Perinatal mental health and parent-infant relationships strategy

North Northamptonshire Family Hubs

Anna Freud
building the mental wellbeing of the next generation

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Acknowledgements

Thank you to all the parents, carers and professionals who shared their expertise, experience and ideas to ensure this strategy represents communities across North Northamptonshire.

Foreword

In co-writing this foreword, we illustrate our shared commitment to supporting perinatal mental health and parent-infant relationships in North Northamptonshire. In supporting this work, we have drawn on our personal and professional experiences, taken an evidence-informed approach and listened to mothers, parents, families and communities, including those whose voices are less often heard.

We are grateful to the parents who shared their experiences. Particularly as stigma prevents many parents from telling others they are feeling anxious, that they are having difficulty bonding with their baby, and too often, they feel unable to seek support. These challenges are felt disproportionately by those living in deprived communities. The strategy will further open the conversation in communities about perinatal mental health, draw on experts by experience and develop peer models of support that parents find valuable.

Colleagues tell us that accessing parent-infant relationship advice is challenging, and they would like more perinatal mental health training. Our ongoing commitment to multidisciplinary training will increase colleagues' confidence in their skills rather than having a purely theoretical focus, and will help colleagues supporting parents and families to build a consensus regarding language and approach.

The strategy reflects our commitment to working across the system to make support available at the earliest opportunity, including antenatally, maximising the impact within the first 1001 critical days. Given the scale of the need, circa 930 mothers in North Northamptonshire will experience a mental health problem in the perinatal period, and circa 928 babies will experience moderate to severe difficulties with the parent-infant relationship, collaborative working across the system is essential. Delivering the outcomes identified in this strategy will be vital to improving perinatal mental health and strengthening parent-infant relationships, and we are committed to championing this work.

Helene Denness
Deputy Director of Public Health

David Watts
Director of Children's Services (Interim)

A note on language in this strategy

Inclusivity is a core value of family hubs. We recognise that families come in all shapes and sizes.

When we say 'mothers' and 'women' , we are referring to all people who have given birth or will give birth.

When we say 'parents', we are referring to parents, carers and guardians.

Executive summary

Background

Mental health difficulties are common during pregnancy and the first years of a child's life. Mothers might experience depression and anxiety as well as other conditions such as postpartum psychosis, and fathers and partners can also experience mental health difficulties. These difficulties can pose a challenge to the wellbeing of the whole family.

Parent-infant relationships, sometimes referred to as bonding or attachment, are a key protective factor in early development and the quality of this relationship supports babies to thrive in infancy and beyond. However, experiencing difficulties in this relationship is associated with risks for problems now and in the future.

This strategy focuses on services and support for mild to moderate perinatal mental health and parent-infant relationship difficulties.

How was this strategy developed?

This strategy was co-produced by professionals and families in North Northamptonshire between February and June 2024. The strategy development was facilitated by Anna Freud. We carried out insight gathering to gain a comprehensive understanding of local service delivery, reach and accessibility, perceptions on the strengths and challenges in service provision and ideas for development. Our methods included reviewing existing research, policies and strategies, collecting and analysing service-level data, discussions with 20 key local stakeholders and an online survey of 106 professionals. We built on information from around 200 parents and carers which had already been shared through previous projects, and held an additional focus group and 1-1 discussions with 13 local parents and carers. In addition, we held five multiagency meetings and workshops, including three family hubs perinatal mental health and parent-infant relationships workstream meetings and two workshops with a wider range of stakeholders.

Local context

Needs analysis

We conducted an analysis of the likely need for perinatal mental health and parent-infant relationship support in North Northamptonshire, drawing from a range of nationally and locally available data sets and tools. Data showed that levels of adversity and deprivation vary across North Northamptonshire, and while slightly below the national average, they're similar enough to make use of national prevalence estimates.

Research suggests that around one in four women experience a mental health problem during the perinatal period which equates to approximately 930 women each year in North Northamptonshire.

Research also suggests that at least 25% of babies will experience moderate to severe parent-infant relationship difficulties, which equates to approximately 928 babies in North Northamptonshire each year.

A further 16-20% of babies are likely to experience mild to moderate parent-infant relationship difficulties which may increase their risk of later mental health problems, and some of these dyads may benefit from universal or targeted support. This equates to between 594-743 babies in North Northamptonshire. In areas of high deprivation and amongst racially minoritised populations, there is likely to be more need.

Service mapping

There is a solid offer of support for mild to moderate perinatal mental health difficulties, although there can be issues with wait times due to increased demand for services. Parent-infant relationship support is not as well described or reported as with perinatal mental health services, and the offer of support for moderate to severe difficulties is very limited.

Key areas for development

We identified five priority areas for development.

Area one: pathways and reach of support for parent-infant relationships
Professionals have limited awareness of the services on offer to support mild to moderate parent-infant relationship difficulties. Existing service provision can have limited accessibility and appeal to diverse communities. There was an identified need for an evidence-based, universal screening tool for parent-infant relationship difficulties. There is limited capacity in the current climate for health visiting and midwifery to prioritise support and advice for parent-infant relationship difficulties.

Area two: pathways to and between perinatal mental health support
There is limited awareness, recognition and valuing of services that support mild to moderate perinatal mental health difficulties. There are also challenges associated with identifying perinatal mental health needs.

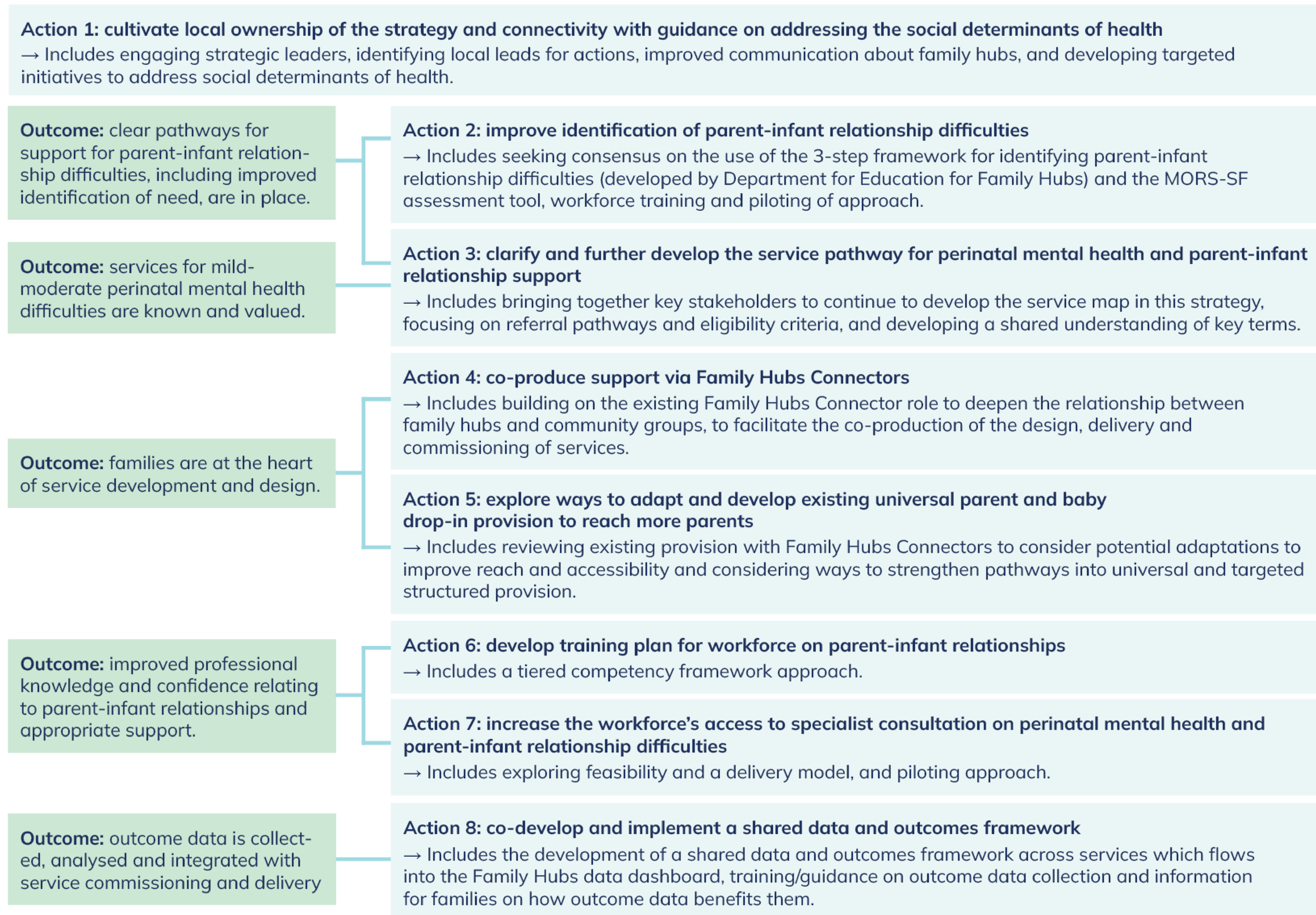
Area three: accessibility of services for families
Local parents and carers did not always know what support was available and they felt it wasn't accessible to everyone. Peer support and community groups were highly valued. Parents sometimes felt that professionals judged them when they saught help. There is a recognised absence locally of seldom heard people's voices in existing insight work, for example those from marginalised ethnic groups, fathers, younger parents and carers, single parents and LGBTQ+ parents and carers.

Area four: workforce development
Feedback suggested that the workforce lacked confidence to support mental health difficulties in the perinatal period, and local training provision may be inconsistent. A gap in knowledge and confidence in supporting parent-infant relationships was also identified, although feedback on this was mixed. There was confusion in the workforce about the family hubs vision and implementation, and low awareness of the Local Maternity and Neonatal System Equity and Equality plan and ongoing actions.

Area five: data, evidence and outcomes
Many local stakeholders recognise evidence-based, insight-led provision as important. Data on service user experience and outcomes is collected at individual service level to varying degrees. There was uncertainty around the overarching outcomes that shape the perinatal mental health and parent-infant relationship strategy locally.

Action plan

We co-developed a Theory of Change and eight aligned actions to address the identified areas for development.



Background

What is perinatal mental health and why is it important?

The time from conception to a child's second birthday (the first 1001 days) is critical for lifelong cognitive, physical, behavioural and social-emotional flourishing.[1] This is a period of rapid development and experiences during this time are foundational. Recognition of the importance of this time period is central to the government's Family Hubs and Start of Life programme.

Pregnancy and the first year of a baby's life (also known as the perinatal period) can be a time of mixed emotions. Feelings of excitement, joy and anticipation may sit alongside self-doubt, worry and uncertainty. Mental health difficulties during this time are common and affect mothers, fathers and partners. Mothers often experience depression and anxiety but other conditions can present during this time, including postpartum psychosis. Mental health difficulties, reduced wellbeing and stress can also impact on a caregiver's ability to care for their baby.

