustrated in Figure 5.

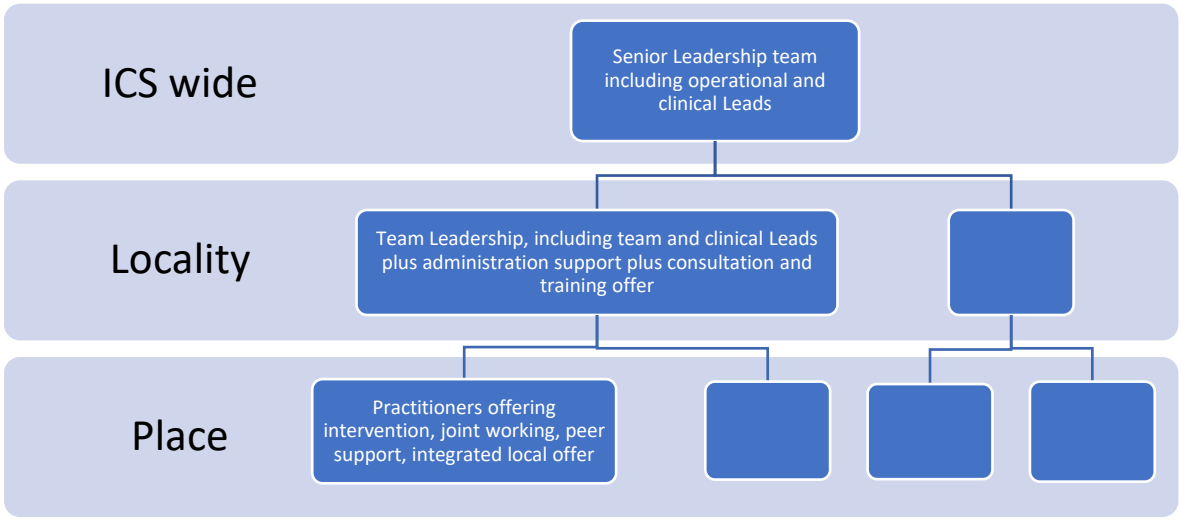

Figure 5 - Structure of a single PIER service working across an ICS.

Teams within the service will serve a locality, consisting of 2-3 "Places" within the ICS, facilitating local leadership. Practitioners within the teams will be allocated to a single Place and will be aligned to the Family Hubs (or Children's Centres) within that Place. This will allow practitioners to have a physical presence in their local community which will support the vision of the Family Hub model. This will allow relationships to be developed locally with professionals, facilitating better integration of services and joint working with families, to provide continuity of care.

This service structure can benefit from the experience of those involved in the establishment and development of other services, for example, the Specialist Perinatal Community Mental Health Services (since 2016) and Maternal Mental Health Services (since 2020).

4.9.1.1 Incorporation of existing services

The PIER Single Service model aims to assimilate existing provision into a single service across the ICS. By adopting a collaborative and integrated approach to commissioning, existing services that currently deliver within the PIER remit would be incorporated into the model described. Provision would also be expanded, and additional teams established to address current gaps for areas that do not currently have services in place. Existing Parent Infant Mental Health Services and Early Years Mental Health Teams within CYP MH services could be adopted to form Place or Locality Teams within the single service.

With team leadership at Place and Locality level, the single service would be expected to deliver a bespoke offer that is tailored to the needs of local populations whilst working within the specifications of the single service. This model supports an integrated approach to commissioning that delivers equity in both quality and quantity of service provision across a wider area whilst also maintaining sensitivity to local need and community cultures.

4.9.1.2 Team structure

Suggested role groups that could support the single ICS wide PIER Service model are outlined in Table 1.

Role group:	**Team Management**
Working across…	ICS / Locality
Able to deliver…	Team management Project management Stakeholder engagement Leadership Collaboration with other services
Example roles might include…	Head of Service, Operational Manager, Project Manager
Role group:	**Clinical Leadership**
Working across…	ICS
Able to deliver…	Clinical leadership Clinical supervision Clinical expertise on parent-child relationships Consultation Training
Example roles might include…	Clinical Lead, Consultant Clinical Psychologist, Parent-Infant Psychologist, Psychotherapist, Systemic Psychotherapist
Role group:	**Practitioners**
Working across…	Place
Able to deliver…	Interventions Collaborative MDT case management Work with a wide range of needs Patient centred approach with baby kept in mind Consultation with other professionals
Example roles might include…	Systemic Family Practitioner, Early Years Practitioner, Health Visitor, Psychologist, Art Therapist, Child Therapist, Nursery Nurse, Parent-Infant Psychotherapist, Family Therapist
Role group:	**Peer Support**
Working across…	Place
Able to deliver…	Peer support to parents Collaborative MDT case management Patient centred approach with baby kept in mind Relevant lived experience
Example roles might include…	Peer Support Worker, Peer Support Volunteer, Peer Support Coordinator

Table 1 – description of role groups that could make up the workforce of a single ICS wide PIER service.

4.9.2 Option B: Place based services working in partnership

In this model, PIER services are commissioned and delivered at each Place across an ICS area. Each service is committed to the guiding principles of the PIER service and contracted to operate to minimum service levels but operate independently of one another.

Each Place based PIER Service has practitioners, peer support and leadership. The services are responsible for developing and delivering their local service offer that is appropriate to the identified and evidenced needs of their local populations.

As part of the commissioning arrangements, these services will form part of an Operational and Clinical Partnership across the ICS area, as illustrated in Figure 6. This partnership will focus on delivery of PIER services and will work primarily to ensure equity across the ICS area, as well as supporting teams through collaboration to reap benefits from working at scale, such as:

- Training
- Peer mentoring
- Scrutiny
- Shared learning
- Quality improvement
- Research

This model could support a consistent and integrated approach to commissioning that delivers equity in the quality and quantity of service provision across a wider area whilst also maintaining sensitivity to local need and community cultures. Service leadership would have strong links to the local population that could support a mirroring of the relationships between professionals and parents and parents and children.

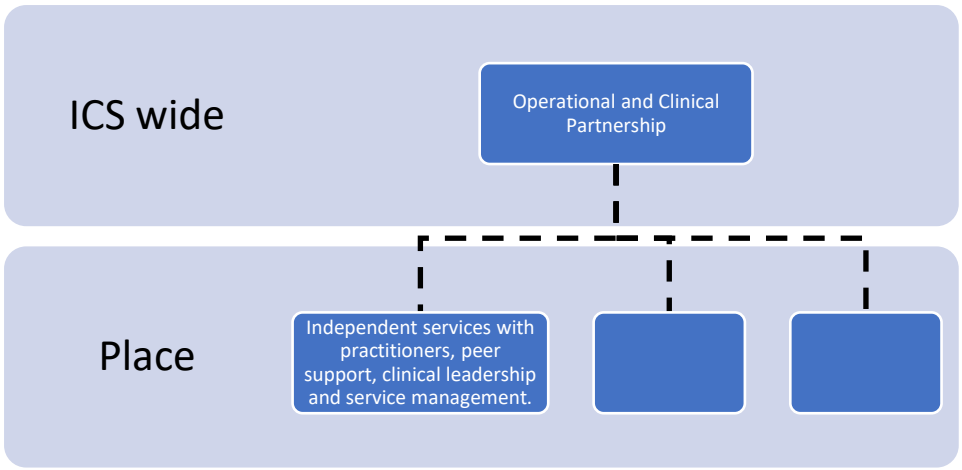

Figure 6 – Structure of a Partnership model of independent PIER services operating at each place in an ICS.

4.9.2.1 Incorporation of existing services

Within the NWC area there are some services that are already offering exemplar approaches to support parent-infant and early years relationships and mental health. In those areas where the remit of the PIER model is already being met, existing services may continue their current operation, whilst becoming part of the Operational and Clinical Partnership. Some areas may require existing services to expand their service offer to meet the remit of the PIER model or to join multiple teams, services or offers. Other areas may require new services to be established from scratch.

Within this model option, services could be delivered by either NHS or third sector providers.

4.9.2.2 Team structure

Suggested role groups that could support the Place based services partnership model are outlined in Table 2.

Role group:	**Operational Partnership Management**
Working across…	ICS
Able to deliver…	Project management Stakeholder engagement Collaboration Network management
Example roles might include…	Network Manager, Programme Manager

Role group:	**Team Management**
Working across…	Place
Able to deliver…	Team management Project management Team leadership Collaboration with other services
Example roles might include…	Head of Service, Operational Manager

Role group:	**Clinical Leadership**
Working across…	Place
Able to deliver…	Clinical leadership Clinical supervision Clinical expertise on parent-child relationships Consultation Training
Example roles might include…	Clinical Lead, Consultant Clinical Psychologist, Parent-Infant Psychologist, Psychotherapist, Systemic Psychotherapist

Role group:	**Practitioners**
Working across…	Place
Able to deliver…	Interventions Collaborative MDT case management

	Work with a wide range of needs Patient centred approach with baby kept in mind Consultation with other professionals
Example roles might include…	Systemic Family Practitioner, Early Years Practitioner, Health Visitor, Psychologist, Art Therapist, Child Therapist, Nursery Nurse, Parent-Infant Psychotherapist, Family Therapist
Role group:	**Peer Support**
Working across…	Place
Able to deliver…	Peer support to parents Collaborative MDT case management Patient centred approach with baby kept in mind Relevant lived experience
Example roles might include…	Peer Support Worker, Peer Support Volunteer, Peer Support Coordinator

Table 2 – description of role groups that could make up the workforce of an ICS Partnership approach to Place based PIER Services.

Consistency will be provided to the workforce across the service in numeration and employee benefits, particularly when workers are employed by different providers such as NHS or third sector organisations.

4.9.3 Comparison of service structure options presented

	Advantages	Disadvantages
Option A: Single ICS level PIER Service	Commissioned as one service, providing opportunity for integrated approach, consistency, and financial security. Improved equity for professionals across the ICS area (e.g. professional development). Consistent referral pathways and governance processes across the ICS. Consistency in leadership. Consistent branding and messages to families. Single line of communication with ICS.	Potential loss of sensitivity to local need and community cultures. Loss of relationship / connection between leadership and communities. Risk of delivering a "one size fits all" model across a broad population. Potential introduction of an additional level of management / leadership. Single funding stream could put ICS population at risk of financial cuts.
Option B: Place based services working in partnership	Commissioned to meet specific needs of local populations. Potential for stronger relationships between clinical team leadership and local populations. Greater scope for variation and creativity in service offer at Place level. Specific resource for the purpose of collaboration and innovation (partnership manager role). Clinical leaders have more authority and freedom to develop service in response to local need. Potentially less NHS bureaucracy.	Potential duplication of leadership in each Place. Risk of service offer becoming diluted or of some Places not investing in early years mental health. Multiple funding streams could put individual teams at risk of financial cuts. Risk of increased bureaucracy working with multiple service providers. Potential limitations of authority of an Operational Partnership could reduce speed of transformation across an ICS. Variation in service offer between places potential source of confusion for families, provider, and commissioners.

Both models present challenges and opportunities. When reviewing service structures, it is essential to maintain focus on providing services in ways that build trusting relationships between families, professionals and the wider village surrounding them, keeping in mind the guiding principles presented in section 3 of this report.

In support of this, systems need to work towards provision of better joint working:

"Kept me passing from one to another and did not help at all. Just had to tell my story multiple times to multiple different people." (Survey Respondent)

"It's like you feel that you don't have too much support and there is no continuous support, there are different silos... I'm not sure if there is no exchange of information - or probably they are very busy and they could not do it - I'm not sure, but it is not very good." (Focus Group Participant)

Systems need to develop greater equity of access to services, as outlined in the 2022 Scoping reports (Appendix A), and as described by the families we consulted:

"I think there should be access to free classes no matter where you live, just because you live in an "expensive area" doesn't mean you can afford lots of classes." (Survey Respondent)

"I found the support we have depend of where we live. Like the postcode lottery." (Survey Respondent)

Families are looking for services that they can build trusting relationships with, that support them during their challenges in ways that work for them:

"I am completing this survey as a grandparent of a 6-year-old child who has started to hit and spit at parents when having a tantrum. It seems like everything is a battle of wills at the moment. I try to support my daughter, but I think she requires more formal help and she has been unable to find help and support in the community in any meaningful way." (Survey Respondent)

"Making it easy to access, so if it is a self-referral thing it not be you email someone but then they are going to ask you to fill in a quiz, and if you fill in the quiz you only got 50%, you don't qualify for the service. It should be 'I need help', 'cool pop in'." (Focus Group Participant)

4.10 Local Need

In both the service structure options presented, the need for local variation in how services are delivered would be recognised. Services should be delivered at Place that are appropriate and accessible to the local community, cultures and system. Services at Place would be supported to maintain their individuality and local expertise and would allow new teams in areas currently underserved to develop to meet identified local needs. Simultaneously, the model would have the potential to provide a minimum standard of acceptable services across the NWC and would ensure parity of access for service users and opportunity for professionals.

To achieve this, it is recognised that significant investment of resource would be necessary to fully understand the needs of each local community, with particular emphasis placed on engagement with and accessibility of services for marginalised communities and in line with the NHS England Core20PLUS5 approach.

The size of the workforce for each locality will be based on population size, birth rates and levels of deprivation, as described in Table 3 and Table 4.

Lancashire and South Cumbria – 5 Places:	Cheshire and Merseyside – 9 Places:
Morecombe Bay	Cheshire East
Pennine Lancashire	Cheshire West
Fylde Coast	Halton
Central Lancashire	Knowsley
West Lancashire	Liverpool
	Sefton
	St. Helen's
	Warrington
	Wirral

Table 3 - Integrated Care Systems and Places in the North West Coast

	Total population aged 0-4	6.5%	Additional 5% in areas of increased deprivation	Total level of need	Initial target (35% of predicted need)
Lancashire & South Cumbria	74,276	4,828	5,060	6,174	2,161
Cheshire & Merseyside	111,629	3,628	8,576	10,251	3,588

Table 4 - Summary of population for ICS areas for children aged under 5 years based on data from the Office of National Statistics, 2020, and accounting for increased need in areas of increased deprivation (ONS 2021) based on the model presented by the Parent Infant Foundation Commissioning Toolkit, 2023.

References and further reading

Family Hubs and Start for Life Programme:

https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme

Parent Infant Foundation Commissioning Toolkit 2022:
https://parentinfantfoundation.org.uk/tools/commissioning-toolkit/

Core20PLUS5 – An approach to reducing health inequalities for children and young people, NHS England, 2022

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

5 Summary

This report has presented a theoretical service model that would support children under the age of 5 and their parents to develop healthy and secure relationships, improving mental health outcomes for all family members across the life course, in line with the ambitions of the NHS Long Term Plan.

The PIER Service model presented here takes a whole-system, community approach with an explicit focus on strengthening family relationships and the 'village' in which the family lives, with trusting relationships held as a core value to both service delivery and outcomes for service users.

This report has explored what this model means in a practical sense in the NWC area and presents two options for how this service could be delivered at scale across an ICS area for all parents and children in their earliest years, reducing variation across the area whilst maintaining service quality and addressing specific local needs.

The next stage of this project will seek to share this report across the health and social care systems in the NWC with the intention of engaging leaders and commissioners in conversation, at scale and at place, about how we can work to realise the ambitions of this model.

6 Acknowledgements

This report was authored by the members of the NWC PIER Network Task and Finish Group: Dr Beth Luxmoore, Kaisu Fagan, Dr Ruth O'Shaughnessy, Dr Helen Honor, Dr Michael Galbraith, Neil Fothergill, Rachel Smethurst, Tracy Greenwood, Melanie Farman, Brian Cooper, Carolyn Watkins, Zoe Tate, Dr Claire Buckley.

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This project would not have been possible without the honest, brave responses of over 150 families from across the North West Coast. We sincerely thank them for their support, and for their generosity in using their often-challenging experiences to improve outcomes for future families.

North West Coast Clinical Networks

Best Practice Service Model for Parent Infant and Early Years Relationship Services

North West Coast Clinical Network for Perinatal and Early Years Mental Health

July 2023

Appendix A: Conception to age 5 mental health support scoping reports

North West Coast Clinical Networks

Review of Mental Health and Relationship Support Services for families from conception to age 5 across the North-West Coast: **Cheshire and Merseyside**

Version	1.1
Date	May 2022
Author	Dr Beth Luxmoore – Clinical Network Manager, Perinatal Mental Health, NWC Clinical Networks, NHSE
Owner	Dr Gillian Strachan – Consultant Psychiatrist and Chair of the NWC Perinatal Mental Health Clinical Network for Lancashire and South Cumbria and Dr Ruth O'Shaughnessy – Consultant Clinical Psychologist and Chair NWC Perinatal Mental Health Clinical Network for Cheshire and Merseyside
Contributors	Ms Tracy Greenwood, Dr Lisa Marsland, Dr Libby Chamberlain - Co-Chairs, 0-5 Subgroup NWC Perinatal Mental Health Clinical Network With thanks to all members of the 0-5 subgroup and contributors from stakeholder organisations.

North West Coast Clinical Networks

Contents

1 Introduction

Since January 2020, the North West Coast (NWC) Perinatal Mental Health (PMH) Network has supported developments in Parent Infant Mental Health (PIMH) across Cheshire, Merseyside, Lancashire and South Cumbria through its Parent Infant Relationships Partnership (PIRP).

In 2021, this multi-disciplinary and inter-agency collaboration produced the NWC Parent Infant Mental Health Care Pathway (Appendix A). This document, along with its supporting guidance, was developed as a tool to support all professionals working with families from conception to age two to initiate supportive conversations with parents about their relationship and bond with their baby. The agreed purpose of the pathway was to raise awareness of the importance of discussing relationships with families in the perinatal period, recognising that simple conversations can be powerful in understanding the needs of families during this critical period of child development.

