Maternal health and wellbeing: examining key influences, impacts and routes to better health for children and their mothers.

2 September 2014

Seminar report

The National Children's Bureau (NCB) and the Women's Health and Equality Consortium (WHEC) held an exploratory seminar to examine maternal health and wellbeing. There were 17 delegates in attendance bringing representation from the Voluntary and Community Sector, Public Health England, NHS England, National Institute for Health Research, Royal College of Paediatrics and Child Health and the Institute of Health Visiting.

Agenda

We welcomed the following speakers to address the group:

- Claire Meek; Assistant Director of Services and Innovation at Family Action – on Family Action's perinatal work; especially the effectiveness of their perinatal support project
- Alison Baum; CEO of Best Beginnings – introducing their work especially the Baby Buddy app and maternal mental health films
- Helen Beecher Bryant; Project Officer at Maternity Action - discussing their recent work developing a report on the social determinants of maternal health
- Barbara Kuypers - NHS England Local Supervising Authority Midwifery Officer - on Health Education England and NHS England's vision for maternal health

This was followed by a guided roundtable discussion which sought to explore where improvements can be made across research, policy and practice.

Notes from the discussion

What good work is going on currently?

A number of delegates highlighted areas of good practice and ongoing work in the field; including:

- CHIMAT have been invited to work with the mental health foundation to develop a mental health commissioning toolkit for perinatal mental health
- NSPCC are leading on a mapping of PIMH services (Perinatal mental health)
- PHE are including mental health and wellbeing as a core part of all of their Big Ambitions work. For the Early Years Big Ambitions perinatal mental health will be a priority. PHE will be undertaking extensive stakeholder engagement over the coming months to start the conversation and begin to develop the Big Ambitions programme.
- WAVE Trust's 1001 critical days campaigning
- International Marce Society for perinatal mental health are capturing the international perspective at their biennial conference this month, bringing the best in the field together in the UK
- International good practice and evidence particularly form Victoria, Australia
- Maternal Mental Health Alliance are due to publish a report on health economics - why we can't afford NOT to invest.
- Millennium cohort study work included findings on the effects of perinatal mental health on a wide range of outcomes. Interest was expressed in revisiting these findings now that those young people involved in the study are older.

However it was noted that there must be better ways to link up and share amongst professionals and organisations in the field what is happening across the country in different sectors. The Early Intervention Foundation was raised as a useful starting point.

It is hoped that the Better Start work, which provides an opportunity to build and disseminate learning over a longer period of time will have a national impact in the tying together of best practice.

Barbara Kuypers offered to share the evidence from a survey of Trusts that is currently in progress about what they're doing with regard to perinatal mental health services.

Where can improvements be made?

The key points of screening and when a mother leaves hospital were seen to be very important in identifying risk factors; and it was felt that practice could be sharpened up at these junctures to improve outcomes. Early intervention begins with screening, long before services come into play. There are concerns that in some screening sessions the mother feels that there was not enough time to talk and is not comfortable to open up about her issues and feelings.

- Health professionals ought to be able to ensure they have the time to talk with pregnant women at screening and are skilled in leading these conversations. A checklist of questions midwives are asking mothers may be helpful.

- The quality of verbal and written Information provided upon leaving hospital could also be improved.

Many health visitors and midwives have issues with capacity and time. The detrimental effect on mothers was noted when a health visitor is seen to be stressed or too busy.

- Mothers need to know that their health visitor has time to listen.

The rigid nature of health visiting systems was also brought up as a hindrance to practice. Health visitors are reporting feeling a loss of autonomy, and there are concerns that they are not able to always identify or support the vulnerable through their core offer as their time is so tight. Concern was raised particularly around the 10-14 day time period for new birth assessment and a financial penalty if new birth visit is done too late. There is felt to be too much paperwork and bureaucracy, tipping the workload balance away from mothers and families. The system is driving the work and this needs to be the other way around.

- More flexibility in the health visiting system would improve outcomes as there could be more flexible transfers between midwives and health visitors to suit individual families, as well as opportunities for the health visitors to have more early contact with parents.

- The system needs to acknowledge that relationships can take time to build and will vary from family to family.

The importance of working across the system was highlighted. And a more flexible system across other services alongside health visiting; including midwifery, GP and other primary care services would be extremely beneficial in many circumstances, especially for more vulnerable women. Currently midwives can be involved with a family until the child is aged two, however not many know about this and fewer still practice this.