Supporting babies', parents', carers and other family members' wellbeing in turn supports lifelong good mental health, positive relationships, a strong economy and a compassionate society.[2] Providing support as early as possible is key to preventing mental health difficulties progressing to longer term conditions and having a lasting impact on parents, babies and wider family members.

By addressing social problems like poverty and discrimination in a joined-up way across local areas, we can support families now and in the future.

Prevalence of difficulties and inequalities

Approximately one in four people who give birth experience a mental health problem during the perinatal period, with anxiety and depression the most common difficulties.[3] The prevalence of paternal postpartum depression varies from 4% to 25% of new fathers within the first year of a child's life.[4] These rates may be even higher among parents from minoritised ethnic groups and those living in low-income households.[5]

We know certain factors can increase risk of mental health problems or poor emotional wellbeing in the perinatal period. However, it isn't always possible to predict who will experience difficulties, as the causes of mental health difficulties, poor wellbeing and stress are complex.

Existing mental or physical health difficulties or financial and career concerns can contribute to perinatal mental ill health. Wider factors such as poverty, experiencing discrimination and poor housing may also impact perinatal mental health.[6] Whole population events, such as the Covid-19 pandemic, can also have a detrimental impact on the mental health of parents, increasing prevalence of depression, anxiety and stress.[7]

Mental health difficulties can be experienced unequally. For example, evidence shows that families from racially minoritised communities experience poorer perinatal mental health outcomes.[8] Families experiencing homelessness face feelings of insecurity, stress, stigma and isolation. They are also less likely to have social support in place. They are also more likely to have histories of abuse and trauma. These factors make them more vulnerable to mental health difficulties in the perinatal period.[9]

What are parent-infant relationships and why do they matter?

The parent-infant relationship is sometimes referred to as attachment (the way a baby relates to their caregiver) or bonding (the way a caregiver feels about their baby). Infant attachment can be reliably measured from around 12 months of age. Prior to this age, assessments can be made about the qualities of parent-infant interactions.

These relationships are a key protective factor in early development, in particular the connection with the primary caregiver. The quality of this early relationship supports babies to thrive in infancy and beyond. Difficulties in this period are associated with issues in the present and future.

Babies are born ready to relate to and communicate with their caregivers. They can express themselves through their behaviours, telling us what they want and need long before they can talk. 'Serve and return' interactions, where caregivers notice babies' social cues and respond appropriately, help babies feel safe and loved. This sensitive caregiving provides the scaffolding for babies to develop confidence to explore their world. It can also act as a buffer to deal with life's later ups and downs.

Parents can be supported to develop their caregiving skills. Positive parent-infant relationships can also be facilitated through family-friendly policies, such as paid parental leave and affordable, accessible childcare.[10]

Prevalence of difficulties and inequalities

Around 40% of babies develop insecure attachment with their main caregiver by the end of the first year of life, with 15% developing an insecure disorganised attachment. This is associated with the most significant developmental risks.[11] In higher risk populations, the rates of insecure attachments tend to be higher, with the highest rates in those experiencing multiple adversities. For example, parent-infant relationship difficulties are more likely to occur within families affected by perinatal mental ill health. Other risk factors include complex social determinants such as low income or homelessness,[12] substance abuse[13] and intimate partner violence.[14]

The Covid-19 pandemic and associated restrictions' impact on wellbeing also had a detrimental effect on some parents' ability to bond with their baby during and after pregnancy.[15]

Interactions between perinatal mental health, parent-infant relationships and infant feeding

Feeding choices are closely intertwined with both parent-infant relationships and perinatal mental health. When going well, breastfeeding can have a protective effect on mothers' emotional wellbeing. The skin-to-skin contact of breastfeeding can also promote a feeling of bonding with the baby, supporting parent-infant relationships.

However, parents with perinatal mental health difficulties are more likely to experience challenges around infant feeding. Challenges like stopping breastfeeding sooner than intended can bring on feelings of failure, potentially exacerbating mental health issues or emotional difficulties. This may also impact the relationship between parent and baby. In addition, mental health difficulties like depression can be a barrier to responsive feeding, where parents feed in response to cues that their baby is hungry or full.[16]

Policy context

There are national and local strategies and action plans on supporting family mental health and wellbeing from pregnancy onwards. At a national level, a key policy document is the Best Start for Life report.[17] It found that support with breastfeeding, perinatal mental health and parent–infant relationships is essential to ensure every baby gets the best start in life.

However, a significant number of areas only offer this support as 'additional' services on a targeted basis. This meant families were not always able to access the support they needed when they needed it. The Family Hubs and Start for Life programme therefore includes additional investment to ensure these essential services are available to all.

Family Hubs and Start for Life

Family hubs offer a whole-family approach to community support. The Start for Life programme, embedded within the family hubs policy, offers preventative, early intervention for families during these crucial first years.

The Marmot review

This called for action to be universal, but with a scale and intensity proportionate to the level of disadvantage, known as 'proportionate universalism'.[18] To deliver this, services must respond to each person's unique health and social situation – with increasing support as health inequalities increase.

Healthy Child Programme

This is the national evidence-based universal programme for children and young people aged 0-19.[19] Support for 0-5 year olds is led by health visiting services. The programme includes pathways for preconception, antenatal, postnatal and early years support. Supporting maternal and family mental health has been identified as one of six 'high impact areas' for the delivery of the 0-5 years offer. 'High impact areas' are areas in which health visiting has a significant impact on outcomes.[20]

Starting Well

Starting Well is one of the key pillars of The NHS Long Term Plan, launched in 2019.[21] By wrapping care around parents, their children and families, the plan aims to increase safety in maternity, provide specialist perinatal mental care and support breastfeeding through the implementation of the UNICEF baby-friendly initiative.

NHS three-year delivery plan for maternity and neonatal services

In March 2023 the NHS published a national 3-year delivery plan for maternity and neonatal services.[22] This plan aims to make maternity and neonatal care safer, more personalised and more equitable. The report sets out the priority actions for trusts and systems for the next three years. It was co-produced with families, professional bodies and wider partners and has four themes:

- listening with compassion
- supporting the workforce
- developing and sustaining a culture of safety
- meeting and improving standards and structures.

This delivery plan will facilitate the best start for babies and their families, supporting perinatal mental health, parent-infant relationships and infant feeding.

The national maternity safety strategy

This aims to halve rates of stillbirths, neonatal and maternal deaths and brain injuries during or soon after birth by 2025.[23] It also aims to reduce the rate of preterm births from 8% to 6%. To achieve this ambition, it is important to address inequalities in care to improve outcomes for the most at-risk groups.

Working towards this ambition can reduce separation of parents and their babies after birth which may improve perinatal mental health, parent-infant relationships and successful breastfeeding.

Six-to-eight-week maternal postnatal consultation

In December 2023, NHS England published guidance for GPs conducting postnatal consultations.[24] This guidance creates an opportunity for improved support, better identification of need and delivery of safer, more equitable and more personalised care. The guidance covers both perinatal mental health and infant feeding.

Local Maternity and Neonatal Systems breastfeeding strategies

All Local Maternity and Neonatal Systems should agree and implement a co-designed breastfeeding strategy. This ensures mothers can access the support that they need when they need it across midwifery services and in the community.[25] Additionally, it supports parent-infant relationships and perinatal mental health.

A practitioner's guide to starting conversations about parent-infant relationships

This document, published in early 2024, provides three conversation prompts to talk to parents and carers and a 3-step framework for supporting families with early relationships.[26]

The Northamptonshire local transformation plan for children and young people's mental health and emotional wellbeing

This plan, published in 2023, sets out the priorities for 2024-2025.[27] This document includes children and young people aged 0-25 and addresses perinatal mental health, parent-infant relationships and infant feeding as part of this strategy. The transformation plan is informed by the Thrive Framework for systems change.[28]

Integrated Care Northamptonshire strategy

This strategy forms the basis for the North and West Northamptonshire joint health and wellbeing strategies. It includes two aims for the perinatal period and early years:

- that pregnant people stay healthy and well
- children grow and develop well so they're equipped to start school

It also includes an outcomes framework based on needs identified in local joint strategic needs assessments (JSNA).

Evidence based interventions and what good looks like

A key element of providing good quality and accessible care is co-production. Co-production can be defined in a range of ways – but usually refers to service users collaborating with service providers as equal partners in decision-making about the design and delivery of services. Examples of promising practice can be seen in the National Lottery Community Fund's A Better Start programme.[29]

Parent-infant relationship support

All families can benefit from support to ensure parent-infant relationships get off to the best possible start. It is important to be able to recognise relationship difficulties and provide support early.

Bonding with the baby during the antenatal period should be encouraged. Evidence shows that skin-to-skin contact immediately after birth is important for promoting this bond. Where this is not possible it will be important to consider other ways of nurturing the relationship between mother and baby.[30] Fathers and partners also play a key role in supporting the development of the relationship between mothers and babies.[31]

The workforce may be able to facilitate early relationships through initiatives which help parents build a bond with their baby and address any concerns they may have.

For example, Bradford District Care NHS Trust developed 'ready to relate' cards for health visitors to use with families to help promote healthy parent-infant relationships.[32]

The Department of Health and Social Care Parent-Infant Relationship conversation prompts have not yet been fully evaluated – but may help identify difficulties early so that families can access support.[33]

Interventions for professionals can help them support families with moderate to severe parent-infant relationship difficulties, including a resource for providers to keep babies in mind.[34] The Parent-Infant Foundation has developed toolkits for the implementation and commissioning of parent-infant relationship services, including guidance on available interventions.[35] The AIMH-UK Infant Mental Health Competency Framework sets out best practice practitioner skills, knowledge and behaviours.[36] This allows them to deliver high quality services to support infant mental health across three levels of expertise.

In addition, National Institute for Health and Care Excellence (NICE) guidance recognises that some people experiencing poor mental health in the perinatal period may also experience difficulties in their relationship with their baby.[37] The guidance recommends that the quality of interactions is assessed at all postnatal contacts. If there are continued difficulties, professionals should consider offering further support.

Perinatal mental health support

The Maternal Mental Health Alliance has brought together national guidelines and recommendations to inform good practice in the UK.[38] This includes evidence-based guidance from the Royal College of Psychiatrists for the provision of services for people of childbearing age, community perinatal standards and inpatient perinatal mental health standards, and National Institute for Health and Care Excellence (NICE) guidelines.

As well as providing evidence-based support and services, barriers to access care must be addressed.[39] These include:

- worrying what others would think
- feeling shame
- assuming that their experiences were normal
- a lack of interest from health professionals.

Supporting mothers' overall wellbeing is also key to perinatal mental health. Mental wellbeing can be understood as a continuum, and this means considering how parents and carers are feeling and coping even if they do not reach the threshold for a diagnosis of a mental health condition. Services can support people by giving them the opportunity to talk to other mothers and parents or supporting mothers to prioritise self-care. This sends a message that there is no shame in seeking support when needed, which can improve mothers' ability to cope with their feelings.