In November 2021, the work of this group was expanded to include children up to five years of age, after identifying a gap in pathways and family support options with a focus on mental health, relationships and wellbeing for families with infants, toddlers and pre-schoolers. At this point the PIRP was rebranded under the name of "Best Start for Life NWC" which was launched at an online Early Years Mental Health Summit for the NWC in February 2022.

Key objectives for the NWC workstream include:

- To develop tools to gather information around current service provision.
- To support stakeholders (CCG and local authority commissioners and service providers) to complete scoping returns for local CCG areas.
- To compile the results of the scoping exercise to summarise the provision of support available.
- To deliver an Early Years Mental Health Summit event for the NWC area to engage with stakeholders and gather feedback.
- To identify areas of best practice service provision in the NWC area.
- To identify gaps in service provision.
- To identify opportunities for commissioner, service and system development.
- To consider what a 'good enough' system looks like.
- To listen and engage with a wide range of stakeholders to canvass views and inform recommendations.

This report outlines a scoping project to understand what provision is available to support the mental health, relationships and emotional wellbeing of families from conception to age five across the NWC to identify examples of best practice and gaps in service provision. The results of the scoping project will be discussed alongside stakeholder feedback from the NWC Early Years Mental Health Summit, with 'next steps' recommendations made for commissioners and systems across Cheshire and Merseyside.

1.1 Infant and Early Years Mental Health - National drivers and policy context

It is now well-established that the first 1001 critical first days of a child's life lay the foundations of wellbeing for their future. The Parent Infant Foundation (PIF) produced a series of reports under the umbrella movement "1001 days", outlining key evidence for the importance of early brain development in shaping healthy futures [1]. Research unequivocally indicates that attuned, responsive parent-child relationships are at the heart of good developmental outcomes for children [2]. Despite burgeoning evidence, at present, there is a lack in national guidance around best practice for parent-infant and 0-5 mental health services (please see reference list and further recommended reading).

The NHS Long Term Plan (2019) places key funding emphasis on improving access to specialist community perinatal mental health services, maternal mental health services and boosting mental health services for parents but makes no mention of parent-infant and early years mental health teams. It should be emphasized that the NHS Mental Health Implementation Plan (2019) states that by 2023/24 *'there will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults…[and] it will require a consideration of the needs of 0-5 year olds'*. The published CCG baseline programme allocations include funding growth for service expansions for 0-18 community CYPMHS (from 2019/20).

1.2 Local Systems and Context – Cheshire and Merseyside

The NHS Five Year Forward View [3], the NHS Long Term Plan [4] and more recently the Health and Social Care White Paper [5] set out a welcome vision of joined-up services and a system built on collaboration rather than competition. This agenda has been taken forward by integrated care systems (ICSs), which bring together providers and commissioners of NHS services with local authorities and other local partners to plan health and care services, as illustrated in Figure 2. The Cheshire and Merseyside Integrated Care System (ICS) is a partnership between statutory and third sector health and social care organisations, aiming to coordinate services and plan in a way that improves local population health and reduces inequalities.

Early Years and Parent-Infant Mental Health services are ideally commissioned as an essential and fully integrated part of the broader system that supports the emotional wellbeing of infants, toddlers and young children. This includes universal and specialist services such as health visiting, maternity, adult and perinatal mental health and the voluntary sector, and as such seek to benefit from the ICS structure. For further information on the services that might be accessed by families from conception to age 5 see Figure 1.

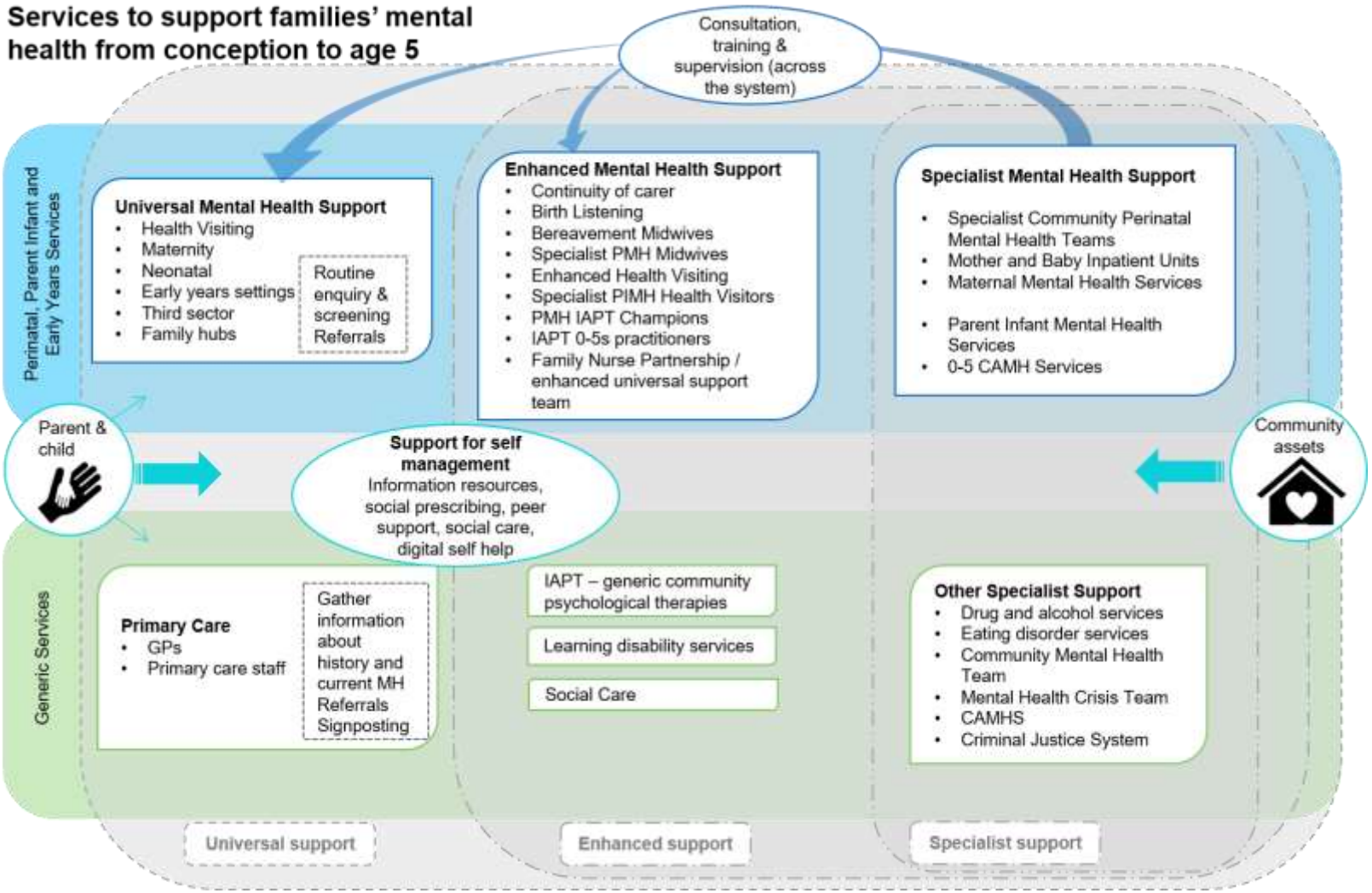

Figure 1 - Perinatal, parent infant and early years mental health services and systems, North West Coast Clinical Networks.

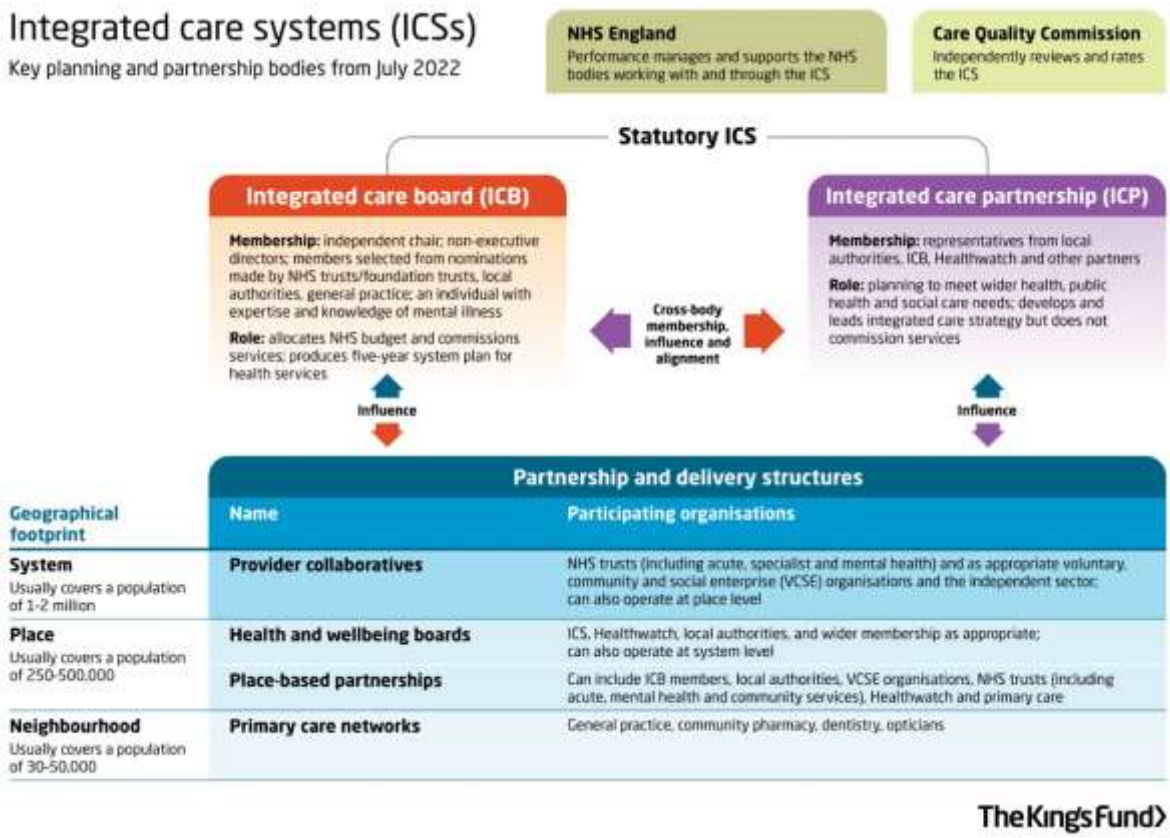

Figure 2 - Integrated care systems (ICSs): key planning and partnership bodies from July 2022, The King's Fund.

Universal Support and Early Prevention is one of the five pillars of the Cheshire and Merseyside Logic Model (see Appendix C) for Children's and Young People's Mental Health. This included the outcome of a scoping analysis for 0-5 CYP MH provision, which this report fulfils.

The Cheshire and Merseyside Children and Young People's Transformation Programme: Beyond, includes Mental Health as a workstream. Within this, a task and finish group has been established to address transformational change for Early Years Mental Health Services (age 0-5).

1.3 Limitations and constraints

In the interest of accessibility and efficacy, this report does not present a full and detailed account of all services delivered to families from conception to age five. Instead the focus is on services that are providing meaningful interventions with parents and children in this age bracket that aim to improve mental health, relationships and emotional wellbeing.

The report does not consider programmes that are delivered by services working under a 0+ age bracket if the interventions offered would be inaccessible or inappropriate for children under the age of five.

Programmes that are designed for school age children (i.e. 4 years and above) have not been included due to this being a small sector of the 0-5 age group.

The report does not include specific details on Maternal Mental Health Services due to their infancy in development and focus on the mother's / birthing partner as opposed to the infant.

Findings are presented based on the data returned and collaborative development of this document with local stakeholders at the time of writing.

2 Scoping of Services and Provision

A simple scoping tool (appendix B) was developed to request details of service provision based around two key areas:

1. Details of services commissioned in the area.
2. Evidence based interventions delivered in the area.

In December 2021, this tool was distributed to CYP Mental Health and Maternity Commissioners in each of the CCGs in the NWC area. Commissioners were asked to work collaboratively with their local authority partners in order to return a single response per area the returns received are summarised in Table 1. Additional information was collated through discussion with service providers and clinicians.

C&M - CCGs	
Cheshire	Returned
Halton	Returned
Knowsley	Returned
Liverpool	Returned
South Sefton	
Southport & Formby	
St. Helen's	Returned
Warrington	Returned
Wirral	Returned

Table 1 - responses to the scoping exercised returned by CCG area.

2.1 Overview of service provision

A summary of the universal and specialist services that are available to families from conception to age 5 are summarised in Table 1.

Cheshire and Merseyside	Parent Infant MH Service	0-5s pathway in CAMHs	IAPT 0-5s	iHV PIMH Champions in IAPT	Health Visiting	Specialist Perinatal MH Health Visitors	Children's Centres / Family Hubs	Antenatal education Provision	Specialist PMH Midwives	Specialist Perinatal MH Service	Maternal MH Service
Cheshire	R	R	R	A	G	G	G	A	G	A	R
Halton	A	R	R	A	G	G	A	A	R	A	B
Knowsley	A	R	G	A	G	R	A	A	G	A	R
Liverpool	A	A	A	A	G	R	G	A	G	A	B
South Sefton	A	R	G	A	G	A	A	A	G	A	R
Southport & Formby	A	R	G	A	G	A	A	A	G	A	R
St. Helen's	R	R	R	A	G	R	A	A	G	A	R
Warrington	A	R	R	A	G	R	A	A	R	A	R
Wirral	R	B	B	A	G	G	A	A	G	A	B

Full provision (G)	Concordant with national or best practice guidelines for that area (see references) and funding is stable.
Some provision (A)	Some provision, but does not meet best practice guidelines, is limited in capacity and/or has short-term funding.
No provision (R)	No provision.
In development (B)	Services or initiatives are currently in development at time of writing (May 2022)

Table 2 - overview of relevant service provision for Cheshire and Merseyside by CCG area

2.2 Mental health services for children aged 0-5 years

This section provides a brief overview of the specialist services providing specific interventions for children under the age of 5. This includes both parent-infant mental health interventions, family interventions and interventions designed to support children within the 0-5 age group. More details of these services, such as the areas in which they operate, funding arrangements and user cohort are provided in appendix E.

Baby and Infant Bonding Support (BIBS)

These services are commissioned in two boroughs (Halton and Warrington) and provide support to parents of babies under the age of six months who are having difficulty bonding or developing their relationship with their baby. The focus is of the programme is on building a trusting and supportive relationship between parent and baby.

Interventions are delivered through supportive sessions for parents and their babies together, or to parents during pregnancy by psychologists and support workers. The sessions may take place at home or in the community, such as at a children's centre or a local clinic. The interventions that are offered are parent-infant psychotherapy and consultation to professionals.

Building Attachment and Bonds Service (BABS)

Mersey Care BABS (Building Attachment and Bonds Service) is a specialist Parent Infant Mental Health (PIMH) service that supports vulnerable parents and infants to build secure attachments and bonds and to break negative life cycles. BABS services are currently commissioned in 2 areas (Knowsley and Sefton) and offer parents and infants easy to engage, therapeutic interventions during the '1001 critical days' – antenatal/postnatal period.

BABS supports parents and infants with their mental health, bond and relationship and helps parents to separate their own challenges (such as Adverse Childhood Experiences, mental health, insecure attachment) which can impact the relationship they have with their child.

PSS Baby Parent Baby Relationship Service

A service to help parents and carers in Liverpool develop strong and healthy relationships with their babies. Focuses on keeping babies safe and helping parents, carers and babies enjoy each other's company and form good relationships, so that babies develop to their full potential.

Parents and carers are supported to overcome blocks; for example, to reprocess early trauma or birth trauma, recognise their baby as a unique individual, understand the baby's developmental needs and practical issues like housing and money.

In some cases, therapy is offered either in groups or with individual families including parent and infant psychotherapy, family therapy, video guidance and rewind therapy.

Growing Together – PSS and Everton in the Community

A therapeutic service focused on helping parents and carers develop strong and healthy relationships with their babies; keeping them safe, helping them enjoy life together and forming

strong and positive bonds. This project seeks to expand existing provision to reach families who are in earlier need of support, as well as offering an innovative and targeted 'fathers' support approach through a collaborative partnership with Everton in the Community's 'Supporting Dads' programme which focuses on giving new dads both practical and soft skills to help them become more engaged in their baby's life.

Fresh CAMHS – Alder Hey Hospital

This CAMH Service has a specific pathway for children aged 0-5 years old. Children in this age range are seen over a 12 month period and will be offered a range of therapy based interventions based on formulation of need and working in partnership with other service providers and agencies.

NCT Parents in Mind – Reflective Parenting Programme

A programme of support offered to parents and carers of children aged four months to two years who are experiencing mild-moderate difficulties with their wellbeing or mental health and are feeling conflicted around relating to their child. Sessions are delivered to parents and carers online, aimed at heightening awareness of the reciprocal parent-child relationship, drawing a parent's attention to how they bring their own experiences of being parented to the interaction with their baby, and how their child's mind is cognitive and distinct from their own, from conception.

Koala North West – Parent Infant Mental Health Targeted Support

This third sector organisation provides one to one support from a PIMHS Co-ordinator. Interventions include Video Interaction Guidance (VIG), additional one to one support from an outreach Worker, PIMHS specific peer support volunteers and parenting programmes.

2.3 Specialist Perinatal Mental Health Services

Specialist community perinatal mental health services cover all areas across Cheshire and Merseyside and is provided through a partnership between Cheshire and Wirral Partnership Trust and Mersey Care Foundation Trust. Organised into three multi-disciplinary teams, the service provides multi-disciplinary assessment, formulation and diagnosis, and interventions to women with moderate to severe mental health difficulties during pregnancy and until baby is two years old.