- Developing truly integrated teams. There needs to be more flexibility across a range of service delivery for care and support to work smoothly for each family.

- Also where delivery happens is important for mothers and their families, the accessibility of health visitors and midwives needs to be considered, they need to be located within pram-pushing distance for most people.

Difficulties were noted with the number of mother and baby units and their locations. Cases were discussed where women have been moved, with or without their babies away from family and social support.

- A review and restoration of a number of mother and baby units.

Midwives and health visitors are in a unique position. Many of these professionals feel as though they are holding families together in the broadest sense and struggle if they cannot see what services are available to link into.

- Health visitors and midwives need to be aware of the full range of effective services available to women and their families locally and how to signpost into them, including what Voluntary and Community Sector services are providing.

Those with experience in the running of Children's Centres noted that a two year olds language delay can often be traced back to maternal mental health issues.

- Health visitors could bring huge benefits if integrated into Children's Centres, especially if staff from the Centres and the health professionals are attending training together.

There was consensus that NHS silo professional education does not work. Universities have a crucial role in impressing upon their students the importance of their learning and development whilst there to their own future practice; especially to address the problem of poor recall of mental health content from their courses.

- Integrated, multidisciplinary, post-registration training needs to happen regularly; i.e. not just health visitors or NHS staff doing one off training in silo.

- New and vibrant, quality trainers ought to be brought in from outside the usual health training systems, for example from the VCS, NGOs, private sector etc...

Money talks – and commissioners are making some very difficult decisions about health and care services locally. We're also working in an increasingly changing marketplace. There is significant risk to good quality services - for example risk to Health Visitor and Midwifery relationships - with the commissioning changes around early years due to take place next year.

- Need to effectively present the health economic assessment on the cost and lost opportunity of not investing in maternal health and wellbeing.

Does early intervention and support work? Does it really make the difference and prevent escalation of the issues? How does everyone know that the support and services they are providing really work? It was felt that although professionals and practitioners in the field will all absolutely know the difference it makes, perhaps there is not sufficient robust evidence to convince those outside the field that this is where investments can be made to have a huge impact. There was a desire to see a Health Economics Model more widely expressed in the field – early intervention for societal benefit. The National Institute of Health Research reminded the group that there is money available to research and evaluate maternal health and wellbeing programmes both via calls each year and through the acceptance of unsolicited applications.

- An outcomes focus with robust research and evaluation of services, support tools, practice development projects etc is crucial and needs to be more routinely built in.

- Desire to see cost benefit analysis, data on the reduced duration of problems for mothers as well as wellbeing measures.

Who or what is needed to make changes?

Whilst some discussion touched on who and what needs to be involved to make these improvements happen, the conversation did not go as deeply as it could have into this.

Much discussion centred on the health professional's personal development, training and competencies. Health visitors and midwives especially need to have the skills to ask the right questions, in the right way, to get the information they need. They also need to be able to know how to deal appropriately with what they learn from the mother or family. Those responsible for the training and development of health visitors and midwives need to source new, dynamic education and learning opportunities, delivered ideally in mixed groups of professionals.

The pervasive culture of mental health stigma clearly affects this area of work. A wider societal shift in attitudes is required.

Many suggestions for improvement centred on system changes. Changes to the internal systems that are used for day to day procedures, changes to the overall strategic system, and changes to the way professionals work together.

In order to develop truly integrated teams, primary care and GPs need to look at what their offer can be.

What one action or area for development is most important to you?

- A multi pronged approach – the NHS cannot work in silo
- A focus on solutions and action
- Directing attention and resources to the **gaps** which are seen in many areas including; capacity, resources, flexibility, support and information
- More integrated working, a collaborative approach with platforms to support this
- Commissioners to 'think out of the box' about who can provide services other than the NHS
- Education needs to be integrated to add breadth
- Consolidation – using real life examples
- Implications of the transition of early years commissioning into local authorities when mental health commissioning is within the NHS
- Parity of esteem between physical and mental health; acknowledging that its not just this sector saying this
- Ending stigmatisation – of pregnant teenagers, of refugees and asylum seekers, mothers with HIV. Myth busting the whole spectrum of stigma and raising the population's emotional intelligence.
- More positive images of mothers and their families
- The sharing of good practice – where do we do that and how?
- Flexibility and responsiveness of the Health Visiting service
- Re-thinking service delivery to integration