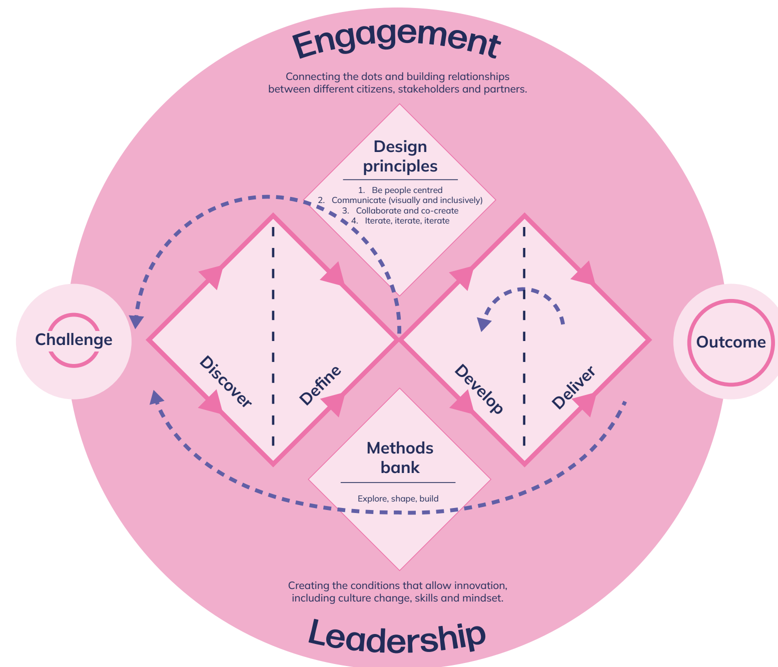
Inequality in perinatal mental health support

National confidential enquiries have highlighted that the quality of care in the perinatal period varies by ethnicity.[40] People from marginalised ethnic groups were asked about their mental health less often during this vulnerable period. If people are not asked about their mental health and emotional wellbeing, they could feel stigma and shame, which may exacerbate their feelings. Inequalities in outcomes for minoritised ethnic groups could be addressed through culturally appropriate adaptations to existing evidence-based interventions.[41]

How was this strategy developed?

This strategy was co-produced with local professionals and families in North Northamptonshire. The strategy development was facilitated by Anna Freud using the Double Diamond methodology.

Figure 1: The Double Diamond by the Design Council[42]



Discover

During this stage, we sought to gain a comprehensive understanding of local need, service delivery, reach and accessibility. We also researched perceptions of the strengths and challenges in service provision and ideas for development.

Review of existing documentation and insights

We conducted a review of existing local research, reports and policies and strategies relating to Family Hubs, Start for Life, perinatal mental health and parent-infant relationships. This included:

- North Northamptonshire's Family Hubs delivery model, Communications and Engagement Strategy, Workforce skills audit and framework, and example workforce development plan
- Northamptonshire Children and Young People's Mental Health and Emotional Wellbeing Local Transformation Plan
- Local Maternity and Neonatal System (LMNS) Equity and Equality Action Plan
- research by Northamptonshire University with local families in Wellingborough
- grant agreements, pathway documents and service operation procedures (SOPs) relating to the delivery of services.

Needs analysis

An analysis of likely need for perinatal mental health and parent-infant relationship support was conducted. This drew from a range of nationally and locally available data sets and the Parent-Infant Foundation's commissioning toolkit (see Appendix A).

Service mapping data

We requested data on service provision from a range of local services. This included statutory and voluntary sector provision, across universal and targeted services.

Discussions with key local stakeholders

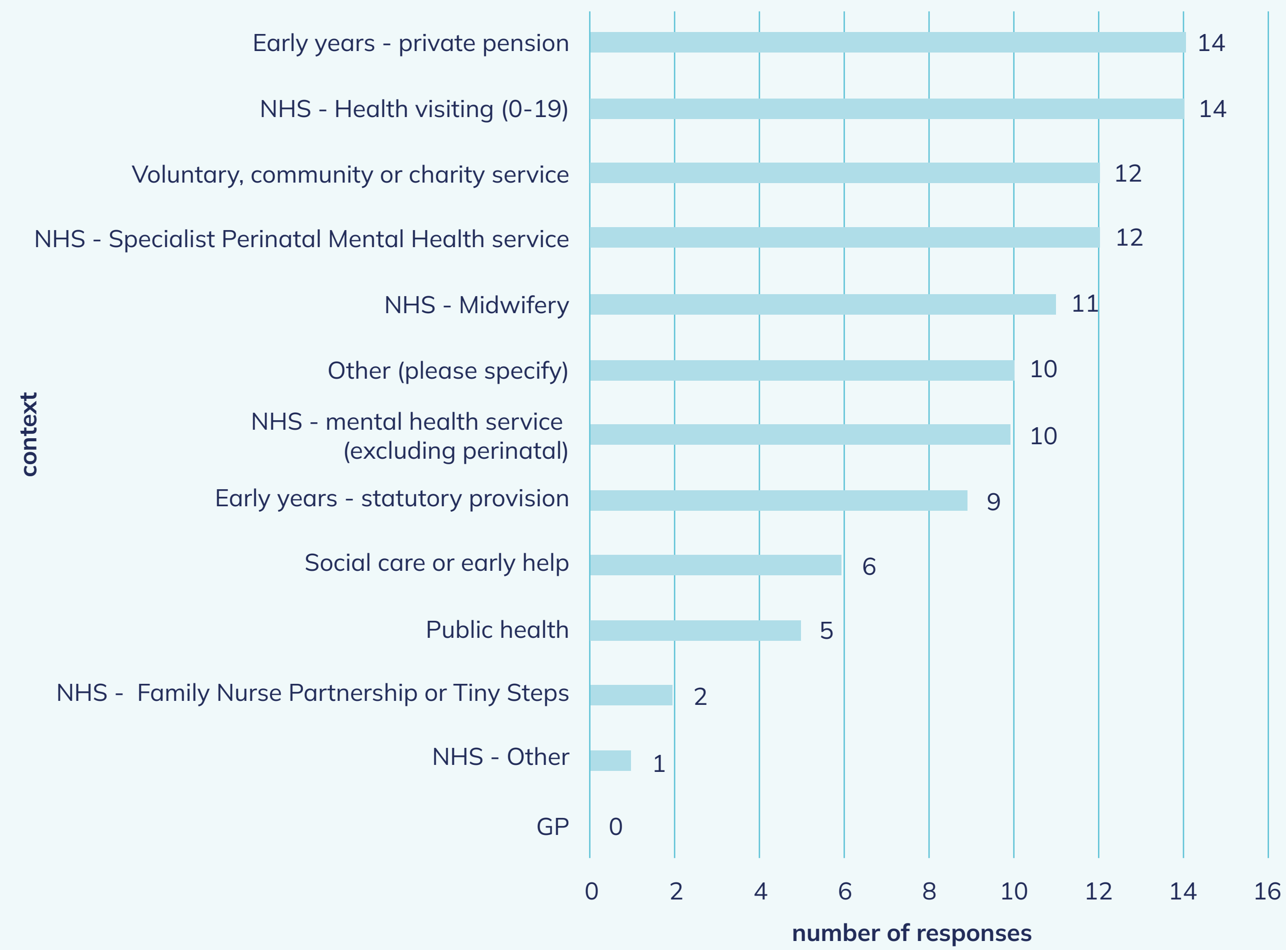
We held 20 one-to-one discussions with key local stakeholders. The discussions were held online using Teams and lasted between 30 mins and one hour. Interviewees included:

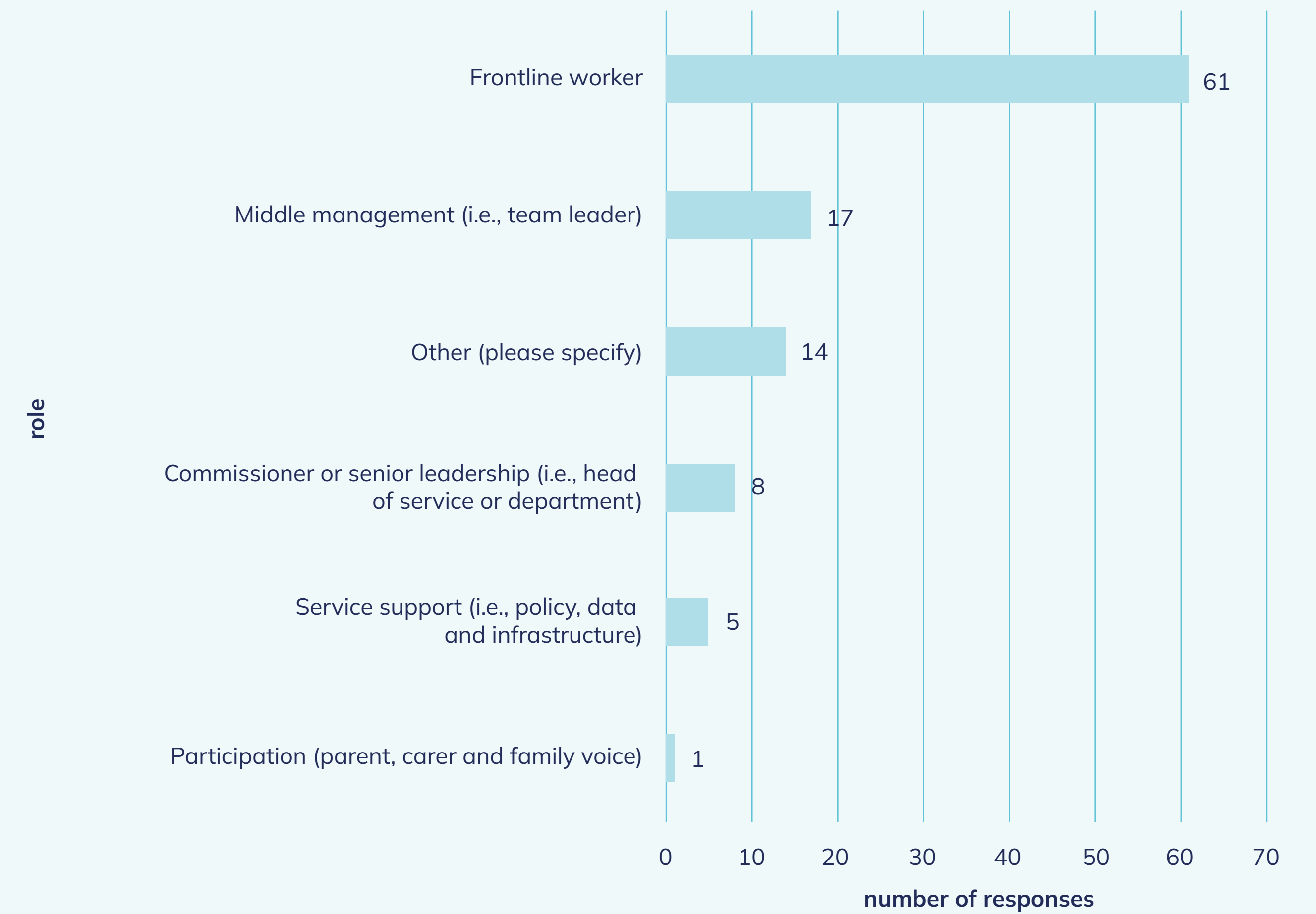
- representatives from 0-19 universal children's services
- maternity services
- specialist perinatal mental health team
- public health
- the voluntary sector
- Family Hubs commissioning
- council-led early years and early help provision

Online survey of practitioners

This aimed to gain a wider range of perspectives from local practitioners. It included anyone directly or indirectly working to support parents, babies and families in pregnancy and the early years in North Northamptonshire. We received 106 responses. Colleagues from the Family Hubs perinatal mental health and parent-infant relationship workstreams led the dissemination of the survey.