The perinatal psychological professions workforce comprises Clinical Psychologists, Systemic Family Therapists, Systemic Family Practitioners, and Assistant Psychologists. The service offers a range of psychological therapies organised through a 'matched care' model of psychological care. Formulation-driven care is the cornerstone of the model, with explicit emphasis on consent and informed choice, in line with Trauma Informed Care approaches in NHS. A person is matched to least intensive evidence-based intervention that will bring about most significant mental health gains within a single episode of care. Many women and families present in a complex way, and the type of intervention offered is guided by a range of factors including the evidence-base, the woman's understanding of her difficulties and relationship with baby, readiness for change, and what aspects of presentation require prioritising. To upskill the wider team, share psychological resources and deliver trauma-

informed care, psychological work is offered in the perinatal team in terms of Levels 1, 2 and 3. The following dyadic and family relationship-based interventions and psychological therapies are available to mothers, babies, couples and families:

Level 1: Therapeutic mother and infant activities:

- Peer Support Worker
- Baby massage groups and individual
- Child-led play sessions
- Baby yoga (CWP team)
- Music group with Philharmonic (Liverpool team)
- Cue card sessions

Level 2: Goal-focussed single modality interventions)

- Co-parenting, communication and the couple relationship – antenatal and postnatal workshops for couples (in development)

Level 3: Psychological therapies:

- Video Interaction Guidance (VIG)
- Circle of Security Parenting Group
- Couples Therapy
- Family Therapy
- Attachment Narrative Therapy

2.4 Children and Young Persons NHS Mental Health Services

All CYPMH Services in C&M are commissioned to deliver services for the 0-5 cohort. However, the rate of referrals into services for this age group is generally low. Fresh CAMHS (Alder Hey Children's Foundation Trust, Liverpool) have a 0-5 pathway. A similar pathway is in development within Wirral CYPMHS; however, this was not reported for other CAMH Services.

Work is on-going within the Wirral CYPMHS team to merge existing 0-5, attachment and Psychotherapy pathways. This will involve two (due to qualify) specialist practitioners who have completed the 0-5 IAPT course, a trainee who is currently doing the 0-2 IAPT course, a part time Senior Child and Adolescent Psychotherapist and a Psychologist with expertise in this area with part of their job plan dedicated to this area of work.

The offer from the team will sit across the whole of community CYPMHS therefore supporting the younger age groups within our MHSTs (infant schools) through to the more complex children sat within our 0-18 team. Work will involve Whole School Approach, consultations, VIG, Early Years parenting courses and Theraplay.

In both Warrington and Halton, interventions offered vary depending on need, however a "family" approach would be adopted. This could involve systemic family therapy or child and adolescent psychotherapy. Other interventions such as art therapy and parenting approaches

may be considered depending on need. In general, the offer would be to support parents and other agencies around the family such as schools and social care.

There is no provision for children under five years old in St. Helen's CYPMHS. Referrals into the service are usually 10 years or older. Any referrals below this age group are signposted to other services.

Knowsley CYPMHS works with children and young people aged 0-18 years. For children under five referred into the service, a holistic approach is adopted to work closely with other agencies to ensure the most appropriate support is offered. This may include liaising with clinical partners around neuro-developmental difficulties or engaging with social care and early help teams for those presenting with difficulties due to social circumstances. At times, children under five are supported where there is a learning difficulty need and medication is required, working closely with multi-agency partners to ensure the correct positive behaviour support is in place before prescribing medication.

2.5 Universal and enhanced service provision - Health Visiting, Specialist PIMH Health Visitors and FNP

In all areas of Cheshire and Merseyside, universal mental health screening and support is delivered through the standardised offer of antenatal, postnatal and health visitor contacts, often known as the Healthy Child Programme, provided through Local Authorities. In line with NICE Quality Standards [6], perinatal mental health should be assessed at all core contacts, including exploration of the parent infant bond as described in the NWC pathways for antenatal and postnatal mental health and Parent Infant Mental Health (see Appendix A).

In Knowsley, a universal integrated pathway has been developed that includes Infant Mental Health and Communication alongside other elements such as sleep, baby weigh and exercise.

In many areas, it was described how further support can be provided by listening visits from Health Visitors, or signpost or referral on to Specialist Health Visitors for Mental Health, GPs, IAPT services, third sector support or specialist services for parent infant mental health, where available. Referrals may also be made to enhanced support offers, such as those outlined in Text box 1 and Text box 2.

Liverpool Early Help Teams

The aim of this initiative is to target provision at the most complex families who are on the cusp of entering social care, to reduce risk and need and to prevent cases escalating to the point that they need a statutory intervention. Referrals must be level 3 cases which are complex and have the potential to escalate. A Team Manager and a Consultant Social Worker will be available for case discussions to establish if a referral is appropriate.

The teams work as 'whole family' approach and all siblings are included in the early help intervention that is offered.

Text box 1 – Liverpool Early Help Teams whole family approach.

A large proportion of Health Visitors are trained in the Brazelton Newborn Behavioural Observations (NBO) System [7] with smaller numbers per service also trained in the Neonatal Behavioural Assessment Scale (NBAS) [8] which support in the assessment of bonding and attachment between newborn babies and their parents.

It is challenging to collate data on the numbers of Health Visitors who have accessed the NBO/NBAS training and achieved accreditation due to changes in the Health Visiting workforce over recent years, as reflected in the iHV State of Health Visiting report, 2021 [9]:*"Health visiting in England is now facing the biggest workforce challenge in living memory with an estimated shortfall of 5,000 health visitors"*.

Additional training investments for Health Visitors and Family Nurses were described, such as basics in Cognitive Behavioural Therapy, mental health awareness and compassion focussed training. These are training packages that focus on the mental health of the parent.

Several areas within Cheshire and Merseyside do not have adequate provision of Specialist Health Visitors for Mental Health (see Table 2). In addition to this, there appears to be variation in the scope and skill set of this role locally, a trend that has been recorded nationally, as noted in a recent report [10]. In general, the role offers specialist one to one support for women and their babies who are experiencing moderate to severe mental health issues.

Some of the Specialist Health Visitors in Cheshire and Merseyside have received training in Video interactive Guidance (VIG) (see Appendix F). this intervention is also provided by some of the Specialist Parent-Infant Mental Health Services and the Specialist Perinatal Service.

The provision of Family Nurse Partnership services [11] across Cheshire and Merseyside is variable (see Table 2). In several areas, this need is now being met by alternative programmes, for example the Enhancing Families Pathway in St. Helen's (see Text box 2). In other areas, FNP has been expanded, for example in Wirral the age range of FNP service users has been extended to support parents with SEND.

St Helen's – Enhancing Families Pathway

The Family Nurse Partnership (FNP) Service is ending and being replaced with this alternative pathway for vulnerable families in St Helens to enable a wider group of families to access needs led additional support.

A six-month pilot programme was commenced on the 1st December 2021. The pilot will take an iterative process to develop the criteria and capacity of the pathway and will be reviewed monthly. The criteria for the programme include:

- Isolated and or unsupported teenager
- Current mental health concerns
- Current drugs and or alcohol misuse
- Current concerns of domestic abuse in relationship
- Looked after child or care leaver

As there is no parental upper age limit, the programme will have a wider reach and subsequent positive impact within the borough. Clients should be less than 32 weeks gestation at the time of referral and can access the programme for up to two years.

Text box 2 – details of the Enhancing Families Pathway pilot pathway in St. Helen's.

2.5.1 Maternity and Antenatal Support and education groups

Provision of antenatal education and support groups are variable across the Cheshire and Merseyside area. Many groups were changed to be delivered online following the onset of the COVID-19 pandemic in March 2020. Several services are still running in this way, whereas some have recently returned to in-person groups.

There are a range of different groups on offer. For example, in Cheshire, the Next Steps group aims to support low level mental health and depression in new mothers. Liverpool Women's Hospital deliver an antenatal programme which covers attachment, mental health and the social baby in partnership with Liverpool Children's Centres. In Warrington and Knowsley, the Solihull Parenting Course is offered to parents of children under two. This nationally recognised model focuses on reciprocity and responsive care giving [12]. In Knowsley there are also antenatal and postnatal programmes that are co-delivered with PIMHS and IAPT practitioners.

Appendix F provides more details of group-based interventions on offer across the area.

2.5.2 Support to families with experience of Neonatal care

The emotional vulnerability of neonatal families is well recognised, with both parents and infants experiencing a prolonged traumatic event which also interferes with the transition to parenthood and on the development of parent-infant relationships. The NFaST report, completed in 2021 [13], reviewed provision in the region and highlighted the need for embedded veteran peer support and psychosocial support within the unit, and clear referral pathways for families as needed.

Provision of tailored support is patchy across the region. Chester has an established peer support service on the unit and other units including Liverpool Women's and Arrowe Park (WUTH) are beginning to establish this, too. Other units have access to 0.1 or 0.2WTE (whole time equivalent) counselling or psychological wellbeing practitioners to offer emotional support to parents. Liverpool Women's and Alder Hey hospitals have recently appointed a 1WTE Clinical Psychologist to work across both units, offering support for parent mental health, parent-infant relationships and indirect support to babies and families via the staff team. However, no other units have access to on-unit parent-infant focused work.

The North West Neonatal ODN are working with partners across the region to try and improve the visibility of neonatal families in existing pathways and ensure that services have a good understanding of their needs. There is also work underway to establish what outreach support should be available for neonatal families post-discharge and whether a more robust screening pathway might help parents to navigate the challenges that the months and years post-discharge can bring.

2.5.3 Children's centres / Family hubs

Sure Start centres are provided by Local Authorities to give help and advice on child and family health, parenting, money, training and employment. Some centres also provide early learning and full day care for pre-school children. The prevalence of Children's Centres varies by Local Authority. An overview of provision is shown in Table 2.

In Liverpool, a network of 11 children centres delivering a range of integrated services across 23 sites, including targeted outreach support as well as centre based activities such as parenting programmes, home learning, support into employment, early learning activities, baby/ early communication groups family support, speech and language support, health clinics and domestic abuse support.

In Halton, Children's Centres core offer includes support, guidance, and advice, access to a range of early learning and play activities, access to adult learning and groups such as baby massage and Incredible Years Baby. Additional targeted services are also offered through the centres across all levels of need.

In April 2022, the UK Government announced that 75 local authorities had been selected as eligible for funding to create new Family Hubs in their areas. These hubs should give parents advice on how to take care of their child and make sure they are safe and healthy, providing services including parenting and breastfeeding support.

One third of this funding (£100million) will be shared among eligible areas to roll out bespoke parent-infant relationship and perinatal mental health support. Four areas were selected in Cheshire and Merseyside: Halton, Knowsley, Liverpool and St. Helens.

2.5.4 Support to Early Years Settings

Working with Early Years (EY) settings is an important mechanism for identifying and supporting children who are at risk of mental and emotional difficulties as well as promoting healthy approaches to mental health and wellbeing.

In Cheshire West and Chester, the Early Years Team provide training for providers and schools to support children with emotional well- being, particularly with relation to attachment, key person and transitions, through a one-day course. Support is also provided via the Early Years & Childcare Network, School Nursery Network, Reception Teacher Network and ECT/ New to EYFS Network. An additional training programme called Monkey Bob is being rolled out to all EY providers. This training aims to give providers skills to support children who have witnessed domestic abuse.

All providers and schools in Cheshire West and Chester also can "buy-in" to Children's Attainment through Leuvern Monitoring (CALM). This recognised model aims to improve levels of wellbeing and involvement in children which supports both mental health and learning.

2.6 Summary of scoping

The results of the scoping exercise show Cheshire and Merseyside has some pockets of good practice and examples of excellent service provision. However, no one CCG area has full provision of Parent Infant Mental Health Services.

Where PIMH services are in place these are often delivered by third sector organisations and are dependent upon non-recurrent funding.

Although NHS Children's and Young Person Mental Health services are usually commissioned from age 0+, only one service in the area (Alder Hey) has a pathway in place for children under five and this was the only service routinely accepting children in this age group. For all other services, when children under 5 are accepted into service, the work done is of a collaborative nature with other organisations, however we have not seen evidence of this documented as a standardised approach.

There is significant variability in the provision of universal services across the area, in terms of the interventions available to families and the skills of the workforce within Health Visiting, Maternity and other early help teams.

The provision of children's centres and family hubs across the area is variable between Local Authority areas. Within this, the level of provision and interventions on offer is also variable.

3 NWC conception to age five mental health summit event

On 9 February 2022, the NWC PMH Network hosted an online event – Relationships and Mental Health: Conception to Age Five. This half day interactive seminar was attended by 150 stakeholders from across the NWC area with representation from adult and children's mental health, maternity, health visiting, local authority, CCGs, early years education and support, third sector groups and service users. The audience heard from national speakers from the Parent Infant Foundation and NHS England as well as service providers from Liverpool and Blackpool. Online interactive tools were used to collate qualitative and quantitative feedback that has informed the development of this report.

The charts below summarise the feedback returned during the Early Years Mental Health Summit for the North West Coast that was held in February 2022. See Appendix D for further details of this event.

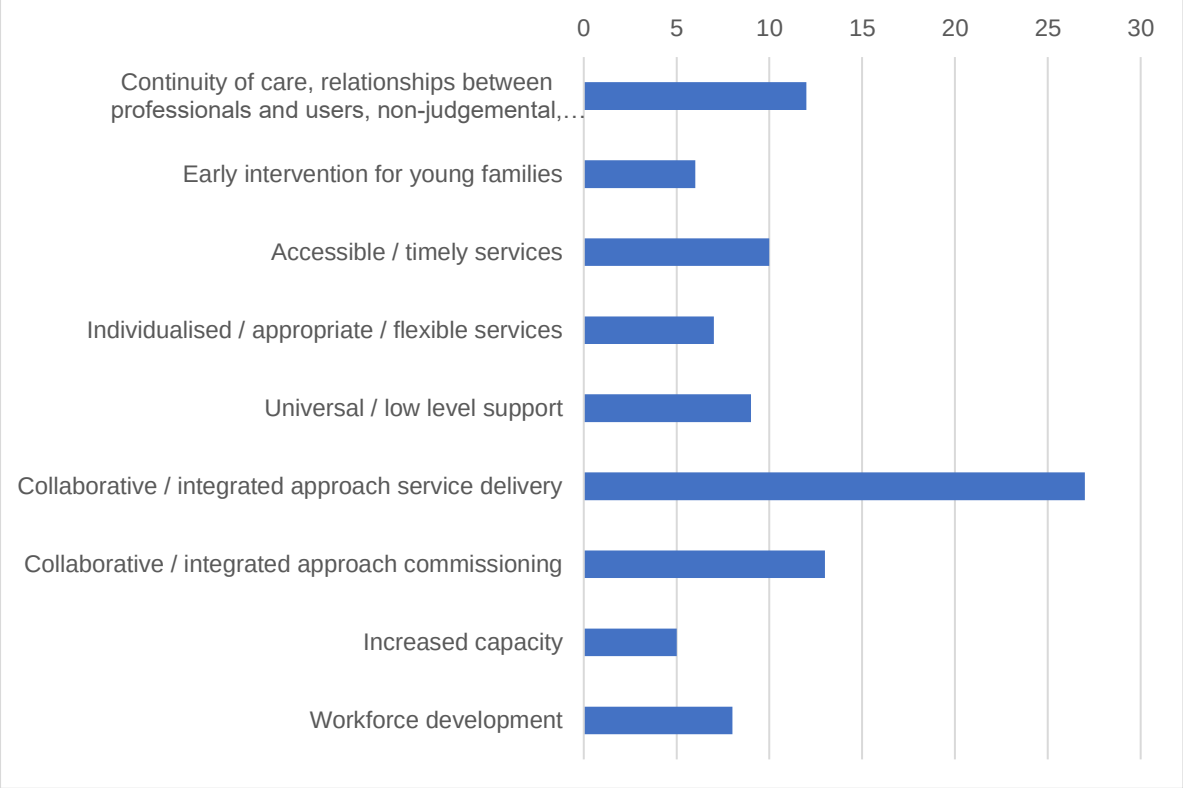

Figure 3 - the most commonly reported themes on what developments should be prioritised following the NWC Early Years Mental Health Summit, February 2022. Based on a thematic review of written responses from audience members.

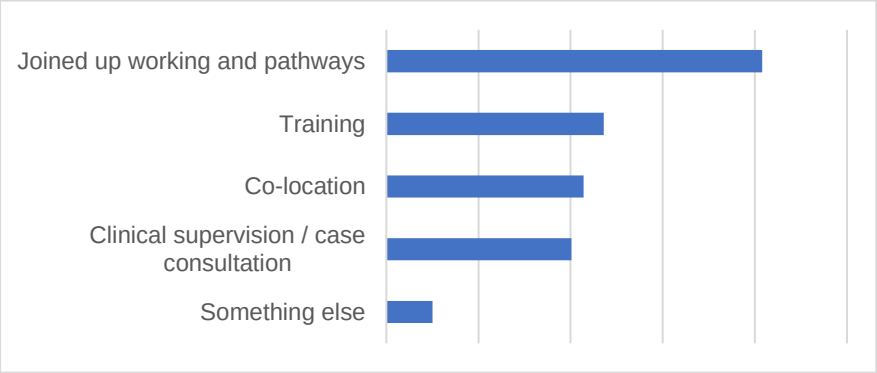

Figure 4 - how can we best support the workforce? Audience members were asked to rank the above 5 options in order of priority. NWC Early Years Mental Health Summit, February 2022.