Figure 2: 106 Survey responses by organisational context and role





Focus group and 1-1 discussions with local families

The views and experiences of local families are central to understanding the strengths and areas for improvement in service provision. Previous insights gathered from local families through family hubs initiatives provided a clear set of areas for development on which to build. Previous insights gathered from approximately 200 parents and carers through family hubs initiatives (including research by Northamptonshire University and through the development of the Family Hubs Communications and Engagement Strategy) were built on in this action plan.

To further enrich this insight, we carried out focus groups and 1-1 discussions with families. We aimed to hear from seldom heard groups, including parents and carers who have recent experience of pregnancy or looking after a baby in North Northamptonshire. We especially sought out those from marginalised ethnic backgrounds, fathers, younger parents and carers, single parents and LGBTQ+ parents and carers.

We sought to engage with families from these seldom heard groups through existing relationships with local services. However, we encountered difficulties reaching these families, indicating the need to further develop relationships between family hub services and diverse community groups.

A total of 13 parents were consulted via the Family Action mild to moderate perinatal mental health support groups held at Kettering Family Hub. Four parents attended a focus group and nine parents gave feedback via written forms and verbal feedback when attending a stay and play group at the family hub. 11 women and two men attended. Demographic details for the focus group were:

Ethnicity:

- seven described their ethnicity as White or White British
- two described their ethnicity as Black British
- one described their ethnicity as White Other

Religion or belief:

- six parents stated they had no religion or belief
- two described themselves as Christian
- one described themselves as Muslim
- four did not provide a response

Relationship status:

- eight of the parents we spoke to were married
- two were single
- three did not provide a response

Socio-economic status:

- three parents described themselves as from a low-income background
- four from a middle-income background
- six did not answer this question

Sexual orientation:

- nine identified as heterosexual
- four did not provide a response

In some cases, demographic information was not provided.

Define

We analysed the insights collected based on the Early Intervention Foundation's Maturity Matrix Mapping Tool.[43] This tool is one way of considering the different parts of a system which contribute to the effectiveness of the support families receive. It provides a set of 10 categories through which to analyse data (see Figure 3).

Using this analysis, we held a workshop with 26 stakeholders in April 2024 to give feedback, sense check learning so far and to gain further insights.

Develop

At a second face-to-face workshop in May 2024 attended by 16 professionals and services, attendees were presented with a summary of the key areas for development and proposed actions. Attendees then developed the strategy.

Figure 3: EIF Maturity Matrix categories

Dimensions	Key elements
Plan	1 Strategy
	2 Commissioning
	3 Workforce planning
Lead	4 Partnership
	5 Leadership
	6 Community ownership
Deliver	7 Services and interventions
	8 Information sharing
Evaluate	9 Outcomes
	10 Using and generating evidence

Local context

Needs analysis summary

We conducted an analysis of the likely need for perinatal mental health and parent-infant relationship support in North Northamptonshire, drawing from a range of nationally and locally available data sets and tools. The full needs analysis can be found in Appendix A.

It explored four questions:

- What is the make-up of the population relating to the perinatal period and early years?
- What is the prevalence of risk factors for perinatal mental health conditions and parent-infant relationship difficulties in North Northamptonshire?
- What do we estimate the prevalence of perinatal mental health difficulties to be locally?
- What do we estimate the prevalence of parent-infant relationship difficulties to be locally?

There were 3714 live births in 2022 in North Northamptonshire. The number of births are expected to fall slowly each year in the future, as they are in England more widely.

Estimates of the number of parents who are likely to need perinatal mental health or parent-infant relationship support are based on areas experiencing the national average levels of adversity and deprivation. Data shows that levels of adversity and deprivation vary across North Northamptonshire, and while slightly below the national average, adversity and deprivation in the area are similar enough to make use of national prevalence estimates.

Research suggests that around one in four women experience a mental health problem during the perinatal period, with anxiety and depression the most common difficulties.[i] This is approximately 930 women each year in North Northamptonshire (see section 3 of needs analysis, Appendix A).

Research also suggests that at least 25% of parent-infant relationships will experience moderate to severe difficulties. This amounts to around 928 babies in North Northamptonshire each year (see section 4 of needs analysis, Appendix A). A further 16-20% of babies are likely to have mild-moderate needs in the parent-infant relationship, which may increase their risk of mental health problems later in life. Some of these dyads may benefit from universal or targeted support. This equates to between 594-743 babies in North Northamptonshire.

[i] Inclusivity is a core value of family hubs. We recognise that families come in all shapes and sizes. The language in this section reflects the language used in the data source to ensure accuracy.

A range of experiences put people at risk of perinatal mental health and parent-infant relationship difficulties. In North Northamptonshire in 2023, estimates are that:

9.7% of the population are from a minoritised ethnic background

10.9% of families are lone parent families

11% of mothers live in a complex social situation (e.g., homelessness, substance misuse, asylum seeker or refugee status)

11% of mothers smoked at the time of delivery

4%-5% of mothers had a traumatic birth and may develop PTSD

21.5% of children live in low-income families (and the percentage is higher in some areas)

4.4% of adults experienced domestic abuse

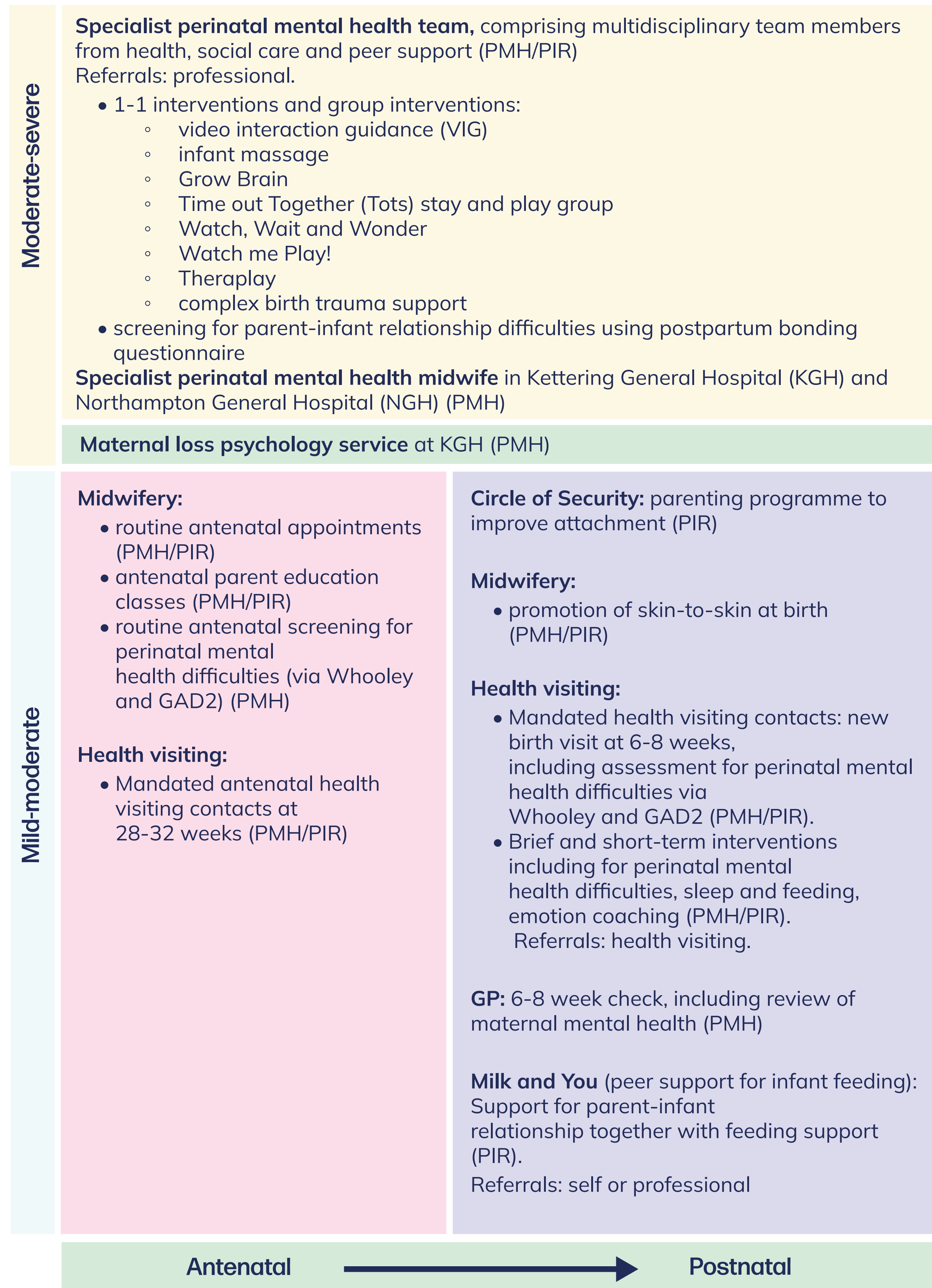
3.75% of new mothers were under the age of 19

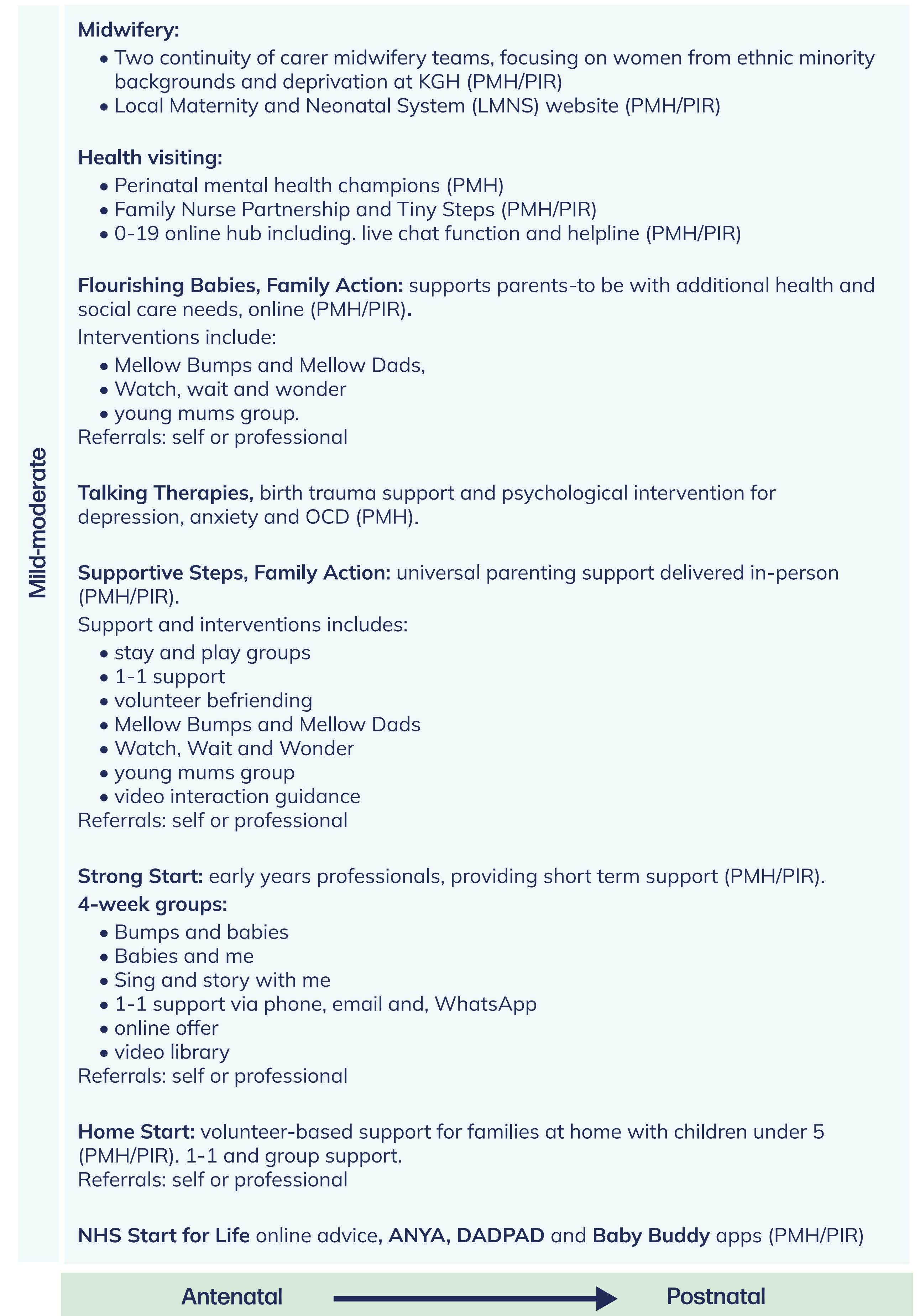
36% of mothers and babies may not benefit from skin to skin contact with their baby at birth

25% of children do not achieve a good level of development at two to two and a half years

These kinds of life experiences can put strains on the mental health of parents and on the relationships between parents and infants.[44]

Figure 4: Map of North Northamptonshire's perinatal mental health and parent-infant relationship services.





As depicted in Figure 4, mild to moderate level support is provided via:

- antenatal and post-birth screening through midwifery and health visiting
- brief interventions offered by health visiting
- Family Nurse Partnership (FNP) and Tiny Steps
- two continuity of carer midwifery teams
- health visiting perinatal mental health champions
- Family Action's Flourishing Babies and Supportive Steps
- Strong Start and Home Start
- two specialist perinatal mental health midwives
- Talking Therapies.

Moderate to severe level support is provided by the Specialist Perinatal Mental Health Service (SPMHS) which offers a range of therapeutic specialisms and evidence-based interventions.

Parent-infant relationship support is not as well described or reported as with perinatal mental health services. Mild to moderate support is primarily provided by Family Action's Flourishing Babies and Supportive Steps. The current offer of support includes:

- health visiting and midwifery routine contacts
- short-term interventions led by health visiting
- two continuity of carer midwifery teams
- Strong Start
- Milk and You
- Family Nurse Partnership and Tiny Steps
- Home Start

As part of the development of this strategy, we requested data from a range of services relating to:

- how families access the service, including referral processes and eligibility criteria
- the number of people referred for and receiving support over the past two years
- the demographic profile of service users
- the main presenting needs of service users
- outcomes data routinely collected for services and information about the effectiveness.

In summary, we found that:

- Anxiety and depression are the main perinatal mental health needs of parents in the region.
- Whilst some services such as the SPMHS and Flourishing Babies have seen an increase in referrals over 2023-2024, other services such as Talking Therapies and Strong Start have seen a fall in referrals.
- There is a general consensus between services to use the General Anxiety Disorder-7 questionnaire (GAD-7), Patient Health Questionnaire-9 (PHQ-9) and to some extent the Mothers Object Relations Scale short form (MORS-SF) outcome measures as part of support for perinatal mental health and parent-infant relationships. However, the use of these measures varies between services. The use of MORS-SF to understand parent-infant relationship difficulties is a more recent development and no data was identified in this research.

We provided North Northamptonshire Family Hubs with the full data set to inform future service planning.

Key areas for development

Following in-depth consultation with local service providers, service leaders, commissioners and families, we identified five priority areas for development. A theme running throughout these the need to address the social determinants of health.

Area one: pathways and reach of support for parent-infant relationships

- navigating the offer
- service accessibility and appeal
- identification of difficulties
- capacity in midwifery and health visiting
- limited specialist support.

Area two: pathways to and between perinatal mental health support

- navigating the offer, particularly for different levels of need
- identification of difficulties.

Area three: accessibility of services for families

- families' knowledge of available services and how to easily access support locally.
- inclusive, trusted and appealing services
- connection between family hubs and diverse community groups.

Area four: workforce development

- knowledge and confidence in the perinatal mental health workforce
- knowledge, confidence and consensus around parent-infant relationship support
- practitioner engagement with the family hubs vision and implementation
- awareness of the details of the LMNS Equity and Equality plan and ongoing actions.

Area five: data, evidence and outcomes

- gaps in data
- difficulty accessing data
- variation in type of data collected
- absence of overarching outcomes framework.

Area one: pathways and reach of support for parent-infant relationships

Insights gathered across North Northamptonshire's services suggest that while there are services available to support parent-infant relationships, they have limited reach and the pathways between services are unclear.

Like many areas across the country, the provision does not have sufficient capacity to meet the estimated need for parent-infant relationship support. This is in part due to an increasing level of need and limited resources. Alongside this challenge, respondents highlighted other factors that contribute to the challenge of meeting the needs of parents in North Northamptonshire.

Navigating the offer for mild to moderate parent-infant relationship support

There appears to be limited professional awareness of which services are on offer and for whom. Some respondents reported feeling there is a duplication of some services, whilst acknowledging that different services may be required to meet the needs of different groups. There is work underway to establish a single point of access for family hubs services.

Service accessibility and appeal

Due to accessibility issues, it is likely that not everyone who could benefit from services is able to use them. For example, access to in-person support can be limited by where families live and access to online support can be limited by digital poverty. It is also likely that services do not appeal to diverse communities locally. See area three, accessibility of services.

Identification of difficulties

Feedback from local stakeholders identified that the health visiting workforce is well trained in identifying difficulties in parent-infant relationships. They are also trained in attachment theory, infant brain development, responsive parenting, the Five to Thrive approach and the Voice of the Child. However:

- There is no universally used evidence-based screening tool for parent-infant relationship difficulties, which prevents a more in-depth understanding of need.
- Professionals may be reluctant to identify problems if they are unsure of where to refer parents and carers on to.
- There is an absence of a shared understanding locally about how best to support parents who experience difficulties in the parent-infant relationship. See area four, workforce development.

Capacity in health visiting and midwifery

The midwifery and health visiting teams are, like so many across the country, under enormous pressure in terms of capacity. In this current climate, parent-infant relationship support can be deprioritised in contacts. Health visitors are struggling to attend the 28-week antenatal appointment, which is a missed opportunity to provide early support around the parent-infant relationship.

The upcoming recommissioning of health visiting is viewed as an opportunity but also a risk. It could help improve the provision of support for parent-infant relationships and perinatal mental health – but there are concerns about the fragmentation of services and a reduction in more specialist provision by health visitors.

Limited specialist support for parent-infant relationships

The SPMHS provides evidence-based interventions for parent-infant relationship difficulties. These cover mothers experiencing moderate to severe mental health difficulties. FNP and Tiny Steps offer support for young mothers. Circle of Security has recently been trialled as part of a randomised controlled trial within the SPMHS and is delivered on a small scale as part of Family Hubs. There is no longer a specialist service available in North Northamptonshire, following the closure of the Northampton Parent-Infant Partnership (NorPIP) in 2021.

Area two: pathways to and between perinatal mental health support

While there are examples of excellent cross-organisational working and communication, there are also challenges in pathways to and between services and support for perinatal mental health. Survey respondents gave an average rating of 3.4 on a scale of 0-5 in response to the question 'how well do services work together to support perinatal mental health?'.

Key areas of difficulty are:

Navigating the offer, particularly for different levels of need

There is a lack of awareness, recognition and valuing of local services that support those with mild to moderate perinatal mental health difficulties. This results in a high referral rate to SPMHS, when it is likely that a proportion of those referred to SPMHS can be better supported by other services. According to data from a pilot project carried out by SPMHS, in June 2023 only 28.8% of referrals remained on the SPMHS caseload at 12 weeks post-assessment. The remaining 71% of referrals either received short term interventions by the SPMHS, were signposted on to more appropriate services or did not require further support after assessment.

The remaining 71% of referrals were either signposted on to more appropriate services, received short term interventions by the SPMHS, or did not require further support after the assessment. Whilst the current process is to signpost to other services following assessment, this means specialist resources are tied up with assessment and triage. It also relies on the specialist workforce being fully aware and up to date on the availability of all the different types and forms of support locally. This may indicate the need for a common referral system and triage process that ensure families are receiving the most appropriate support at the right time.

Identifying difficulties

There are challenges associated with identifying perinatal mental health needs.

Health visitors and midwives undertake screenings via the Whooley and GAD2 outcome measures. Data from midwifery suggests a gap in screening at two time points:

- An average use of the GAD2 of 19% at the 28-week appointment
- An average use of the GAD2 of 10% at postnatal discharge and the Whooley questions around 59%.

Following this screening, if a parent reports a difficulty on either measure, other more dedicated measures (such as the GAD-7 and PHQ9) are used to better assess difficulties. Referrals are then made to the SPMHS or other services as appropriate.

The lack of shared language or agreement on the definition of 'mild to moderate' and 'moderate to severe' perinatal mental health difficulties is likely to impact pathways of care. See area four, workforce development.

I had really bad anxiety in my pregnancy. I had breathing issues which I'd not had before. I spoke to my midwife about it and I got a referral to the perinatal mental health team, but because I wasn't severe enough. I had to refer myself to the IAPT team.

Local parent

Area three: accessibility of services for families

North Northamptonshire Family Hubs has conducted several important pieces of insight work with local families. These help to better understand perspectives around the accessibility of local services. The challenges raised through this work are described below. Anna Freud also gained insight from 13 parents and carers as part of the development of this strategy.