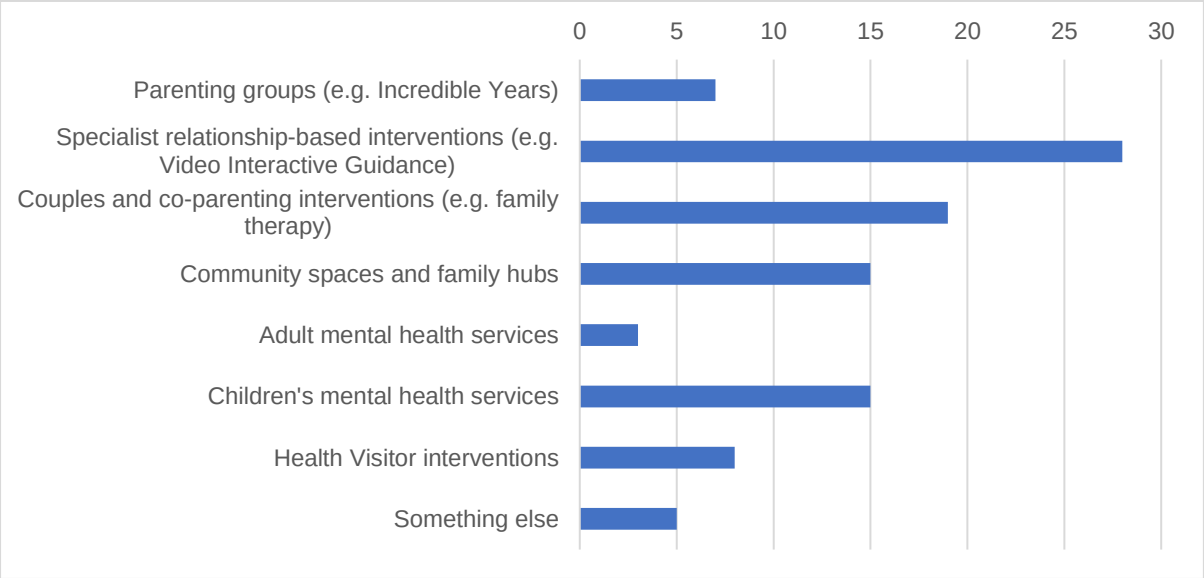

Figure 5 - what do we need more of? Audience members were asked to vote for which of the listed interventions are most needed in our communities. NWC Early Years Mental Health Summit February 2022.

A key theme that was highlighted during presentations, discussions and feedback at the event was the need for pathways that facilitate co-delivery and joining-up service providers, as illustrated in Figure 3 and Figure 4. This would help to deliver services that are better suited to families and more effective in meeting outcomes as well as supporting staff to feel effective and enabled. It is recognised that to support joint up models of service delivery, it is necessary to also adopt an integrated approach to service commissioning.

The case for collaborative working in the health and care system has been strengthened by the experience of the Covid-19 pandemic, as the response has depended on different parts of the system working together. In recent years, the work of ICSs and STPs has focused on several areas, including:

- reaching a shared view between system partners of local needs and the resources available for health and care.

- agreeing a strategic direction for local health and care services based on those needs and resources.
- driving service changes that are needed to deliver agreed priorities.
- taking a strategic approach to key system enablers, for example by developing strategies around digital technologies and estates.
- establishing infrastructure and ways of working to support collaborative working, for example by putting in place new governance arrangements to enable joint decision making and agreeing system-wide leadership arrangements.
- strengthening collaborative relationships and trust between partner organisations and their leaders [14].

These ambitions lend themselves to our stakeholder feedback and existing good practice which emphasise the need for integrated pathways and services.

4 Recommendations

Clear themes can be identified from the cumulation of the above work around how this programme can be progressed. Both the locally sourced evidence and national best practice guidance indicate that it is in the best interest of families and children to adopt a collaborative approach to developments. This should be seen across the system at both a commissioning level and a service delivery level.

Recommendation 1: Integrated commissioning approach to early years mental health support

Development of an integrated commissioning model that clearly outlines:

a. What services need to be commissioned for each stage of the journey from conception to age 5 to specifically support parent-infant relationships and mental health for babies, infants and toddlers. This should include both universal and specialist service provision.
b. What organisations (e.g. health, local authority, third sector) should take responsibility for commissioning each of these services.
c. A model for collaboration between stakeholders to ensure that services that are developed and commissioned are sustainable and appropriate to the local community. This should include, but not be limited to current and former service users, clinicians, commissioners and managers from a variety of disciplines, organisations and backgrounds.
d. Consistency in outcome measures.

Recommendation 2: Model of best practice for joint delivery of services

Develop model of best practice for joint working and service delivery to support relationships and mental health from conception to age 5. This model should provide a reference framework that will build a system to better support joint working. The model should include:

a. What a 'good enough' system looks like – including leadership and professional relationships.
b. What services need to be in place – including staffing models.
c. What interventions are needed within services.
d. Minimum workforce and training needs for each service.
e. Workforce training plan to build capacity and to upskill the universal workforce, to ensure equity across the ICS area.
f. How and when services / multi-disciplinary professionals should work together to deliver interventions.
g. How families should experience a seamless journey through and between services.
h. Consistency in KPIs / outcome measures between services.
i. Joint working between Specialist Perinatal Mental Health Services and Children's and Young Persons Mental Health Services to close the gaps around provision of parent infant mental health interventions, in line with the NHS Long Term Plan objectives.

Additional recommendations

It is recommended that the current NWC Best Start for Life group is re-named in order to avoid any confusion with emerging Local Authority governance relating to the Best Start for Life funding.

The proposed name for the workstream going forward is Perinatal, Parent-Infant and Early years Relationships Group (PPIER Group). This would also help to reflect the integrated approach to development.

This NWC group will sub-divide into a Cheshire and Merseyside PPIER-Group and a Lancashire and South Cumbria PPIER-Group.

5 References

[1] Parent Infant Foundation, “Evidence Brief Series,” London, 2020.

[2] Wave Trust, “Conception to age 2 - the age of opportunity,” London, 2013.

[3] NHS England, “NHS Five Year Forward View,” NHS England and NHS Improvement, London, 2014.

[4] NHS England and NHS Improvement, “The NHS Long Term Plan,” NHS England and NHS Improvement, London, 2019.

[5] Department of Health and Social Care, UK Government, “Health and social care integration: joining up care for people, places and populations,” UK Government, London, 2022.

[6] NICE, “Antenatal and postnatal mental health Quality Standard QS115,” 2016.

[7] “Newborn Behavioural Observations,” [Online]. Available: https://www.brazelton.co.uk/courses/nbo/.

[8] “Neonatal Behavioural Assessment Scale,” Brazelton Centre UK, [Online]. Available: https://www.brazelton.co.uk/courses/nbas/.

[9] iHV, “The State of Health Visiting Survey,” 2021.

[10] O. a. B. J. Homonchuk, “Specialist Health Visitors in Perintal and Infant Mental Health,” Department of Social Policy and Intervention, University of Oxford, Oxford, 2022.

[11] “Family Nurser Partnership Services,” NHS, [Online]. Available: https://fnp.nhs.uk/.

[12] “The Solihull Approach,” [Online]. Available: https://solihullapproachparenting.com/.

[13] Spoons & North West Neonatal Operational Delivery Network, “Neonatal Families and Staff Together (NFaST) Evaluation Report,” 2021.

[14] The King's Fund, “Integrated care systems explained: making sense of systems, places and neighbourhoods,” The King's Fund, London, 2021.

[15] A. F. W. Initiative, “Brain Story Certification,” 2022. [Online]. Available: https://www.albertafamilywellness.org/training?msclkid=9cd10533b40211ecaa1bc8cc19beb5a0.

5.1 Recommended further reading

- Department of Health and Social Care, “The Best Start for Life: a vision for the 1,001 critical days”, March 2021
- Cross-party manifesto, “The 1,001 Critical Days”, 2015
- First 1,001 days all party parliamentary group. “Building Great Britons”, 2015
- B. Lewing, M. Stanford, and T. Redmond, “Planning early childhood services in 2020 Learning from practice and research on children’s centres and family hubs”, November 2020
- B. Lewing, J. Gross and D. Molloy, “Leading and delivering early childhood services 10 insights from 20 places across England and Wales”, February 2022
- Tavistock and Portman Foundation Trust and the Anna Freud Centre (AFC), “THRIVE model”, Wolpert, Harris et al., 2014
- NICE Clinical Guidance, “Antenatal and postnatal mental health: clinical management and service guidance” [CG192] published 2014, updated 2020.
- NICE Quality Standard, “Children’s attachment” [QS133], 2016
- NICE Quality Standard, “Postnatal care” [QS37], statement 9, updated 2021
- NICE Quality Standard, “Early years: promoting health and wellbeing in under 5s” [QS128], 2016
- NICE Guidance, “Social and emotional wellbeing: early years” [PH40], 2012

Online resources and organisations:

Early years alliance | (eyalliance.org.uk)

National Centre for Family Hubs

Early Intervention Foundation (eif.org.uk)

AiMH – The Association for Infant Mental Health professionals in the UK

Resources for Professionals - Parent-Infant Foundation (parentinfantfoundation.org.uk)

North West Coast Clinical Networks

Review of Mental Health and Relationship Support Services for families from conception to age 5 across the North-West Coast: **Lancashire and South Cumbria**

Version	1.1
Date	May 2022
Author	Dr Beth Luxmoore – Clinical Network Manager, Perinatal Mental Health, NWC Clinical Networks, NHSE
Owner	Dr Gillian Strachan – Consultant Psychiatrist and Chair of the NWC Perinatal Mental Health Clinical Network for Lancashire and South Cumbria and Dr Ruth O'Shaughnessy – Consultant Clinical Psychologist and Chair NWC Perinatal Mental Health Clinical Network for Cheshire and Merseyside
Contributors	Ms Tracy Greenwood, Dr Lisa Marsland, Dr Libby Chamberlain - Co-Chairs, 0-5 Subgroup NWC Perinatal Mental Health Clinical Network With thanks to all members of the 0-5 subgroup and contributors from stakeholder organisations.

North West Coast Clinical Networks

Contents

1 Introduction

Since January 2020, the North West Coast (NWC) Perinatal Mental Health (PMH) Network has supported developments in Parent Infant Mental Health (PIMH) across Cheshire, Merseyside, Lancashire and South Cumbria through its Parent Infant Relationships Partnership (PIRP).

In 2021, this multi-disciplinary and inter-agency collaboration produced the NWC Parent Infant Mental Health Care Pathway (Appendix A). This document, along with its supporting guidance, was developed as a tool to support all professionals working with families from conception to age two to initiate supportive conversations with parents about their relationship and bond with their baby. The agreed purpose of the pathway was to raise awareness of the importance of discussing relationships with families in the perinatal period, recognising that simple conversations can be powerful in understanding the needs of families during this critical period of child development.

In November 2021, the work of this group was expanded to include children up to five years of age, after identifying a gap in pathways and family support options with a focus on mental health, relationships and wellbeing for families with infants, toddlers and pre-schoolers. At this point the PIRP was rebranded under the name of "Best Start for Life NWC" which was launched at an online Early Years Mental Health Summit for the NWC in February 2022.

Key objectives for the NWC workstream include:

- To develop tools to gather information around current service provision.
- To support stakeholders (CCG and local authority commissioners and service providers) to complete scoping returns for local CCG areas.
- To compile the results of the scoping exercise to summarise the provision of support available.
- To deliver an Early Years Mental Health Summit event for the NWC area to engage with stakeholders and gather feedback.
- To identify areas of best practice service provision in the NWC area.
- To identify gaps in service provision.
- To identify opportunities for commissioner, service and system development.
- To consider what a 'good enough' system looks like.
- To listen and engage with a wide range of stakeholders to canvass views and inform recommendations.

This report outlines a scoping project to understand what provision is available to support the mental health, relationships and emotional wellbeing of families from conception to age five across the NWC to identify examples of best practice and gaps in service provision. The results of the scoping project will be discussed alongside stakeholder feedback from the NWC Early Years Mental Health Summit, with 'next steps' recommendations made for commissioners and systems across Lancashire and South Cumbria.

1.1 Infant and Early Years Mental Health - National drivers and policy context

It is now well-established that the first 1001 critical first days of a child's life lay the foundations of wellbeing for their future. The Parent Infant Foundation (PIF) produced a series of reports under the umbrella movement "1001 days", outlining key evidence for the importance of early brain development in shaping healthy futures [1]. Research unequivocally indicates that attuned, responsive parent-child relationships are at the heart of good developmental outcomes for children [2]. Despite burgeoning evidence, at present, there is a lack in national guidance around best practice for parent-infant and 0-5 mental health services (please see reference list and further recommended reading).

The NHS Long Term Plan (2019) places key funding emphasis on improving access to specialist community perinatal mental health services, maternal mental health services and boosting mental health services for parents but makes no mention of parent-infant and early years mental health teams. It should be emphasized that the NHS Mental Health Implementation Plan (2019) states that by 2023/24 *'there will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults…[and] it will require a consideration of the needs of 0-5 year olds'*. The published CCG baseline programme allocations include funding growth for service expansions for 0-18 community CYPMHS (from 2019/20).

1.2 Local Systems and Context – Lancashire and South Cumbria

The NHS Five Year Forward View [3], the NHS Long Term Plan [4] and more recently the Health and Social Care White Paper [5] set out a welcome vision of joined-up services and a system built on collaboration rather than competition. This agenda has been taken forward by integrated care systems (ICSs), which bring together providers and commissioners of NHS services with local authorities and other local partners to plan health and care services, as illustrated in Figure 2. The Lancashire and South Cumbria Integrated Care System (ICS) is a partnership between statutory and third sector health and social care organisations, aiming to coordinate services and plan in a way that improves local population health and reduces inequalities.

Early Years and Parent-Infant Mental Health services are ideally commissioned as an essential and fully integrated part of the broader system that supports the emotional wellbeing of infants, toddlers and young children. This includes universal and specialist services such as health visiting, maternity, adult and perinatal mental health and the voluntary sector, and as such seek to benefit from the ICS structure. For further information on the services that might be accessed by families from conception to age 5 see Figure 1.

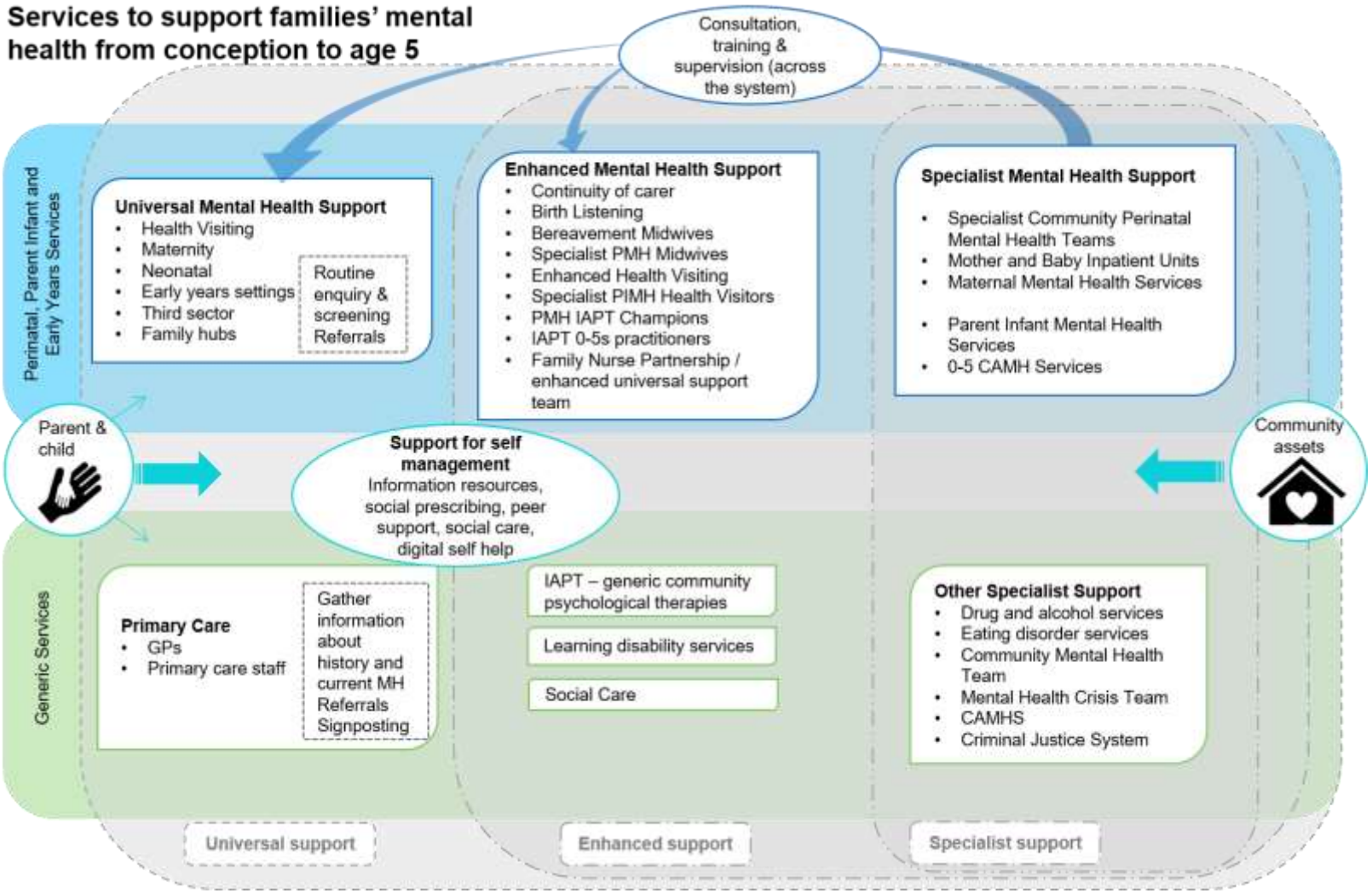

Figure 1 - Perinatal, parent infant and early years mental health services and systems, North West Coast Clinical Networks.