Families' knowledge of available services and how to easily access support locally

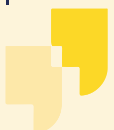
Previous research by the University of Northampton with 123 parents and carers in Wellingborough reported that they did not know what support was available and felt existing services weren't accessible to all. This was compounded by professionals also being unsure where to signpost to.

This was echoed in research for the NNC communications and engagement strategy, which reported a lack of awareness of services and difficulty navigating the system. This is likely to be more prevalent in families who are under stress or are struggling with mental health difficulties and their relationship with their baby. Email and the council website were rated highly as preferred means of communication, alongside Facebook and Instagram.

In the focus group held as part of this work, parents also reflected that they didn't always know where to access services and support and often relied on information and referrals from professionals. However, some professionals are unaware of services available locally:

The health visitor was really attentive. She referred me to the perinatal mental health services team and the health visitor suggested I go to the children's centre in Wellingborough, but actually there was another one much closer to where I lived and I started going there.

Local parent

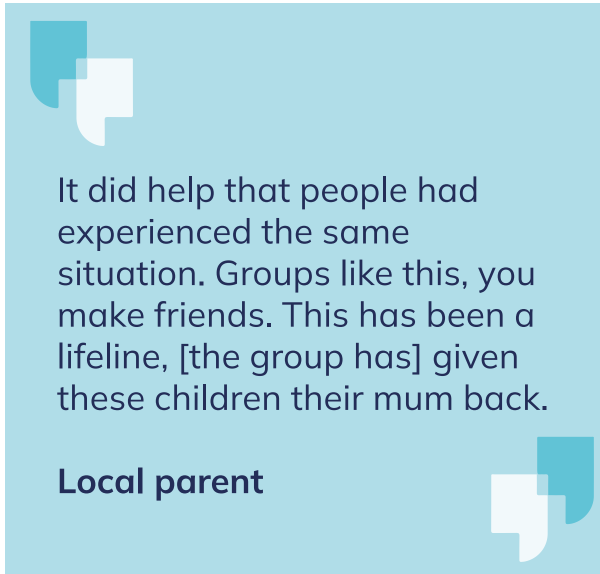


Shouldnt have to try so hard to find the support

Local parent

Inclusive, trusted and appealing services

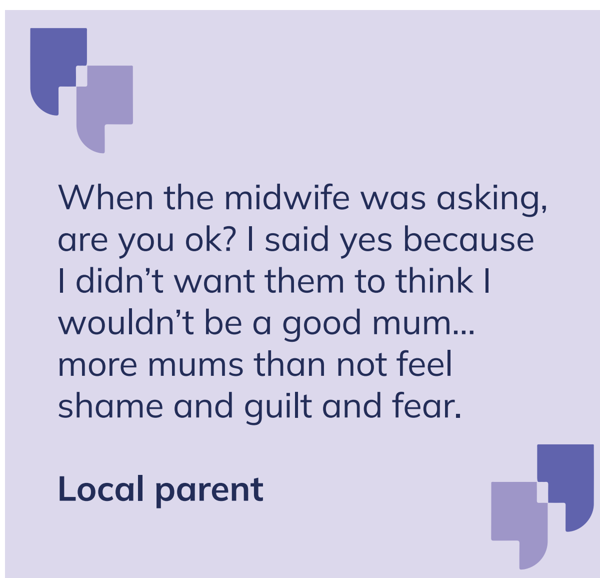
Parents and carers' preferred and primary source of support is their family and friends. Peer support and community groups are also highly valued. Parents value a non-judgemental environment and being with other people facing similar challenges.



It did help that people had experienced the same situation. Groups like this, you make friends. This has been a lifeline, [the group has] given these children their mum back.

Local parent

In terms of more formal services, parents spoke about a fear of being judged by professionals when discussing difficulties and asking for help.



When the midwife was asking, are you ok? I said yes because I didn't want them to think I wouldn't be a good mum... more mums than not feel shame and guilt and fear.

Local parent

You don't want to ask for help because you fear social services will get involved.

Local parent

Some parents commented that they saw several midwives, health visitors and other professionals during pregnancy and following their baby's birth. As a result, they didn't feel able to build a relationship with a consistent professional. This impacted their ability to open up and share concerns.

It was a different midwife each time. They asked how I was, but it was like I was wearing a mask. It's difficult to build up a relationship.

Local parent

Survey respondents were asked to what extent their service is effective in addressing barriers to access faced by a range of diverse groups of people. The findings highlight a local challenge around how services appeal to, relate to and serve diverse members of the community.

The following are the proportion of respondents that thought services effectively addressed accessibility barriers faced by members of each group:

- 68% for those living in deprived areas
- 56% for those in Black, Asian and other minority ethnic groups
- 61% in supporting fathers and partners
- 63% for those living with a disability
- 58% for those with lesbian, gay, bisexual, transgender and other queer identities.

They've already closed down one local group. There should be groups available in all areas. I had to drive a long distance. I live in Corby and had to travel to Wellingborough - not everyone will have that opportunity.

Local parent

Support for parent-infant relationships often includes fathers and partners, but targeted support is limited and it appears that fathers and partners are not as engaged with support as mothers.

Connection between family hubs and diverse community groups

The insight work conducted as part of the development of this strategy highlighted that diverse communities and community networks should be better integrated into the family hubs agenda. There is a local absence of seldom heard voices in insight work – including those from ethnically minoritised backgrounds, fathers, younger parents and carers, single parents and LGBTQ+ parents and carers.

Area four: workforce development

Knowledge and confidence of the perinatal mental health workforce

Improving perinatal mental health support has been a focus locally over the past few years. Many parts of the workforce have received training on perinatal mental health. However, the responses to the survey of local professionals indicated a desire for further training in this area.

Respondents were asked to what extent they agree with the statement, "I have had sufficient training and development on perinatal mental health, appropriate to my role." Of the 79 respondents, 63% reported having sufficient training and development in relation to perinatal mental health, whilst 19% of respondents disagreed and 15% of respondents responded as 'neutral'.

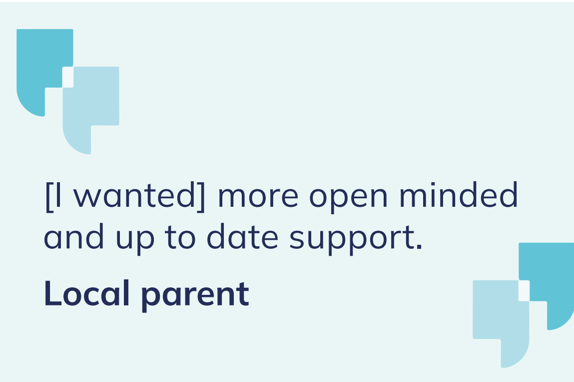
In terms of their perceived ability to identify signs and symptoms linked to a perinatal mental health condition, 70% of respondents felt well-equipped to do so, whilst 10% felt ill-equipped and 20% of respondents

chose 'neutral'. There may be a lack of consistency in the training offered to professionals, resulting in varying knowledge and approaches to support. It may also be that rather than there being a skills gap, the universal services workforce may lack confidence in delivering support.

Knowledge, confidence and consensus around parent-infant relationship support

The workforce's knowledge and confidence around parent-infant relationship support was a mixed picture. Whilst the quantitative survey findings suggested a high level of knowledge and confidence, qualitative feedback from the survey and 1:1 discussions pointed towards a potential area for development. Of the 67 survey respondents, 80% felt equipped to identify signs and symptoms of parent-infant relationship difficulties and 87% felt their knowledge of parent-infant relationships is appropriate to their role.

Fewer respondents felt they had had sufficient training and development appropriate to their role at 72%, with 7% of respondents disagreeing and 20% responding neutrally. Through the qualitative data, respondents described a health visiting workforce well trained in supporting parent-infant relationships. However, they highlighted potential gaps in knowledge and confidence more broadly across the workforce.



[I wanted] more open minded and up to date support.

Local parent

Practitioner engagement with the local family hubs vision and implementation

Local practitioners indicated some confusion about what family hubs and the local offer constitute.

Awareness of the LMNS Equity and Equality plan

There is also a low level of awareness of the details of the LMNS Equity and Equality plan and ongoing actions. North Northamptonshire's LMNS Equity and Equality plan includes two continuity of carer midwifery teams. These are focused on supporting women from Black, Asian and minority ethnicity populations and those living in areas of deprivation. A greater awareness of the LMNS Equity and Equalities plan and joint support for implementation across the system through complementary area-based plans would support faster progress towards equitable outcomes, promote wellbeing and may reduce pressure on specialist services. This would enable services meet families' needs in a more joined up way.

Area five: data, evidence and outcomes

Many local stakeholders recognise that evidence-based and insight-led provision is important. Data on service user experience and outcomes is collected at the individual service level to varying degrees. Local challenges associated with outcome data collection include:

- significant gaps in data collected, making it challenging to see what support is working for whom
- data not being easily available when it is collected
- a wide variation in the types of data collected, including measures used.

Feedback identified several reasons for these challenges, including:

- difficulties capturing the impact of informal support and services that are highly responsive to need, which adapt regularly
- a lack of time and resources to collect data
- the requirement to prioritise the collection of KPIs determined by commissioners to the detriment of other data collection
- fatigue around data collection and concerns about duplication
- the collection of outcome data being driven by service commissioners with differing priorities and approaches

There was uncertainty around overarching outcomes that shape perinatal mental health and parent-infant relationship strategy locally. The family hubs workstream has made progress in developing a logic model, but this is not yet fully developed or embedded in the system.

Vision and Theory of Change for perinatal mental health and parent-infant relationship support

Vision

Stakeholders in North Northamptonshire took part in an exercise to consider what successful perinatal mental health and parent-infant relationship support would look and feel like for babies in North Northamptonshire. These ideas could contribute to the development of a local vision statement.

What would it look and feel like for babies if we get support for perinatal mental health and parent-infant relationship difficulties right?

I feel secure in my attachment.

I feel stimulated, calm, content, responded to, clean, dry and fed.

I feel seen, heard, loved and cared for.

I feel peaceful.

I coo and vocalise.

I am full of oxytocin.

I like being close to my caregiver.

I play, respond, listen, cuddle and relax – '5 to thrive'.

I have access to prompt and appropriate care for my physical and mental health.

I am happy and feel valued in society.

I feel safe when my mum, parent or carer needs space or extra support.

It's okay for my mum, parent or carer to not be okay.

I grow up to be healthy, happy and able to develop healthy relationships with others. I'm able to play a positive part in society.

My parents or caregivers:

My parents or carers are confident of their support system's capacity to respond to their needs.

My parents or carers feel seen, heard, loved and cared for. In turn, they can help me thrive.

My parents or carers are confident that they understand my needs and can respond to them positively.

My parents or carers can speak to staff who will recognise when they need support or if I am struggling.

People will ask my parents or carers about how they feel about me, what is good and what is tough.

My mum, parent or carer has help and advice so they can keep taking their medication and stay well.

My parents or carers can think about their own experience of being parented as we develop our relationship and access support when needed.

Perinatal mental health (PMH) and parent-infant relationships (PIR) support in North Northamptonshire: A Theory of Change

Why is the strategy needed?

Up to a quarter of mothers (around 930 women each year in North Northamptonshire) and a tenth of fathers experience PMH difficulties around pregnancy, birth and up to a child's second birthday.

Approximately 25% of parent-infant relationships (928 babies) will experience moderate-severe difficulties and a further 16-20% (594-743 babies) will experience mild-moderate difficulties.

Gaps have been identified in the provision of support for PMH and PIR difficulties in North Northamptonshire.

Who is it intended to help?

All women, peope who give birth, babies, partners and families in North Northamptonshire during pregnancy and the first two years of a baby's life, with a particular focus on health inequalities experienced by those living in poverty or from racially minoritised communities.

Change mechanisms
How and why does the strategy work?

Local families from diverse communities are seen as essential partners in the design, delivery and commissioning of services.

Staff in universal services know how to identify need, provide help for mild-moderate difficulties, and refer onto other provision when necessary.

Data (including service user experience) informs service transformation.

A shared professional language and definitions relating to parent-infant relationships and perinatal mental health facilitate service delivery.

PMH and PIR are included in joint health and wellbeing strategy and local plans.

Shorter term outcomes

Families are at the heart of service development and design.

Clear pathways for support for PIR difficulties, including improved identification of need are in place.

Services for mild-moderate PMH difficulties are known and valued.

Improved professional knowledge and confidence on parent-infant relationship and appropriate support.

Outcome data is collected, analysed and integrated with service commissioning and delivery.

Medium term outcomes

Families access the right support, at the right time.

More families from diverse community groups access services.

Services and support are evidence-based, maximising potential impact.

Referrals to specialist perinatal provision are appropriate to need.

Data is used to understand what services work, for whom and why.

Primary or long term outcomes

Improved maternal mental health outcomes.

Improved quality of parent-infant relationships.

Improved child health and development outcomes.

Reduced health inequalities.

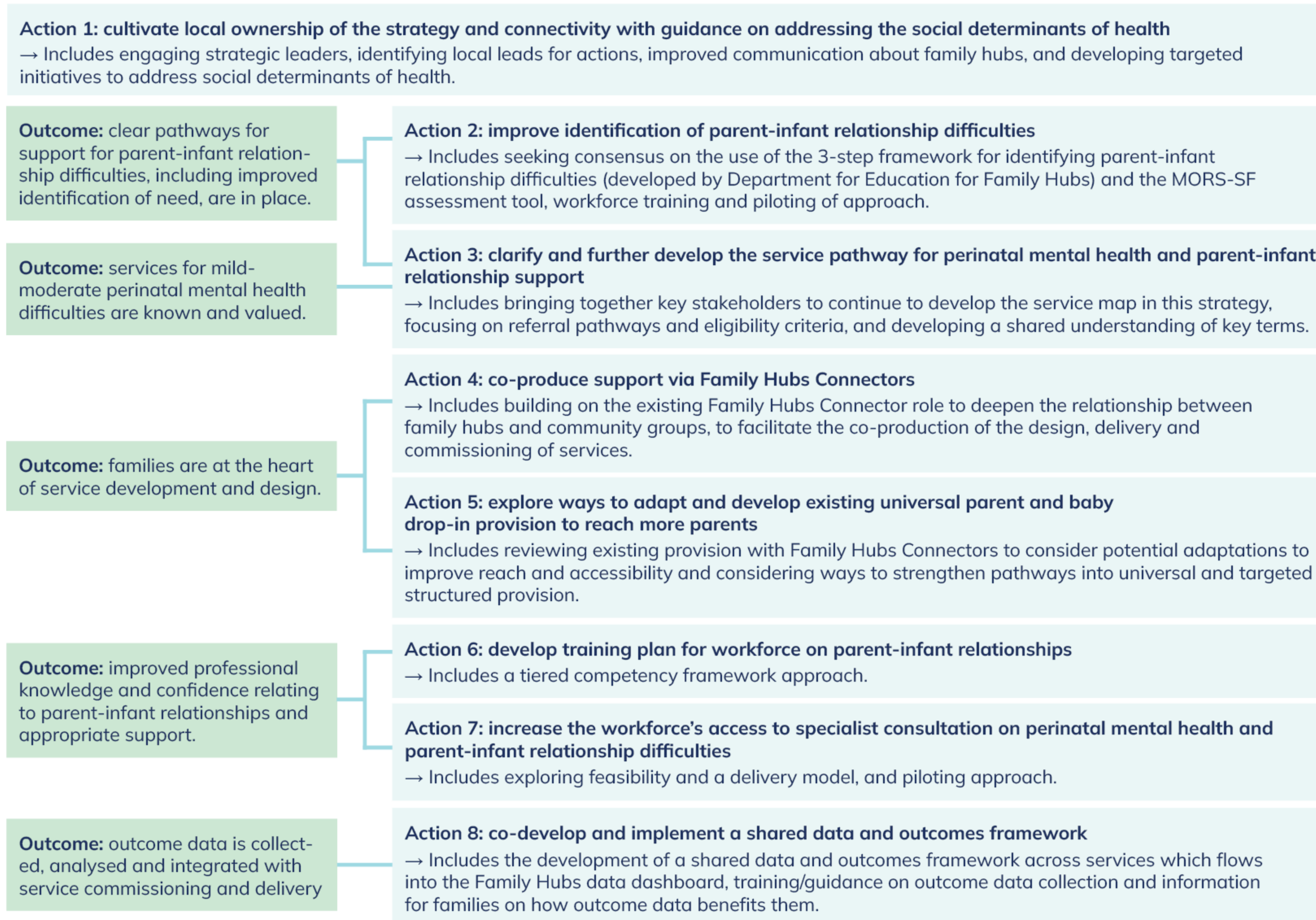
Moderators
What factors will influence the change process?

- strategic buy-in and ownership
- political change, influencing strategic decision-making and funding
- competing priorities for service delivery
- growing and changing need in the local population
- practitioner buy-in and ownership
- engagement of families with the family hubs programme
- capacity of staff to deliver change

Perinatal mental health and parent-infant relationships support actions

We have established eight actions to address the areas for development in North Northamptonshire's perinatal mental health and parent-infant relationships services and support. These were co-developed with local stakeholders and align with achieving the outcomes set out in the Theory of Change.

Table 1: Summary of short-term outcomes and associated actions



Action 1: cultivate local ownership of the strategy and connectivity with guidance on addressing the social determinants of health
→ Includes engaging strategic leaders, identifying local leads for actions, improved communication about family hubs, and developing targeted initiatives to address social determinants of health.

Outcome: clear pathways for support for parent-infant relationship difficulties, including improved identification of need, are in place.

Outcome: services for mild-moderate perinatal mental health difficulties are known and valued.

Action 2: improve identification of parent-infant relationship difficulties
→ Includes seeking consensus on the use of the 3-step framework for identifying parent-infant relationship difficulties (developed by Department for Education for Family Hubs) and the MORS-SF assessment tool, workforce training and piloting of approach.

Action 3: clarify and further develop the service pathway for perinatal mental health and parent-infant relationship support
→ Includes bringing together key stakeholders to continue to develop the service map in this strategy, focusing on referral pathways and eligibility criteria, and developing a shared understanding of key terms.

Outcome: families are at the heart of service development and design.

Action 4: co-produce support via Family Hubs Connectors
→ Includes building on the existing Family Hubs Connector role to deepen the relationship between family hubs and community groups, to facilitate the co-production of the design, delivery and commissioning of services.

Action 5: explore ways to adapt and develop existing universal parent and baby drop-in provision to reach more parents
→ Includes reviewing existing provision with Family Hubs Connectors to consider potential adaptations to improve reach and accessibility and considering ways to strengthen pathways into universal and targeted structured provision.

Outcome: improved professional knowledge and confidence relating to parent-infant relationships and appropriate support.

Action 6: develop training plan for workforce on parent-infant relationships
→ Includes a tiered competency framework approach.

Action 7: increase the workforce's access to specialist consultation on perinatal mental health and parent-infant relationship difficulties
→ Includes exploring feasibility and a delivery model, and piloting approach.

Outcome: outcome data is collected, analysed and integrated with service commissioning and delivery

Action 8: co-develop and implement a shared data and outcomes framework
→ Includes the development of a shared data and outcomes framework across services which flows into the Family Hubs data dashboard, training/guidance on outcome data collection and information for families on how outcome data benefits them.

Action one: cultivate local ownership of the strategy and connectivity with national and local guidance on addressing the social determinants of health

Why? To increase credibility, support partnership engagement and compliance and ensure actions are taken forward in a timely manner. Joined-up thinking across strategic plans supports faster progress towards equitable outcomes, promotes wellbeing and reduces pressure on services.

What will we do?					
Identify and engage key strategic leaders responsible for perinatal mental health and parent-infant relationships service commissioning and delivery in the strategy.	Identify practice leads responsible for short and long term ownership of each action in this strategy	Develop a strategy to more effectively communicate the vision and implementation approach of North Northamptonshire's Family Hubs to professionals, to improve engagement and foster ownership.	Consider ways to leverage the voluntary and community sector network to bolster statutory service provision.	Increase awareness and implementation of national and local guidance on addressing the social determinants of health, including families living in poverty and racially minoritised communities. These include: • Core20Plus5 plan targets • Local Maternity and Neonatal services Equity and Equalities Plan	Integrate and develop perinatal mental health and parent-infant relationships strategy through interconnection with other maternity and early years service planning.
How will we measure progress?					
An increase in joint strategy and commissioning meetings related to perinatal mental health and parent-infant relationships support. This will indicate level of buy-in to strategy.	Frequent monitoring of progress towards achieving actions in this plan initially via the family hubs perinatal mental health and parent-infant relationships workstream.	Feedback from key stakeholders. Improved engagement in family hubs activity and progress towards implementing the action plan.	Evidence of discussion at strategic and operational level to consider feasibility and approach.	Evidence of targeted initiatives to address social determinants of health linked to equity plan and wider equity plans across the system.	The strategy is monitored at a senior level and progress is routinely reported. Other local strategies relating to families in the perinatal period refer to the perinatal mental health and parent-infant relationships strategy.
Example risks and mitigation					
Workforce turnover related to funding uncertainty. This will be mitigated by promotion of strategy to wider stakeholders, detailed recording of decision-making and effective handover.					

Action two: improve identification of parent-infant relationship difficulties

Why? To better identify difficulties in the parent-infant relationship and work towards ensuring the right help is provided at the right time.