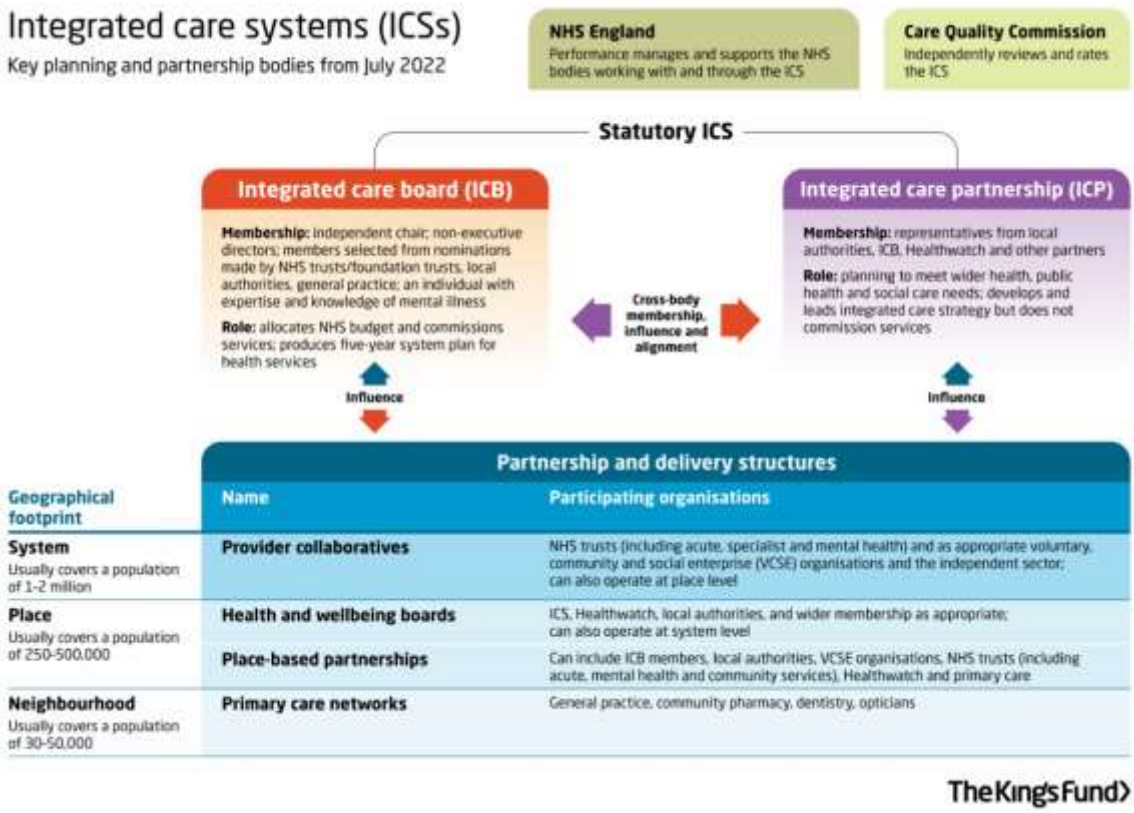

Figure 2 - Integrated care systems (ICSs): key planning and partnership bodies from July 2022, The King's Fund.

The L&SC Health and Care Partnership (ICS) have developed a Children & Young People's Mental Health and Emotional Wellbeing Strategic Transformation Plan (see appendix C). This seeks to ensure that children and young people in L&SC group up with healthy minds, feeling confident and resilient, and able to fulfil their potential. This plan sets out ambitions to work in partnership with the local system to strengthen the early help, to develop the offer for age 0+ and to increase access to mental health services from age 0+.

Need to include here information about L&SC transformation work, ICS etc – reference to strategic plan.

1.3 Limitations and constraints

In the interest of accessibility and efficacy, this report does not present a full and detailed account of all services delivered to families from conception to age five. Instead the focus is on services that are providing meaningful interventions with parents and children in this age bracket that aim to improve mental health, relationships and emotional wellbeing.

The report does not consider programmes that are delivered by services working under a 0+ age bracket if the interventions offered would be inaccessible or inappropriate for children under the age of five.

Programmes that are designed for school age children (i.e. 4 years and above) have not been included due to this being a small sector of the 0-5 age group.

The report does not include specific details on Maternal Mental Health Services due to their infancy in development and focus on the mother's / birthing partner as opposed to the infant.

Findings are presented based on the data returned and collaborative development of this document with local stakeholders at the time of writing.

2 Scoping of Services and Provision

A simple scoping tool (appendix B) was developed to request details of service provision based around two key areas:

1. Details of services commissioned in the area.
2. Evidence based interventions delivered in the area.

In December 2021, this tool was distributed to CYP Mental Health and Maternity Commissioners in each of the CCGs in the NWC area. Commissioners were asked to work collaboratively with their local authority partners in order to return a single response per area the returns received are summarised in Table 1. Additional information was collated through discussion with service providers and clinicians.

L&SC - CCGs	
Blackburn with Darwen	Returned
Blackpool, Fylde & Wyre	Returned
Chorley & South Ribble	Returned
Greater Preston	Returned
Morecambe Bay	
West Lancashire	

Table 1 - responses to the scoping exercised returned by CCG area.

2.1 Overview of service provision

A summary of the universal and specialist services that are available to families from conception to age 5 are summarised in Table 1.

Lancashire and South Cumbria	Parent Infant MH Service	0-5s pathway in CAMHs	IAPT 0-5s	iHV PIMH Champions in IAPT	Health Visiting	Specialist Perinatal and Infant MH Health Visitor	Children's Centres / Family Hubs	Antenatal education provision	Specialist PMH Midwives	Specialist Perinatal MH Service	Maternal MH Service
Blackburn with Darwen	R	R	R	A	G	R	A	A	G	G	G
Blackpool	B	B	B	G	G	G	G	G	G	G	G
Fylde & Wyre	R	R	R	A	G	G	A	A	G	G	G
Chorley & South Ribble	R	R	R	A	G	G	A	A	G	G	G
Greater Preston	R	R	R	A	G	G	A	A	G	G	G
Morecambe Bay	R	R	R	A	G	A	A	A	G	G	G
West Lancashire	R	R	R	A	G	G	A	A	G	G	G
East Lancashire	R	R	R	A	G	G	A	A	G	G	G

Full provision (G)	Concordant with national or best practice guidelines for that area (see references) and funding is stable.
Some provision (A)	Some provision, but does not meet best practice guidelines, is limited in capacity and/or has short-term funding.
No provision (R)	No provision.
In development (B)	Services or initiatives are currently in development at time of writing (May 2022)

Table 2 - overview of relevant service provision for Lancashire and South Cumbria by CCG area

2.2 Mental health services for children aged 0-5 years

This section provides a brief overview of the specialist services providing specific interventions for children under the age of 5. This includes both parent-infant mental health interventions and interventions designed to support children within the 0-5 age group. More details of these services, such as the areas in which they operate, funding arrangements and user cohort are provided in appendix E.

Blackpool NHS Parent Infant Mental Health Service

The service will work predominantly with children aged 0-2 and their families but also intends to provide therapeutic interventions to the 3-5 cohort working in partnership with CAMHS and universal health to ensure that children and their families are able to access support where there are difficulties in the nurturing relationship. Evidence based interventions will be offered on both an individual and group basis.

This service will be funded for the initial two years by the National Lottery Community Fund from 1st March 2022 until 29th February 2024. Subject to successful evaluation, it is anticipated that the service will continue and will be funded from recurrent NHS monies.

Good Enough Start – Millom

Provides support to parents across four levels of intervention.

- Universal (Green) – accessible to all parents during the perinatal period. Up to 6 individual contacts and small group support as well as joint working with other services. The relationship is held as the pivotal focus to all conversations.
- Universal Plus (Yellow) – increased regular individual contacts adjusted as appropriate.
- Specialist (Amber) - bespoke 1:1 intervention programme planned step by step over time agreed with, and by the client. On-going client/practitioner assessment and target setting empowering self-help and building confidence.
- Specialist referral (Red) - Step up and down to specialist support needs as appropriate. Support parents and infants throughout the process and offer specialist support on discharge between perinatal community outreach visits.

2.3 Specialist Perinatal Mental Health Services

The Specialist Perinatal Community Mental health Teams and Specialist Mother and Baby Unit (Ribblemere MBU) for Lancashire and South Cumbria are provided by Lancashire and South Cumbria Foundation Trust (LSCFT). The Community services are organised into three multi-disciplinary teams, the service provides multi-disciplinary assessment, formulation and diagnosis, and interventions to women with moderate to severe mental health difficulties during pregnancy and, as required, up to 24months postnatal. A range of multi-disciplinary needs led interventions are offered, and parent infant relationships are assessed to identify need using both standardised outcome measure tools.

During care with both the impatient team and the community teams, parents can be offered interventions to support bonding and attachment with their babies.

On the MBU this could include:

Therapeutic Activities:

- Peer Support Worker input
- “Baby Friendly” Feeding Support and Advice (BFI Accredited staff)
- Baby massage individual or group
- Meaningful Infant focussed activity (led by Activities Co-ordinator)
- Child-led play sessions with nursery nurse
- Neo-natal Behavioural Observation (NBO trained staff)

Psychological therapies:

- Video Interaction Guidance (VIG)
- 1:1 Psychological therapy and formulation to include PI relationship.

In the SPCMHTs this could include:

Therapeutic Activities:

- Peer support or Support worker input to build on social support, readiness for baby.
- Structured Plan of interventions with Nursery Nurses
- Baby massage individual with nursery nurse.
- Child-led play sessions with nursery nurse
- Neonatal Behavioural Observation
- Nursery Nurse Group

Psychological therapies:

- Video Interaction Guidance (VIG)
- 1:1 Psychological therapy and formulation to include PI relationship

2.4 Children and Young Persons NHS Mental Health Services

Blackpool CAMHS is currently commissioned for ages 0-18, however the service has not been promoted as an early years mental health service and therefore receives few referrals for children under 5 years old. This situation was also reflected by professionals within other services who might refer children into CAMHS, such as Health Visiting, who reported that they didn’t refer into CAMHS due to the understanding that the service did not work with the under 5 age group.

In the financial year 2021/22, 10 referrals were made to the service for children in this age range, all of whom were 5 years old at the time of referral and only 18 contacts were made with these patients.

For children that are referred into Blackpool CAMHS, assessments would be made to consider how the family could best be supported with consideration made to the whole system and opportunities for partnership working with other service providers. There are

aspirations that the new PIMHS in Blackpool will work in collaboration with CAMHS to close the gap in service provision for this age group.

In Morecambe bay, CAMHS has parenting practitioners who are IAPT trained in Incredible Years and run interventions for parents including those of children aged 0-5.

East Lancashire Child and Adolescent Service (ELCAS) provides a mental health service for young people up to the age of 16. It was reported that referrals under the age of five are very rare and if received would be signposted to Health Visiting and Early Help Teams. The service also provides Primary Mental Health Workers in GP practices who will consult with families with children of any age up to 18.

In addition to this in East Lancashire, Children's Psychological Services (LSCFT) operates a school age service in terms of acceptance criteria. However, within the service, PTSD therapy is also offered to children aged 3 or 4, due to an acknowledgement that this is not available elsewhere. This has been manageable for the service due to low demand.

Up until 2018, there was an Emotional Health Team for East Lancashire as part of this service. This was a team of 10 professionals dedicated to children under five affected by hidden harm. This team worked in partnership with two Family Nurse Partnership teams who worked with children under two, providing psychological supervision.

Clinical Psychologists were also based within Children's Centres (see section 2.5.3) in East Lancashire covering all ages and specialist input was provided to Blackburn with Darwen.

These services have since been decommissioned. The East Lancashire Children's Psychology Service Team has maintained the skills needed to provide a service for children under five (e.g. PCG, VIG, Theraplay, IY and parental interventions), however this has not been commissioned and current capacity does not allow for any stretch of existing resource.

2.5 Universal and enhanced service provision - Health Visiting and Specialist PIMH Health Visitors

In all areas of Lancashire and South Cumbria, universal mental health screening and support is delivered through the standardised offer of antenatal, postnatal and health visitor contacts, often known as the Healthy Child Programme, provided through Local Authorities. In line with NICE Quality Standards [6], perinatal mental health should be assessed at all core contacts, including exploration of the parent infant bond as described in the NWC pathways for antenatal and postnatal mental health and Parent Infant Mental Health (see appendix A).

In many areas, it was described how further support can be provided by listening visits from Health Visitors, or signpost or referral on to Specialist Health Visitors for Perinatal and Infant Mental Health, GPs, IAPT services, third sector support or specialist services for parent infant mental health, where available. Referrals may also be made to enhanced support offers, such the Lancashire Child and Family Wellbeing Teams. These teams may work with children and families needing early help services. The main focus of the service is to provide an enhanced level of support which is prioritised towards those groups or individuals who

have more complex or intensive needs or who are at risk and particularly where it is considered that providing early help will make a positive difference.

In Blackpool, Fylde and Wyre the third sector organisation Homestart offers volunteer led support to families around parent-infant mental health.

There is a commitment in the region for Health Visitors to be trained in the Brazelton Newborn Behavioural Observations (NBO) System [7]. This system is a tool designed to help parents and practitioners share together the fascinating uniqueness of a baby, though observing their behaviour and from that developing an understanding of the baby's communication. Some Health Visitors are also trained in the Neonatal Behavioural Assessment Scale (NBAS) [8] which support in the assessment of bonding and attachment between newborn babies and their parents.

It is challenging to collate data on the numbers of Health Visitors who have accessed the NBO/NBAS training and achieved accreditation due to changes in the Health Visiting workforce over recent years, as reflected in the iHV State of Health Visiting report, 2021 [9]:*"Health visiting in England is now facing the biggest workforce challenge in living memory with an estimated shortfall of 5,000 health visitors"*.

Additional training investments for Health Visitors and Family Nurses were described, such as Solihull Approach [10] and Alberta Brain Certification online training [11] are offered in Blackpool.

Across Lancashire and South Cumbria, the NWC Clinical Network has invested in a "train the trainer" model for the Institute of Health Visiting's (iHV) Perinatal and Parent Infant Mental Health Champions Training and Father's Perinatal Mental Health Champions Training. Local staff from across Health and Social Care professions deliver free, online training sessions to anyone working with families in the perinatal period.

All areas of Lancashire have adequate provision of Specialist Health Visitors for Perinatal and Infant Mental Health (see Table 2) apart from Blackburn with Darwen. South Cumbria locality is also lacking this dedicated role. A strong approach to joint working between the individuals in this role has led to a reduced variation in service provision by this role, however capacity could be increased. In general, the role offers specialist one to one support for women and their babies who are experiencing moderate to severe mental health issues.

One Health Visitor in Blackpool has received training in Video interactive Guidance (VIG) (see Appendix F). In Lancashire, parent-infant interaction observation scale (PIIOS) [12] training is being completed by Specialist Health Visitors for Perinatal and Infant Mental Health for use in targeted one to one referrals. PIIOS is a validated assessment tool, designed for use by front line practitioners to assess parent-infant interactions between two and seven months.

As part of a research project, a pilot of Behavioural Activation training with supervision is also being offered to some Health Visitors in Blackpool. This training will support Health

Visitors to deliver an intervention to support postnatal mothers suffering mild to moderate depression with a baby aged one year or under

2.5.1 Maternity and Antenatal Support and education groups

Provision of antenatal education and support groups are variable across the Lancashire and South Cumbria area. Many groups were changed to be delivered online following the onset of the COVID-19 pandemic in March 2020. Several services are still running in this way, whereas some have recently returned to in-person groups.

A range of different antenatal courses are offered across Lancashire and South Cumbria, such as Bump Birth and Beyond in Fylde and Wyre which has a focus on bonding.

In Blackpool the universal antenatal education programme is called Baby Steps. The programme focuses on supporting parents to increase their reflective function and keep their baby in mind, as well as recognising the impact that having a baby can have on a couple's relationship. Baby Steps is delivered by Blackpool Health Visiting staff. Also on offer to all families in Blackpool is the Being A Parent parenting course. This is a universal parenting 8-week parenting course for families with Early Years children. It helps parents learn how to communicate better in everyday situations for help bringing up confident, happy and co-operative children. Further information about group interventions provided in Blackpool via the Early Help and Support Service is provided in Text box 1.

Early Help and Support Service in Blackpool

The Early Help and Support Service led by Blackpool Council/Local Authority relaunched their strategy and structure, during Winter 2021. The approach of the team is to ensure that all Blackpool families get 'the right help, at the time and in the right place with the right people'; the model aligns closely with the Blackpool Better Start vision and place based approach to provision of support for Early Years families.

To support the strategy and roll out of the new structure, and to ensure the continuation of key services, Blackpool Better Start supports the Early Help and Support Service to strengthen their Early Years offer and provide training and development in relation to evidence based interventions and practice. These evidenced based programmes are;

- The Safe Care parenting programme, which works with parents whose children are at risk of abuse or neglect, and
- the Video Interactive Guidance brief intervention model, which supports attunement between parent and child, and
- The Survivor Mums' Companion this programme is a fully manualised 10 module psycho-educational "self-help" programme. The programme is specifically for pregnant women who have experienced trauma in childhood who are at-risk or are currently experiencing post-traumatic stress disorder (PTSD). It aims to address re-encountered trauma-specific problems, including PTSD symptoms during pregnancy; PTSD symptom management; and affect and interpersonal regulation. SMC will form part of the trauma strategy and a suite of interventions that aim to break intergenerational cycles of abuse. Blackpool is currently the only location in the UK to be delivering this trauma focused programme. The Centre for Early Child Development (CECD) has worked with the programme developers and local parents to edit the programme and tailor it to better meet the needs of Blackpool families.