What will we do?				
Seek to achieve consensus at strategic level on the use of the 3-step framework for identifying parent-infant relationship difficulties (developed by Department for Education for family hubs)[45], and MORS-SF assessment tool as a follow-up when difficulties are identified.	Design and deliver training and guidance on using the 3-step framework and MORS-SF for staff providing universal and targeted services.	Ensure connectivity with the family hubs data dashboard.	Pilot the use of the tools and collect feedback from professionals and families to review and develop the approach. Work towards embedding universal screening of parent-infant relationships via these tools.	Further develop and clarify the pathway for parent-infant relationship support (see action three) to ensure that there is an appropriate support offer is available when need is identified.
How will we measure progress?				
Evidence of discussion and decision-making.	Attendance rates at training. Trainee satisfaction. Feedback from professionals on the guidance.	Scores from the tools are routinely recorded and inputted into the family hubs data dashboard.	Feedback from families and professionals. Monitor usage of tools. Scores from the tools are routinely used to assess need and inform referral decision-making.	

Example risks and mitigation
Workforce engagement in training. Mitigated by strategic and managerial buy-in and prioritisation. Difficulty adapting routine practice to include tools. Mitigated by inclusion in Standard Operating Procedures. Lack of clarity on where to refer once need is identified. Mitigated by action three. Inability to meet need for support following identification due to capacity. Mitigated by action three.

Action three: clarify and further develop the service pathway for perinatal mental health and parent-infant relationship support

Why? To ensure that once need has been identified, professionals are able to refer families on to appropriate support. To improve professional awareness and valuing of available services for mild to moderate perinatal mental health difficulties.

What will we do?			
Identify and bring together key stakeholders from across North Northamptonshire's mild to severe parent-infant relationships support offer and mild to severe perinatal mental health support offer to continue developing the service map in this strategy, focusing on referral pathways and eligibility criteria. This should be developed in collaboration with the development of the single front door for family hubs. Parent-infant relationships: achieve consensus on a definition of parent-infant relationship support. Perinatal mental health: develop a shared understanding of mild to moderate and moderate to severe need. Disseminate and promote service pathways.	Trial a staged approach to collaborative multi-service fora for referrals to be discussed and triaged, starting with Family Action and SPMHS and with a view to extending this approach to include other agencies. Develop a learning culture, for example by holding seminars or 'lunch and learn' sessions with guest speakers from other services (e.g., young carers).	Consider the feasibility of creating or agreeing on one website or app to act as a 'one stop shop'. This would cover all information relating to parent-infant relationship and perinatal mental health resources and support, targeted at professionals and parents. This could also include accessible childcare and would be trialled by professionals and service users.	Consider actions to mitigate the gap in specialist parent-infant relationship support locally. This may include an increase in targeted service delivery (for example through Tiny Steps) or via a dedicated parent-infant relationship service.
How will we measure progress?			
Engagement from a range of key stakeholders and services, including: Family Action's Flourishing Babies and Supportive Steps teams, health visiting, midwifery, Talking Therapies, SPMHS, Strong Start, Home Start, Circle of Security, GPs and Milk and You. The coproduction of clear referral pathways and eligibility criteria. Host a language resources workshop. This allows for sharing of information on trusted sources for translation services for perinatal mental health and parent infant relationships. Feedback from professionals on the service map and guidance.	Feedback from families on their experiences of professionals' knowledge of available support. Feedback from professionals on improved cross-organisational working.	Families' feedback on being signposted to appropriate support. Improvement in appropriate referrals. Impact on uptake of services.	
Example risks and mitigation			
Challenges with maintaining an up-to-date representation of available services. Mitigated by a lead professional taking responsibility for updating the guidance and flowchart as part of their named role responsibilities. Limited support available for severe difficulties in the parent-infant relationship. Mitigated by consideration of a specialist offer.			

Action four: co-produce support via Family Hub Connectors

Why? To develop service provision so that it can meet the needs of families from a diverse range of communities (including those with experience of living in poverty and who are racially minoritised) and family formations (inclusive of fathers, grandparents, other carers and LGBT+ families).

What will we do?
Build on the existing Family Hub Connector role to deepen the relationship between family hubs and community groups and facilitate the co-production of the design, delivery and commissioning of infant feeding services. Family Hub Connector(s) may have experience of economic deprivation, speak community languages or are otherwise embedded in seldom heard local communities. Their role is to represent and build relationships with families who rarely engage with services (for varied reasons including stigma and previous experiences of discriminatory or poor-quality services).
How will we measure progress?
Recruitment of Family Hub Connectors from a range of communities and are trained to fully participate in decision-making around service design and delivery. Adaptation of local decision-making processes to ensure Family Hub Connectors can fully participate (e.g., by making meeting documentation and timings accessible). Connectivity with the family hubs peer support standards for delivery and other initiatives around community engagement including the Maternity and Neonatal Voices Partnership (MNVP). The views of diverse communities are represented in local decision-making relating to support for perinatal mental health and parent-infant relationships. User feedback on accessibility, reach and quality of support. Increase in the number of families from underrepresented groups accessing support that meets their needs - influencing the continuous improvement of responsive and equitable support.
Example risks and mitigation
Difficulty recruiting Family Hub Connectors. Mitigated by outreach work through local community groups and existing family hubs services.

Action five: explore ways to adapt and develop existing universal parent and baby drop-in provision to reach more parents

Why? To respond to families' feedback about their desire for more accessible informal drop-in support groups.

<table>
<tr><th colspan="2">What will we do?</th></tr>
<tr><td>Review existing provision of universal parent and baby drop-in groups to consider how the model could be further developed to ensure that services reach the target audience.
Draw on the learning from this strategy and engage family hubs connectors and service providers to consider potential adaptations, including:
geographical location of groups
the needs of diverse community groups
improved promotion of available services (see action three)
blended outreach and engagement activity (e.g., via a text or telephone service). This may operate prior to or alongside an informal café or network provision through a warm front door
use of peer support workers who are reflective of the local population (including those living in poverty and racially minoritised communities)
work with families to develop their confidence in accessing services in the preferred medium, helping to overcome any stigma associated with seeking support on mental wellbeing and care
a warm welcome for all family members within the first 15 steps into the service whether virtual or in real life
no immediate form-filling to support the process of seeking help
Revise the model where appropriate and regularly review data and outcomes aligned with the shared data and outcomes framework (see action nine).</td><td>Building on families' engagement with drop-in groups, consider actions to strengthen pathways into universal and targeted structured provision.</td></tr>
<tr><th colspan="2">How will we measure progress?</th></tr>
<tr><td>Evidence of implementation of existing insights from local research, including this strategy.
Co-production of adaptation with Family Hubs Connectors and families.
Outcome data collection and feedback from families and professionals.</td><td>Uptake of universal and targeted structured services.</td></tr>
<tr><th colspan="2">Example risks and mitigation</th></tr>
<tr><td colspan="2">Increased demand on universal services staff. Mitigated by increased service delivery by peer support workers.
Funding and capacity risks around developing new services. Mitigated by promoting or adapting existing provision.</td></tr>
</table>

Action six: develop training plan for workforce on parent-infant relationships

Why? To improve professional knowledge and confidence, create a shared language around parent-infant relationship support and ensure consistent advice is provided to families.

What will we do?

Develop a training and delivery plan, engaging with relevant partner agencies. The plan should include an articulation of:

- the rationale for training
- content of training, including:
  - a working definition of parent-infant relationship support
  - a stepped approach to training
  - appropriate for different roles and required levels of expertise
  - input on working with diverse communities
  - the workforce to be trained
  - expected outcomes.

This may include consideration of the Association for Infant Mental Health competency framework. It may also involve extending the delivery of the Voice of the Child training delivered locally by Family Nurse Partnership.

Pilot the training package and collect data on training satisfaction and impact.

Review and develop training based on feedback, with a view to creating a rolling, sustainable training package.

How will we measure progress?

Development of a training and delivery plan.

Training is co-produced with families and those with lived experience of parent-infant relationship difficulties.

Training attendance rates by profession and role.

Training satisfaction feedback.

Pre- and post-training review of trainees' knowledge and confidence.

Feedback from families suggest they receive consistent, helpful support

Example risks and mitigation

Workforce turnover. Mitigated by a rolling programme of training.

Staff capacity to attend training. Mitigated by strategic and managerial buy-in and prioritisation.

Action seven: increase the workforce's access to specialist consultation on perinatal mental health and parent-infant relationship difficulties

Why? To further develop the confidence of universal service practitioners to support mild-moderate perinatal mental health and parent-infant relationship difficulties and prevent unnecessary referrals into specialist provision.

What will we do?

Explore the feasibility of providing universal services with access to consultation from specialist services. This may include discussion on:

- identifying specialists best placed to provide consultation, and their available capacity
- identifying practitioners in universal services to receive consultation and their capacity
- the preferred delivery method of consultation (i.e., via case discussions, 1:1 sessions or group drop-in sessions).

Co-develop and pilot a feasible, practical and sustainable consultation model. This should include advice and support relating to working with diverse community groups. Review and develop model based on feedback.

How will we measure progress?

Evidence of active exploration of the feasibility of specialist consultation, including discussions with strategic leads and subject specialists.

Number of consultation sessions provided.

Feedback from consultants and those receiving consultation.

Impact on support provided to families.

Example risks and mitigation

Increased pressure on the specialist staff's capacity. Mitigated by reduction of other responsibilities or further recruitment.

Poor uptake of consultation offer by universal services workforce. Mitigated by effective promotion of offer and managerial support.

Action eight: co-develop and implement a shared data and outcomes framework

Why? To better understand the impact of local services. This will inform strategy and service development through shared priorities and a confident and knowledgeable workforce.

What will we do?			
Co-develop a shared data and outcomes framework across perinatal mental health and parent-infant relationship services. This will build on the logic model developed by the family hubs perinatal mental health and parent-infant relationships workstream and will feed into the family hubs data dashboard. The framework might include: • agreed set of indicators, outcome measures and qualitative data collection related to perinatal mental health and parent-infant relationship services • data relating to the social determinants of health • consideration of the join up between data collected services commissioned by Family Hubs and services not commissioned by family hubs Pilot, refine and embed the shared data and outcomes framework for services commissioned by family hubs.	Develop and deliver training and associated guidance on the importance of outcome data collection and how to use the family hubs data dashboard.	Co-create a short information leaflet for families on why outcome data is important and how it benefits them.	Work towards the adoption of key outcomes in a wider partnership framework of outcomes and indicators.
How will we measure progress?			
Development of a framework. Feedback from families on the use of the data and evidence framework in practice. The agreed data collection requirements are made explicit in the commissioning by family hubs of all new services. Learning from the data are fed back to professionals and families. Evidence and evaluation reports are routinely shared with stakeholders.	Training attendance rates and training satisfaction feedback. Trends towards improvement in compliance with data collection requirements.	Creation and ongoing dissemination of information to families via services and online. Feedback from families indicates that they are informed about the benefits of outcome monitoring and feel engaged and empowered.	Partners have a clear view of which parts of the system are working well and use this to inform strategy and service development.
Example risks and mitigation			
Limited staff capacity and willingness to collect outcome data, mitigated by strategic and managerial buy-in and prioritisation, and staff training on the benefits of outcome data collection. Families' unwillingness to provide feedback or complete outcome measure collection, mitigated by information and face-to-face support on the benefits of data collection. Lack of data analysis skills to support interpretation of data, mitigated through training.			

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