Text box 1 - details of the specialised group interventions offered in Blackpool as part of the Early Help and Support Service.

There is also a range of postnatal and parenting groups on offer. For example, in Lancashire the Incredible Years Parenting support and groups and Parent Know-how (10 week online course) are offered by the Parenting Team within the Lancashire Healthy Young People and Families service.

The "Get Set, Go" group offered in Morecambe Bay is a practical 8 week programme for parents and carers of 2-3 year olds, where parent and child come together to learn more about what makes us tick. This programme aims to increase toddler's school readiness skills, ensuring they are as confident as possible to make a successful transition from home or nursery life into school. Taking evidence-based research, play opportunities and everyday interactions, the group supports parents to tune in to their toddler in a way that promotes their speech and language development, school readiness and emotional regulation.

In Blackpool staff are to be trained in SafeCare – a 20 week 1:1 parenting programme for neglect which has three modules that cover safety in the home, parent-infant/child relationship and health, as well as a programme called Caring Dads for dads who are abusive.

Appendix F provides more details of group-based interventions on offer across the area.

2.5.2 Support to families with experience of Neonatal care

The emotional vulnerability of neonatal families is well recognised, with both parents and infants experiencing a prolonged traumatic event which also interferes with the transition to parenthood and on the development of parent-infant relationships. The NFaST report, completed in 2021 [13], reviewed provision in the region and highlighted the need for embedded veteran peer support and psychosocial support within the unit, and clear referral pathways for families as needed.

Provision of tailored support is patchy but growing. Lancashire Women are now working with Burnley, Preston, Blackpool and Lancaster Neonatal units to deliver a programme of support which includes community wellbeing groups for neonatal families to come together and individual support to parents who are struggling with their own wellbeing while on the unit or post-discharge. The Reproductive Trauma Service (Maternal Mental Health Service for L&SC) is also now starting to offer support to mums who are experiencing PTSD as a result of their neonatal journey. However, none of these services have a specific remit around supporting families where there are struggles within the parent-infant relationship.

The North West Neonatal ODN are working with partners across the region to try to reduce and mitigate the impact of trauma on the unit, improve the visibility of neonatal families in existing pathways and ensure that services have a good understanding of their needs. There is also work underway to establish what outreach support should be available for neonatal families post-discharge and whether a more robust screening pathway might help parents to navigate the challenges that the months and years post-discharge can bring.

2.5.3 Children's centres / Family hubs

Sure Start centres are provided by Local Authorities to give help and advice on child and family health, parenting, money, training and employment. Some centres also provide early learning and full day care for pre-school children. The prevalence of Children's Centres varies by Local Authority. An overview of provision is shown in Table 2.

Lancashire is intending to submit a bid to DfE to develop a small number of Family Hubs with partners. This is on the back of a successful bid for funding to support digital projects called "Growing Up Well".

Family hubs aim to remove barriers for parents to get support and ensure better outcomes for them and their children. For the youngest children, this should include support to develop strong and healthy parent-infant relationships as a foundation for lifelong mental health. Children's Centres offers might include a range of interventions to support this such as parenting education, baby massage, structured play groups, drop-in support, psychological interventions and signposting, as well as providing a hub for standardised care such as health visitor appointments.

In April 2022, the UK Government announced that 75 local authorities had been selected as eligible for funding to create new Family Hubs in their areas. These hubs should give parents advice on how to take care of their child and make sure they are safe and healthy, providing services including parenting and breastfeeding support.

One third of this funding (£100million) will be shared among eligible areas to roll out bespoke parent-infant relationship and perinatal mental health support. Two areas were selected in Lancashire and South Cumbria: Blackburn with Darwen and Blackpool.

2.5.4 Support to Early Years Settings

Working with Early Years (EY) settings is an important mechanism for identifying and supporting children who are at risk of mental and emotional difficulties as well as promoting healthy approaches to mental health and wellbeing. It is noted that there are likely interventions being delivered for and by nurseries, child-minders and other providers of early years education in Lancashire and South Cumbria, however these have not been returned as part of this scoping exercise.

2.6 Summary of scoping

The results of the scoping exercise show Lancashire and South Cumbria has some pockets of good practice and examples of excellent service provision. However, no one CCG area has full provision of Parent Infant Mental Health Services.

Where PIMH services are in place these are currently dependent upon non-recurrent funding. The services that have been shared have been developed to a high standard of service provision, meeting best practice standards, although only serving a small proportion of the area's population. These could have the potential to offer a model for service provision that could be learned from across the L&SC borough.

Although NHS Children's and Young Person Mental Health services across L&SC are commissioned from age 0+, none of the services in the area currently have a pathway in

place for children under five and none are routinely accepting children in this age group. When children under 5 are accepted into services, the work described is of a collaborative nature with other organisations, however we have not seen evidence of this documented as a standardised approach.

There is significant variability in the provision of universal services across the area, in terms of the interventions available to families and the skills of the workforce within Health Visiting, Maternity and other early help teams, although there has been some coordinated effort to standardise provision of training.

The provision of children's centres and family hubs across the area is variable between Local Authority areas. Within this, the level of provision and interventions on offer is also variable. With the provision of the Best Start For Life funding in only two Local Authority areas, this variability is likely to continue and potentially be exacerbated.

3 NWC conception to age five mental health summit event

On 9 February 2022, the NWC PMH Network hosted an online event – Relationships and Mental Health: Conception to Age Five. This half day interactive seminar was attended by 150 stakeholders from across the NWC area with representation from adult and children's mental health, maternity, health visiting, local authority, CCGs, early years education and support, third sector groups and service users. The audience heard from national speakers from the Parent Infant Foundation and NHS England as well as service providers from Liverpool and Blackpool. Online interactive tools were used to collate qualitative and quantitative feedback that has informed the development of this report.

The charts below summarise the feedback returned during the Early Years Mental Health Summit for the North West Coast that was held in February 2022. See Appendix D for further details of this event.

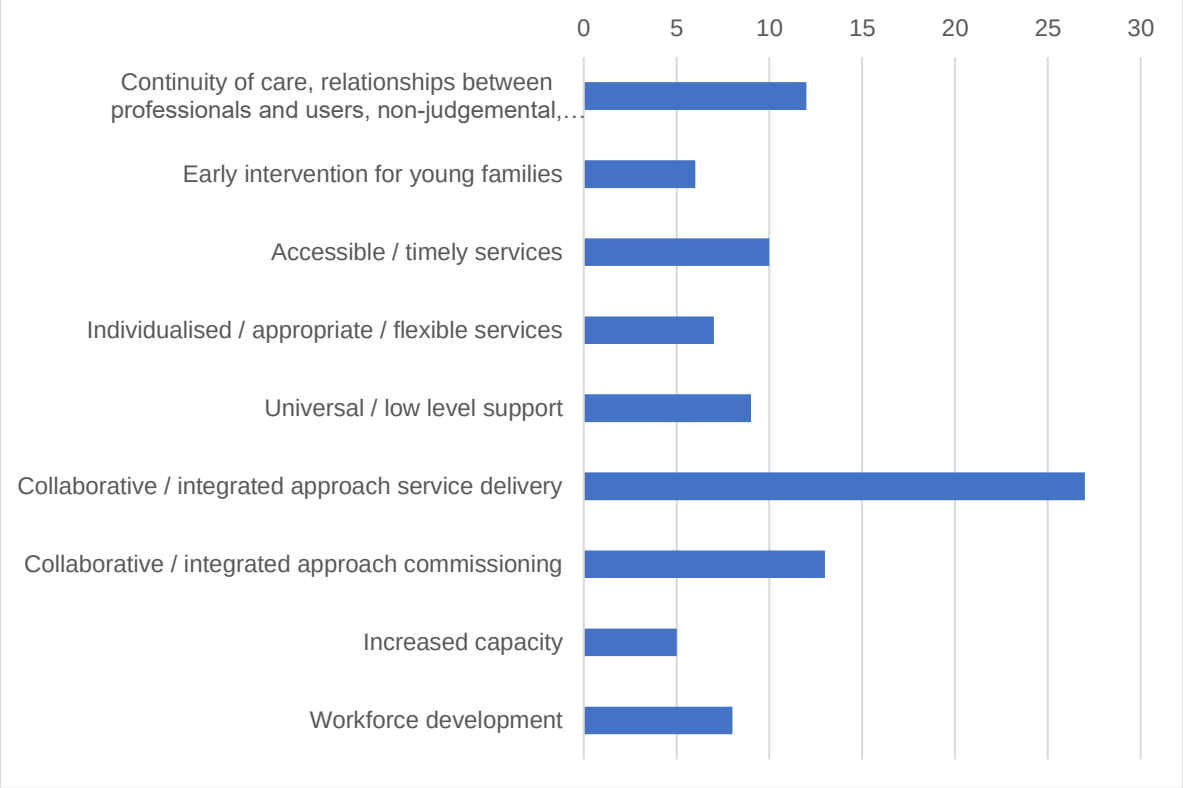

Figure 3 - the most commonly reported themes on what developments should be prioritised following the NWC Early Years Mental Health Summit, February 2022. Based on a thematic review of written responses from audience members.

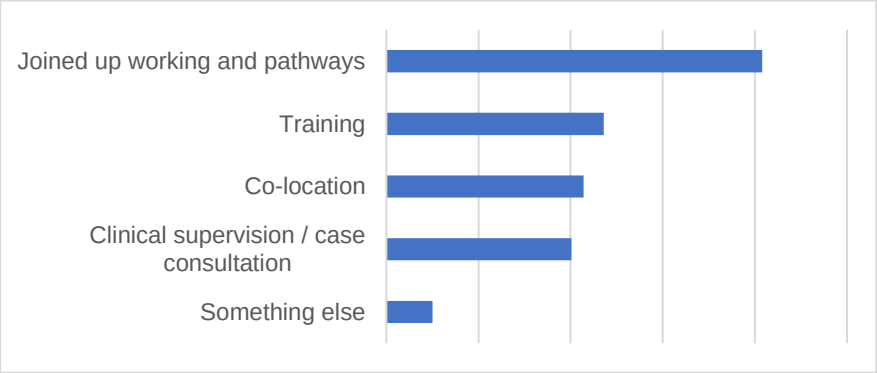

Figure 4 - how can we best support the workforce? Audience members were asked to rank the above 5 options in order of priority. NWC Early Years Mental Health Summit, February 2022.

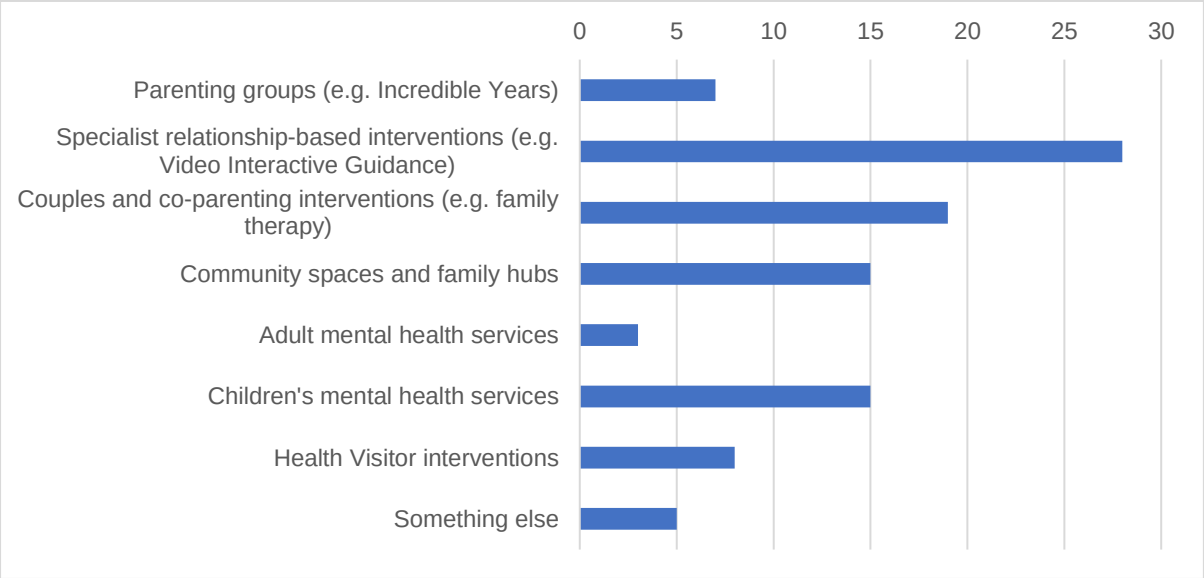

Figure 5 - what do we need more of? Audience members were asked to vote for which of the listed interventions are most needed in our communities. NWC Early Years Mental Health Summit February 2022.

A key theme that was highlighted during presentations, discussions and feedback at the event was the need for pathways that facilitate co-delivery and joining-up service providers, as illustrated in Figure 3 and Figure 4. This would help to deliver services that are better suited to families and more effective in meeting outcomes as well as supporting staff to feel effective and enabled. It is recognised that to support joint up models of service delivery, it is necessary to also adopt an integrated approach to service commissioning.

The case for collaborative working in the health and care system has been strengthened by the experience of the Covid-19 pandemic, as the response has depended on different parts of the system working together. In recent years, the work of ICSs and STPs has focused on several areas, including:

- reaching a shared view between system partners of local needs and the resources available for health and care.

- agreeing a strategic direction for local health and care services based on those needs and resources.
- driving service changes that are needed to deliver agreed priorities.
- taking a strategic approach to key system enablers, for example by developing strategies around digital technologies and estates.
- establishing infrastructure and ways of working to support collaborative working, for example by putting in place new governance arrangements to enable joint decision making and agreeing system-wide leadership arrangements.
- strengthening collaborative relationships and trust between partner organisations and their leaders [14].

These ambitions lend themselves to our stakeholder feedback and existing good practice which emphasise the need for integrated pathways and services.

4 Recommendations

Clear themes can be identified from the cumulation of the above work around how this programme can be progressed. Both the locally sourced evidence and national best practice guidance indicate that it is in the best interest of families and children to adopt a collaborative approach to developments. This should be seen across the system at both a commissioning level and a service delivery level.

Recommendation 1: Integrated commissioning approach to early years mental health support

Development of an integrated commissioning model that clearly outlines:

a. What services need to be commissioned for each stage of the journey from conception to age 5 to specifically support parent-infant relationships and mental health for babies, infants and toddlers. This should include both universal and specialist service provision.
b. What organisations (e.g. health, local authority, third sector) should take responsibility for commissioning each of these services.
c. A model for collaboration between stakeholders to ensure that services that are developed and commissioned are sustainable and appropriate to the local community. This should include, but not be limited to current and former service users, clinicians, commissioners and managers from a variety of disciplines, organisations and backgrounds.
d. Consistency in outcome measures.

Recommendation 2: Model of best practice for joint delivery of services

Develop model of best practice for joint working and service delivery to support relationships and mental health from conception to age 5. This model should provide a reference framework that will build a system to better support joint working. The model should include:

a. What a 'good enough' system looks like – including leadership and professional relationships.
b. What services need to be in place – including staffing models.
c. What interventions are needed within services.
d. Minimum workforce and training needs for each service.
e. Workforce training plan to build capacity and to upskill the universal workforce, to ensure equity across the ICS area.
f. How and when services / multi-disciplinary professionals should work together to deliver interventions.
g. How families should experience a seamless journey through and between services.
h. Consistency in KPIs / outcome measures between services.
i. Joint working between Specialist Perinatal Mental Health Services and Children's and Young Persons Mental Health Services to close the gaps around provision of parent infant mental health interventions, in line with the NHS Long Term Plan objectives.

Additional recommendations

It is recommended that the current NWC Best Start for Life group is re-named in order to avoid any confusion with emerging Local Authority governance relating to the Best Start for Life funding.

The proposed name for the workstream going forward is Perinatal, Parent-Infant and Early years Relationships Group (PPIER Group). This would also help to reflect the integrated approach to development.

This NWC group will sub-divide into a Cheshire and Merseyside PPIER-Group and a Lancashire and South Cumbria PPIER-Group.

5 References

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[2] Wave Trust, “Conception to age 2 - the age of opportunity,” London, 2013.

[3] NHS England, “NHS Five Year Forward View,” NHS England and NHS Improvement, London, 2014.

[4] NHS England and NHS Improvement, “The NHS Long Term Plan,” NHS England and NHS Improvement, London, 2019.

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[6] NICE, “Antenatal and postnatal mental health Quality Standard QS115,” 2016.

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[12] Warwick Medical School, “Parent Infant Interaction Observation Scale (PIIOS),” January 2022. [Online]. Available: https://warwick.ac.uk/fac/sci/med/study/cpd/cpd/piios/.

[13] Spoons & North West Neonatal Operational Delivery Network, “Neonatal Families and Staff Together (NFaST) Evaluation Report,” 2021.

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[15] “Family Nurser Partnership Services,” NHS, [Online]. Available: https://fnp.nhs.uk/.

[16] O. a. B. J. Homonchuk, “Specialist Health Visitors in Perintal and Infant Mental Health,”

] Department of Social Policy and Intervention, University of Oxford, Oxford, 2022.

5.1 Recommended further reading

- Department of Health and Social Care, "The Best Start for Life: a vision for the 1,001 critical days", March 2021
- Cross-party manifesto, "The 1,001 Critical Days", 2015
- First 1,001 days all party parliamentary group. "Building Great Britons", 2015
- B. Lewing, M. Stanford, and T. Redmond, "Planning early childhood services in 2020 Learning from practice and research on children's centres and family hubs", November 2020
- B. Lewing, J. Gross and D. Molloy, "Leading and delivering early childhood services 10 insights from 20 places across England and Wales", February 2022
- Tavistock and Portman Foundation Trust and the Anna Freud Centre (AFC), "THRIVE model", Wolpert, Harris et al., 2014
- NICE Clinical Guidance, "Antenatal and postnatal mental health: clinical management and service guidance" [CG192] published 2014, updated 2020.
- NICE Quality Standard, "Children's attachment" [QS133], 2016
- NICE Quality Standard, "Postnatal care" [QS37], statement 9, updated 2021
- NICE Quality Standard, "Early years: promoting health and wellbeing in under 5s" [QS128], 2016
- NICE Guidance, "Social and emotional wellbeing: early years" [PH40], 2012

Online resources and organisations:

Early years alliance | (eyalliance.org.uk)

National Centre for Family Hubs

Early Intervention Foundation (eif.org.uk)

AiMH – The Association for Infant Mental Health professionals in the UK

Resources for Professionals - Parent-Infant Foundation (parentinfantfoundation.org.uk)

North West Coast Clinical Networks

Best Practice Service Model for Parent Infant and Early Years Relationship Services

North West Coast Clinical Network for Perinatal and Early Years Mental Health

July 2023

Appendix B: Family feedback report

NHS
North West Coast
Clinical Networks

Parent & Infant Early Relationships (PIER) Task and Finish group Family Feedback

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Background

The Parent and Infant Early Relationships Task and Finish group (PIER) was established in October 2022 to develop a model of best practice for joint working and service delivery to support relationships and mental health from conception to age 5.

One of the guiding principles of the service model was that:

"The service will be co-produced with families with lived experience of early years relationships and mental health challenges."

A Lived Experience Lead was recruited to the PIER Task and Finish group. This role provided ongoing expertise by experience and assistance with data collection from families, to ensure a wide range of lived experience informed the development of the service model.

Feedback was collected from families using an online survey, supported by two online focus groups. The survey questions are presented in Appendix A, and the focus group guide in Appendix B. The feedback survey ran from **January – February 2023** and was widely promoted through PIER Task and Finish group members and partner organisations. Survey respondents were also invited to join focus groups, which took place in **March 2023**.

Demographics

- **150 survey respondents** from **16 postcode areas / 61 districts:** Aberdeen, Bolton, Bromley, Bristol, Chester, Croydon, Crewe, Blackpool, Guildford, Liverpool, Manchester, Oxford, Paisley, Preston, Stockport, Warrington

- **2 – 4 responses per postcode area**, with the exception of the following geographical clusters:
    - **35 responses from Chester**
    - **22 from Blackpool**
    - **33 from Liverpool**
    - **25 from Warrington**

- **94% white** (3% mixed, 2% Asian, 0.7% Black)

- **90% Mothers** (9% Dads, 1% Others)

- **Only 9 respondents currently pregnant**, otherwise **evenly split** between parents of 0-2's, 2-5's and 5+

- **9 individuals** attended a focus group (8 female / 1 male)

The scope of this project did not extend to conducting additional outreach activity into marginalised communities. We recognise that traditional data gathering methods, such as those we have employed, often do not serve to amplify marginalised voices.

While the demographics of respondents within our results are not unusual for a survey of this type, and broadly in line with national and local trends (see Appendix C) we do need to employ caution when making generalisations. Within the North West Coast there are clusters of BAME communities and any new service should work closely with those local communities to ensure that they are meeting the needs of all.

Executive Summary

- Parents are comfortable being asked about this topic, but the more they worry about their relationship with their child, the less comfortable they are to discuss it.

- Parents would value conversations about their relationship with their child throughout the 0-5 period, but especially during the first year and at developmental checks.

- Informal sources of parenting support are highly utilised, but not necessarily by preference.

- The majority of respondents show a clear preference for support in a non-clinical setting. There is also a concern that home visits and online support can lead to isolation and the exacerbation of mental health issues if not combined with the opportunity for face to face and group activity.

- Of the things that negatively affect the parent / child relationship the majority of responses related to the parent, with less than a quarter relating to the child.

- In terms of who parents would like support from, peer support is viewed as valuable, offering a different and potentially more accessible alternative to clinicians. Volunteer Peer supporters in particular are perceived to be more interested in the individual than employees, due to their own motivation for the role and structural reasons (e.g., a perception that clinicians lack time).

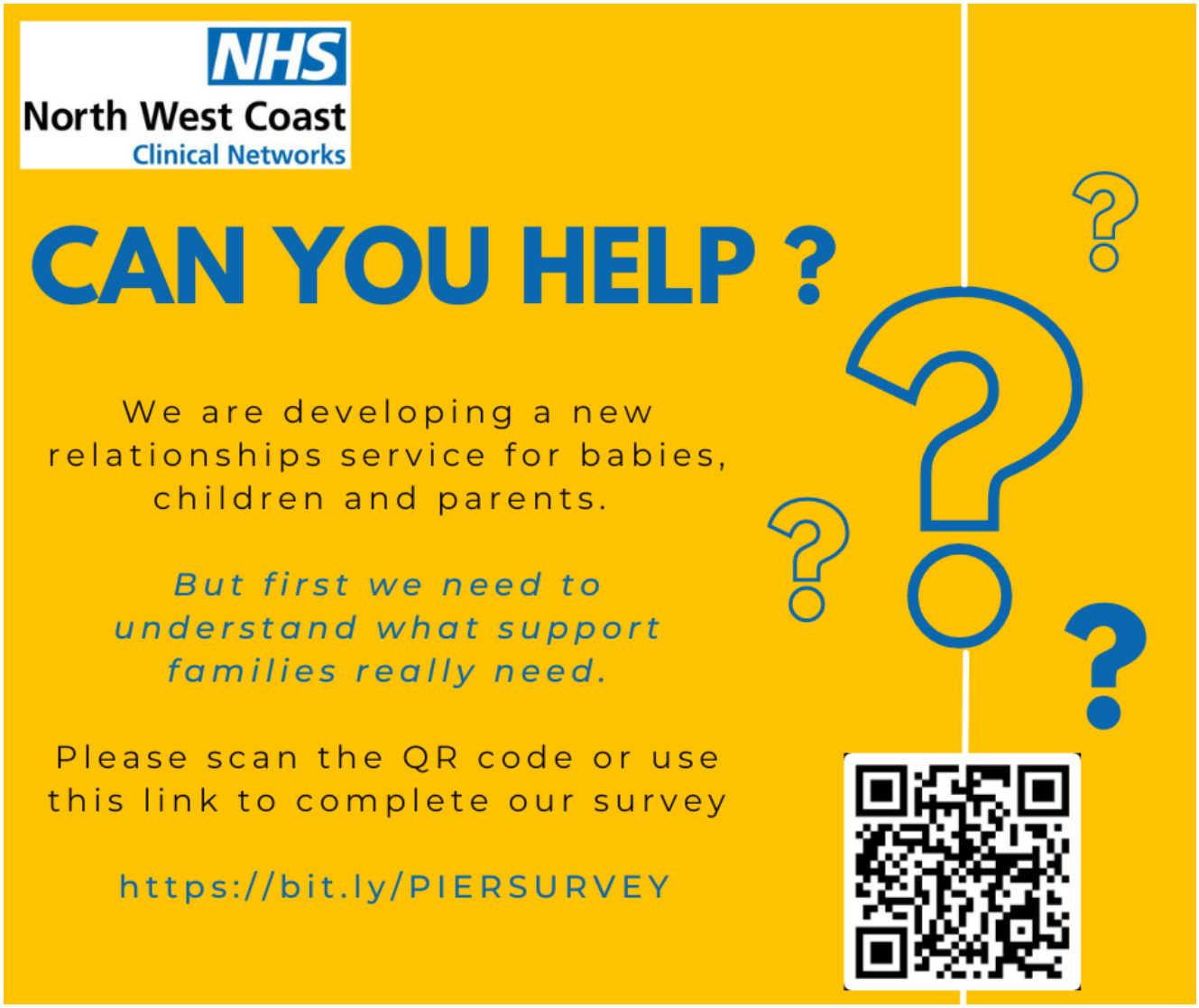
- There are many positive examples of voluntary and children's centre support. But, availability of these services is a postcode lottery.

- Trust is key and relationships need to be built with the service provider to ensure this.

- Dad's / non-birth partners need targeted support. There is little out there for them and yet they also struggle with both bonding and attachment and the practical aspects of caring for a baby.

- Focus group participants particularly emphasised the importance of service accessibility – both physical and emotional. High visibility of services within the community is vital to build confidence.

- Both survey respondents and focus group participants reported a strong link between confidence in the practicalities of caring for children with increased levels of bonding and attachment.



Describing our findings

Is there a demand for this service?

In short, yes. Of the family members we surveyed the majority (82%) responded positively to the question, *"Would you feel comfortable being asked about your relationship with your child?"* This was supported in our focus groups, with all participants feeling that either themselves, or their partner would have benefited from being offered a relationships service.

"He [my boyfriend] could have benefited from something around relationship with a baby and bonding… he didn't feed him for the first three days because he didn't dare because he was too dainty" (Focus Group Participant)

"It is something that would help a lot for those inexperienced parents. Simple things like how to care, how to do, first time we don't know anything!" (Focus Group Participant)

In addition, over half of our survey respondents (54%) had experience of non-NHS service that they felt benefited them or their child. In many cases, parents had turned to these services after initially trying to access support via the NHS but finding that it did not meet their needs.

"[Local charity] helped my confidence with my parenting, with their help I was able to breastfeed which helped support the bond between me and my child immensely. Gave advice on what was normal infant behaviour. Had mental health support from [Local NHS IAPT service]. I did not find the service useful or welcoming and it only ended in making my Anxiety worse and broke my trust in Mental Health services." (Survey Respondent)

In total over a third (**35%**) of respondents 'often', 'always' or 'sometimes' worried about their relationship. It is worth noting that when these responses are analysed against the responses for the question *"Would you feel comfortable being asked about your relationship with your child?"* a more nuanced pattern appears. This seems to indicate that those who are less comfortable being asked about their relationship are more likely to have some level of concern about it.

"Would you feel comfortable being asked about your relationship with your child?"
Don't Know: 47% "often / sometimes" worry (0% always)
No: 63% "sometimes" worry (0% always / often)

Where do parents currently go for support?

When it comes to reaching out for support, informal sources are highly utilised. Almost two thirds of respondents (64%) would normally head for the internet and over three quarters (78%) rely on family and friends for help with their parenting concerns. This is compared to

less than a third who would speak to their Health Visitor or GP (29%/30%) and just 14% who would visit their local Children's Centre.

Our respondents had many positive things to say about informal support, in particular through technology. Apps like Peanut, WhatsApp, Facebook and Instagram were mentioned as being helpful as well as websites such as the BBC.

"Big Little Feelings on Instagram, talking about a more gentle way to parent and guide behaviour through example. Lots of practical ways to help and deal with certain behaviours e.g., hitting, potty training, introducing siblings etc." (Survey Respondent)

"I googled activities to do with my child at home and found a BBC website with ideas of games to play." (Survey Respondent)

"It surprised me how much I had to learn about parenting approaches, breastfeeding and normal infant sleep from Instagram accounts and Facebook pages rather than NHS pages" (Survey Respondent)

However, when we interrogated this further it became apparent that it is not always straightforward preference guiding the choice to access informal support. Instead, parents may shy away from approaching NHS services because of fear of stigma, accessibility issues or the belief that services are too oversubscribed to cater for them.

"You don't want to ask the question because you don't want to be seen as, 'oh, what do you mean you don't know how to feed a baby, don't know how to bath a baby'. It's that stigma around and I think, like you say, that's why people go for the informal approach of searching Google as opposed to asking someone. Because they don't want to be seen as, 'well she doesn't know the answer to that question" (Focus Group Participant)

"For me there's a fear that it's going to end up with like, very dramatically, a child being taken off you. You know, if you say that you are struggling with something… or... you don't like them… well they are not going to think I'm appropriate and they are just going to take the kid off me. That's not the end goal of what I want from support, so I think it's the fear of the repercussions of what asking for help can be" (Focus Group Participant)

"Time taken to access any services and lack of available support in the [local] area needs addressing" (Survey Respondent)

And there is recognition that informal sources of support can do harm, as well as good.

"Self-help resources can do more harm than good, making me feel like I'm doing it wrong or I'm not good enough. 'If you do this thing, your child's behaviour will be fixed" (Survey Respondent)

"I engaged with some online peer support and also tried a number of self-help resources. I think I/we benefited to a degree from these, however I think a more 'directed' approach would have been more helpful as I was trying to seek support in certain areas I wasn't completely sure were actually having any bearing on my parenting/my relationship with my child" (Survey Respondent)

"There is loads of stuff online as well but you could do yourself in by looking at all these amazing people that are like crafting everything from scratch. You can read contradicting things". (Focus Group Participant)

Barriers to accessing support

In addition to a fear of stigma our respondents gave us further insights into the barriers to accessing support.

Many commented that **assumptions** were made about who needed support, and these assumptions led to a lack of tailored, appropriate support, in particular for Dad's / non-birth partners.

"my baby was in hospital recently and my partner, male partner, and I were there and automatically it was me being made to practice with the asthma pump on her and I said, 'no can he do it because actually we are both going to be doing this' but that really sets the standard, doesn't it? For the expectations in the relationship and who's going to be doing childcare and I think ensuring that the services is as equal as possible" (Focus Group Participant)

"even when you hear 'parent' you hear Mum" (Focus Group Participant)

"My partner is male and… I absolutely think he 100% would have benefitted from something. You know everything is geared towards us, 'we've carried the baby, the midwives' appointments'. Neither of us know how to raise this baby but he's just chucked at this baby." (Focus Group Participant)

"Services are understaffed, and there is a massive, MASSIVE, amount of worry around engaging with services and saying you are struggling as a parent, because there is so much judgement on men particularly, "How can they parent! It must be an idiot man not knowing what he is doing! Where is the mother!" (Survey Respondent)

Continuity of care, or lack thereof, was cited as a major factor in a general loss of trust in services to deliver.

"Kept me passing from one to another and did not help at all. Just had to tell my story multiple times to multiple different people." (Survey Respondent)

"It's like you feel that you don't have too much support and there is no continuous support, there are different silos... I'm not sure if there is no exchange of information - or probably they are very busy and they could not do it - I'm not sure, but it is not very good." (Focus Group Participant)

"I asked for mental health support during pregnancy but never received any. This was particularly damaging as there was also no antenatal or parenting classes running." (Survey respondent)

Parents own **mental health issues**, in particular anxiety, prevents many from reaching out to services.

"I 100% should have asked for help but it feels like a big step to get the phone number of your health visitor, try and get through to them, and actually say "I think I need help" (Focus Group Participant)

"it's so hard with anxiety to get out" (Focus Group Participant)

And even for those without mental health issues, the sheer **logistical challenge** of life with young children can prove insurmountable.

"It takes a lot to either make that first contact or attend that first group with all the logistics of trying to get a small person out and you as well" (Focus Group Participant)

"it's harder when it is just the child and the Mum or Dad. Once that child is in bed you can't leave the house and you feel like you are trapped. Where is the support for single parents wanting to even go for a walk for 20 minutes?… It's such a taboo subject" (Focus Group Participant)

For parents with children with **additional needs**, this is even more acute.

"I take her out (child with ALN) but I feel like everyone is just judging me and her and how she is being, and it's easier to stay at home" (Focus Group Participant)

"I had a Health Visitor who then disappeared. Another one come; she went. Then another one come, and went. And I was like, 'where do I go now?' There was nothing and then I had nobody coming out to me or even checking on whether she was okay. She was premature, she was tiny... to me there is a gap in that... definitely for Mum's like myself there was nothing. It was just like 'oh yeah, you've had your baby prem so now she's here, she's fine, but you don't really know because, you know, there is a lot of things that prem babies struggle with that term babies don't"

"I feel there is a real gap in services for my family and my daughter. She is 7 and diagnosed with ADHD, emotional dysregulation and sensory processing difficulties... As a family it would be lovely to be able to attend somewhere safe for my 2-year-old and daughter to play

and for us to get involved too. Somewhere that won't judge her behaviour and has an understanding, where parents can talk to professionals and other parents." (Survey Respondent)

Finally, there is a general **lack of information** about the importance of this aspect of parenting, coupled with a **lack of awareness of local services** – where they exist.

"Why do parents not know this information? Why are they not given this? It should be everyone is given this [information about bonding and attachment] like everyone is given the option of an antenatal class. Everyone should know that about their baby" (Focus Group Participant)

"I think there should be access to free classes no matter where you live, just because you live in an "expensive area" doesn't mean you can afford lots of classes." (Survey Respondent)

"I found the support we have depend of where we live. Like the postcode lottery" (Survey Respondent)

"I am completing this survey as a grandparent of a 6-year-old child who has started to hit and spit at parents when having a tantrum. It seems like everything is a battle of wills at the moment. I try to support my daughter but I think she requires more formal help and she has been unable to find help and support in the community in any meaningful way." (Survey Respondent)

What promotes strong relationships, and what undermines them?

When it comes to building strong relationships with their children, over half of parents are clear that **more time** both with their child (55%) and for themselves (52%) would be of benefit.

"This time [second baby] … I've realised that time with your children is precious and I feel like maybe COVID has had a big impact on work life balance. For me, this second time around I would take more time out of work" (Focus Group Participant)

"You can't pour from an empty cup; you need to look after you. You need to be in good shape to look after it, so it's the time things, you can't create more time but it's your mindset, what are your practical tools to look after yourself… you go to the bottom of the list when you have a baby" (Focus Group Participant)

"It is difficult when working to spend as much time with my children as I would like to do so. A lot of times you feel guilty and I think help with this, especially when your children are younger would be great" (Survey Respondent)

"Trying to balance work/life is the biggest challenge, which no amount of services can support with. It is a wider cultural problem. As parents, we constantly feel guilty not

spending more time with our children. This brings more tiredness, stress, and ultimately spending more money on childcare." (Survey Respondent)

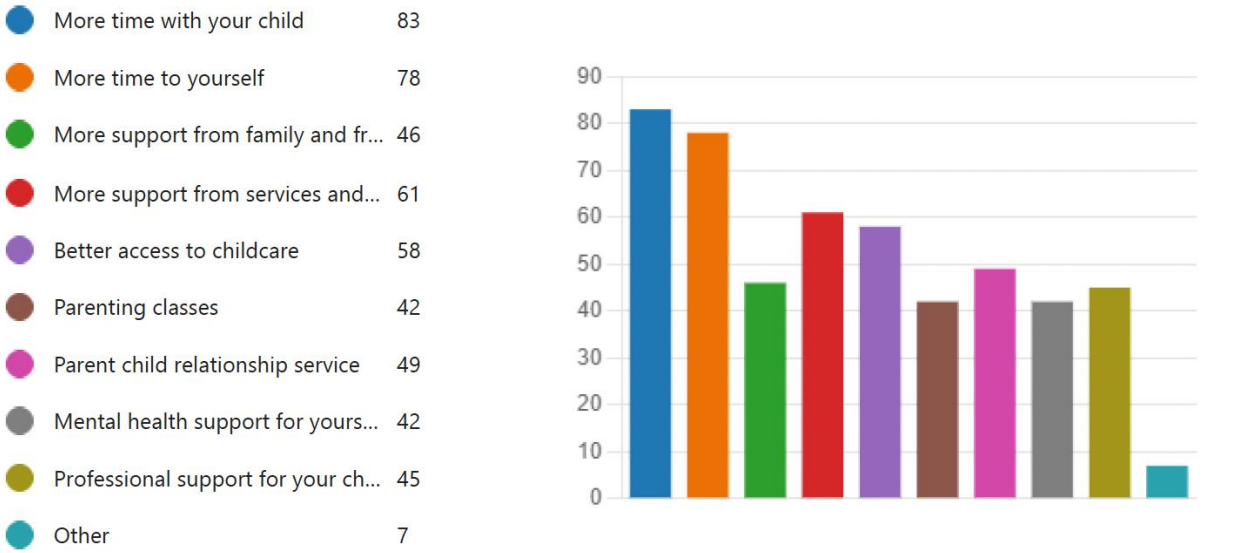
"Mums/parents should know the importance of self-care and taking time for yourself I forgot to look after myself because I was so focused on looking after the baby" (Survey Respondent)

And when parents do have time with their children, they often feel **ill-equipped** to make best use of this precious resource.

"I think, especially when they were younger and they don't do anything, an hour with them, it's like, what do I do, I should be doing something with them. They are awake, they are happy, what do I do now? How do I engage with them?" (Focus Group Participant)

Other **structural barriers** to bonding can be seen in the following graph:

18. Which of the following do you think might help you to build a stronger relationship with your child?



For many parents, there is a strong link between the **practicalities of parenting** and bonding.

"No-one teaches what to do with a baby, like you say those really practical things. Everyone says, oh you used to go into hospital and they teach you how to bath a baby this that and the other and its very different now" (Focus Group Participant)

"They do these things through pregnancy [antenatal classes, infant feeding team] but once you've got the baby then there isn't anything is there, other than the weaning…" (Focus Group Participant)

"I feel like there is a big stigma around your feeling, especially myself obviously like I say I was only 18/19 when I had my little boy so, I think you feel like you should know and like you give birth, you get handed this baby, don't get me wrong, I'm not saying there is no support out there, but you are just expected to know what to do. And I feel like people, especially kind of the younger ones, they don't dare say, do you know what can I have a little bit of help? How do you bath your baby? 'Cos you are just sent home and you are just expected to know." (Focus Group Participant)

When asked the question, *"What does having a strong relationship with your child mean to you?"* parents independently cited a number of common themes:

When it comes to identifying the factors that hinder the development of positive relationships, parents where more likely to focus on themselves than on their child. Adults' mental health was felt to have had the most negative impact (53%), followed by child's behaviour (38%). When all options were taken into account over half (57%) of the responses to the question, *"Do you feel that any of the below have negatively affected the relationship between you and your child?"* related to the adult, with just under a quarter (24%) relating to the child.

"I saw a psychotherapist and this did help me to understand the impact of my own childhood abuse and to understand how it could impact on my own parenting. It gave me time to reflect and act." (Survey Respondent)

"[Local charity] were one of the biggest players in me getting support with my mental health that helped me bond with my first child. They have been a tremendous support with

struggles with my son and I contribute their support to post-natal depression not being as bad second time round." (Survey Respondent)

"I appreciate the support for me and it not just be baby focused. I feel working on my personal issues separately helps my mental health and therefore improves my ability to parent." (Survey Respondent)

The following graphic summarises the free text responses to the question, *"What would make you doubt your relationship with your child?":*

What would "good" look like?

So, what would make for an accessible service that families would feel comfortable engaging with?

When it comes to **who** parents feel comfortable discussing their relationship with their child with, peer support (with lived experience) was a strong favourite, with over a third of parents (36%) selecting this option. Health Visitors and Mental Health Professionals followed at under a fifth (17% / 14%). Midwives scored particularly poorly (4%), however that should be taken in the context of our sample population, the majority of whom were no longer under the care of maternity services.

In terms of **when** families would like to engage in these conversations, our respondents told us that this would be valuable throughout the 0-5 period, but especially during the first year and at developmental checks.

"It's having that support network there that's in the know, knows the constant guidelines and is able to help you along the journey of having a baby. They are not babies for long, they go from new-born infant to toddler to walking and they all come with different challenges that you are just expected to just get on with" (Focus Group Participant)

"It would have been nice to speak to a professional in those first few days where we were still in the hospital recovering to be able to talk about it. I still feel guilt about it now even more so that I felt that connection straight away with my second after a natural healthy labour and birth. I feel awful that I had to work to feel that connection with my first and with my second it was just there." (Survey Respondent)

When it comes to service delivery, a **hybrid approach** that utilises new technology, but does not entirely rely on it, was seen as the gold standard. Employing the option for both one to one visits and community groups was believed to be the best approach to meeting the needs of different families, as well as the differing needs of each family throughout their parenting journey.

"The dynamics of all three [WhatsApp, zoom and face to face group] settings, the dynamics of all three are completely different and cater to completely different types of people" (Focus Group Participant)

"I'm pregnant now and I can't get to things in the week because my husband works away and my little boy is in bed. So being able to access stuff like yoga and things on zoom that's like a gamechanger" (Focus Group Participant)

"I lost my social skills because of COVID… and my little girl was colic, milk intolerant, she literally didn't sleep for the first 6 months of her life. I preferred it to be online because I don't like going out anymore… I don't know how to go from that to being able to go out with her on my own" (Focus Group Participant)

"It could be seen as a little bit isolating if it is like you are coming to your house whereas getting it into a community setting there is opportunities for Mum's and Dad's to meet other Mum's and Dad's with babies of a similar age creating that village of people that are in the same boat as you, you can have those conversations with and stuff like that... you are getting the information about what else goes on" (Focus Group Participant)

"personally, I wouldn't want anyone in my house. I think having the Health Visitor come round, that just adds for me a layer of judgement" (Focus Group Participant)

"I definitely think there should be an option especially for Mothers with postnatal depression, psychosis, anxiety to have that option at home. If they are feeling up to it in like a community centre where they know they can go there it's a safe space. But if they don't feel safe leaving the house then have someone come in and see them in the house just one on one" (Focus Group Participant)

Most importantly any service needs to be **non-clinical**, **relaxed, non-judgemental**, **consistent** and **physically easy to access**.

"not clinical, community, something that is easily accessible, bus routes, train routes, not steps everywhere" (Focus Group Participant)

"somewhere you would go anyway" (Focus Group Participant)

"near your home, the reason being you are so stressed with everything with the baby maybe you don't have time to go anywhere else. Or if it is too far away the traffic, where to park or even if you have to take a bus it can take too much" (Focus Group Participant)

"I went to a children's centre with my youngest… and I was really struggling with her and depression around second child. I found that they were so non-judgemental I just thought of them as friends, but not friends, and I found I could be really open with them and they were really good at picking out what was going well between me and my daughter and they really helped me to bond with her. It was that professional but not seen as a social services type professional or health visitor type professional" (Focus Group Participant)

In terms of what the service would provide, a thematic analysis of the survey data breaks this down into the following key areas:

- **Education on child development**
- **Reassurance on typical behaviours**
- **Opportunity to meet other parents**
- **Mental health support for parents**
- **Advice**
- **Practical parenting skills (e.g., sleeping, weaning, feeding, first aid)**
- **Group activities**
- **Self-help resources**
- **Signposting to other services**
- **Peer Support**
- **Activities for parents, both alone and with their child**

And there should be a high level of emphasis on empowering parents as the experts in their own families.

"whatever you set up has to really focus around the Mum and the Dad or the parents, that family, as the experts and just having that recognition because that gives you confidence in yourself if you think, oh someone else thinks that about me, then it gives you a bit of a boost and a bit of confidence and then building on that as to all the other things, the practical elements and what you do with a baby, how to play with a baby" (Focus Group Participant)

"I honestly believe it's just down to the child and as a Mother or a Father you know your child the best and that instinct is the only thing you should be going on"… "Yeah, but it's having confidence in that, and if you are sleep deprived" (Focus Group Participant)

The role of **peer support** within any new service should be prioritised. Families feel strongly that peer supporters, especially those working in a voluntary capacity, provide a different and at times more accessible alternative to clinical support.

"I would see them [the volunteer] as more able to give because they are obviously doing it for a reason. You usually find volunteers who are helping in specific areas they've been there, done that, they needed the support and that's why they are doing it because they know how beneficial and how helpful it can be. So, for me volunteers would be the main driver and the most beneficial." (Focus Group Participant)

Peer supporters may also be able to reach those less inclined to access traditional methods of service delivery.

"I feel like men might be, hmm, this healthcare professional or this whoever is showing me how to change a baby and they're going to then watch me. And then they feel on edge. But, if it was delivered by a peer support, another Dad who felt that exact same way, I feel like there would be moments when I would prefer not to be there, and he would benefit from me not being there not looking over his shoulder." (Focus Group Participant)

The opportunity to access **informal peer to peer support** should also be built into services, through the running of group activities that enable parents to meet each other.

"Zoning into the people that could potentially be at the same groups as you... there in that moment with you, they are at the same stage as you, so those sorts of peer-to-peer support would obviously be worthwhile 'cos they know exactly what you are going through, sleep deprivation, a whingy baby, teething baby, all those different milestones they'll kind of be doing the same thing." (Focus Group Participant)

"it's just as important not to feel alone, everyone's wrangling with the same things aren't they, everyone's tearing their hair out about the same thing at some point and it's vital, just someone to listen to" (Focus Group Participant)

Finally, the things that make a service easy to engage with vary from **heightened visibility** in the community, through social media and other forms of advertising,

"it's been nice that the children's centres in [place] have been promoting themselves quite a lot more on Facebook recently. Every single day you are seeing what's coming up in every single place. And then they are putting the photographs up of all the babies and what they are doing... for people who are anxious and quite unsure 'what am I going to be doing when I get there' those pictures are saying 'this is what your baby is going to be doing'. I found that really good." (Focus Group Participant)

to **easy referral processes**,

"Making it easy to access, so if it is a self-referral thing it not be you email someone but then they are going to ask you to fill in a quiz, and if you fill in the quiz you only got 50%, you don't qualify for the service. It should be "I need help", "cool pop in" (Focus Group Participant)

And the **language** used in service literature and by staff.

"the language is so important, avoid anything clinical. It's got to be in the voice that parents use" (Focus Group Participant)

"the experience I had with Health Visitors weren't that great and I found them condescending and patronising. Whereas with the children's centre staff I built up such a good relationship with them… I felt there was not that judgement there" (Focus Group Participant)

Co-location of services also serves not only to make them more practically useful to parents, but can also serve to make the experience of attending less intimidating and more welcoming.

"I went to a class [at local parents' hub] there and then it's what they promote, so it's that credibility, you know what they do they are connected so like the sling library was there and Koala are there on a Monday. You can just tip up and have coffee, but there is also other things going on" (Focus Group Participant)

But, fundamentally, the most important enabling factor for families is **trust**. For parents, discussing their relationship with their child can provoke high levels of anxiety and fear of stigma. Being able to develop a trusting relationship with someone within a service, almost regardless of the professional or voluntary role of that individual, is the key that allows many parents to finally reach out and access the support they and their children deserve and need.

"I had a really good experience this time around compared to when I had my daughter 7 years ago. I feel like my Health Visitor was really good and she saw I was in this time a bit of a not a great place and kind of ran with it. She referred me for one-to-one counselling and [local charity mental health] course and she referred me to the Children's Centre to get on their little baby massage courses and things like that. So, she really took the lead and just did it and... and we talked about trust, she was really good." (Focus Group Participant)

Thanks & Recognition

This report would not have been possible without the honest, brave responses of over 150 families from across the North West Coast. We sincerely thank them for their support, and for their generosity in using their often-challenging experiences to improve outcomes for future families.

In addition, we would like to thank members of the PIER Task & Finish group for generously sharing their insights and prior research, as well as for promoting our survey so widely.

And finally, thanks go to Smile Group for their professional assistance in running our family focus groups.

Dr Beth Luxmoore; Clinical Network Manager, North West Coast
Kaisu Fagan; Lived Experience Lead, PIER Task & Finish Group

Appendix A: Survey Questions

1. **Where would you normally go for help around parenting concerns?**
   GP, Health Visitor, Internet, Friends & Family, Children's Centre, Other

2. **Where do you prefer to access support and appointments?**
At home in person, At home via video or telephone, A community venue such as a children's centre, GP surgery, Hospital, Other

3. **Have you ever been concerned about the relationship between you and your child?**
Never, Rarely, Sometimes, Often, Always

4. **Do you feel that any of the below have negatively affected the relationship between you and your child?**
Your mental health, Your child's behaviour, Your child's health, Trauma during pregnancy, labour or birth, Lack of time together, Your own experiences of childhood, Other

5. **What has helped your relationship between you and your child?**
Support from friends, Support from family, Support from professionals, Information online

6. **Have you experienced any of the following types of services to support you as a parent?**
Parent infant relationship or bonding services, Peer support (group or individual), NHS mental health services, Support from a charity, Self-help resources

7. **If you used any of these services, it would be helpful to know more about your experience. Did you receive support for yourself as an individual or for your child or for both of you together? How did you find this approach? Did your experience help the relationship between you and your child to grow stronger?**

   If you did not use any of these services, do you think these could have been helpful to you?

8. **Would you feel comfortable being asked about your relationship with your child?**
Yes, No, Don't know

9. **Who would you feel most comfortable to have a conversation with about your relationship with your child?**
Health Visitor, GP, Midwife, Mental Health Professional, Peer Supporter, I would not be comfortable having this conversation, Other

10. **When would you prefer to have these conversations with professionals?**
During pregnancy, During the new-born period, During your child's first year, At your child's development checks, Between ages 2-5, Other

11. **What does having a strong relationship with your child mean to you?**

12. **What would make you doubt your relationship with your child?**
13. **What support would you expect to receive from a parent-child relationship service?**

14. **Which of the following do you think might help you to build a stronger relationship with your child?**
More time with your child, More time to yourself, More support from family and friends, More support from services, Better access to childcare, Parenting classes, Parent child relationships service, Mental Health support for yourself, Professional support for your child, Other
Is there anything else that you would like to tell us

Appendix B: Focus Group Discussion Guide

How do you feel about the idea of a service to help parents with their relationship with their child?	• Informal support options (internet, friends and family) overwhelmingly more popular / helpful amongst survey respondents than formal ones (GP, HV, CCs) (Q5 & Q9) • Majority of respondents comfortable to be asked about their relationship with their child (Q12) • More time (with child and self) are top responses to "which of the following might help you build a stronger relationship" How can a service help address structural realities such as this? (Q18)
What would be the barriers to accessing this type of service?	• Tell us about barriers you have experienced to accessing any type of family related service • Can you describe a good experience of accessing a service? • When would this be most useful to you? (Q14, survey responses equally spread throughout pregnancy – 5yr) • Where would this be most welcome? (Q6, survey respondents show clear preference for home/community settings over clinical ones) • Where does trust in professionals come in? (Q13 MWs score particularly poorly, but all clinical roles score lower than peer supporter)

Peer support is often mentioned as a popular form of support for parents – what does peer support mean to you?	• Is there a difference between
	  ○ paid peer support workers,
	  ○ volunteers,
	  ○ programmes delivered by the NHS,
	  ○ programmes delivered by charities/community groups,
	  ○ informal settings such as mother and baby groups
	• Peer Support is the most popular response to Q13 "Who would you feel most comfortable to have a conversation with…" why?

Appendix C: Lancashire & South Cumbria Demographic Comparison Data

Region	White	Asian	Black	Mixed
National (2021)[1]	71.7%	9.3%	4%	2.9%
West Lancashire[2]	98.1%	0.8%	0.2%	0.8%
Pennine Lancashire	82.7%	15.6%	0.3%	1%
Morecambe Bay	96%	2.5%	0.4%	0.9%
Fylde Coast	97.3%	1.3%	0.2%	1%
Chorley & South Ribble & Greater Preston	90.6%	6.8%	0.6%	1.5%

[1] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest

[2] MLCSU Equality and Inclusion Team, July 2020