

Background to the Perinatal and Infant Mental Health National Seminar

The Mental Health Foundation (MHF) and The National Children's Bureau (NCB) worked in partnership to convene a national seminar on perinatal and infant mental health in July 2015. Our organisations want to increase awareness of the wider determinants of child health inequalities, experience and outcomes and how they impact across the life course. We are interested in maternal health, how this impacts on health in early years and on longer term outcomes for children. Both organisations are also profoundly concerned about the slow pace of change in developing maternal mental health services, on account of the needs of mothers themselves, and also because of the long term impact that unaddressed maternal mental health problems have on child development. We see the development of these services as being one of the biggest single opportunities to improve the mental health of children and young people. The seminar was also supported by WAVE Trust and the Maternal Mental Health Alliance (MMHA).

The purpose of the seminar was to identify the work being done and the support needed by NHS England Strategic Clinical Networks (SCNs) across the country, and to share this more widely, with the overall intent of providing a national picture that supports the commissioning of perinatal mental health services. 11 of 12 SCNs for Mental Health and Maternity, Children and Young People attended the event which is significant in terms of how this opportunity was perceived. Other professionals also attended including; Geraldine Strathdee - National Clinical Director for Mental Health, DH officials and NHSE staff tasked with managing funding for perinatal work and relevant data and information streams. As well as Voluntary and Community Sector colleagues, Clinical Commissioning Group (CCG) members, psychiatrists/psychologists, consultant midwife, researchers and an obstetrician. All delegates have been given the opportunity to comment on the content of this report and their feedback has enriched and improved its quality. We hope that this report will help to inform national leaders and those working within SCNs about potential improvements in the ways we support mental health and wellbeing and help already stretched budgets to have greater impact.

The issues

This section explores the issues raised and draws upon highlights from discussions at the seminar. It does not necessarily provide a consensus view of all SCN areas represented on the day.

Participants at the Perinatal and Infant Mental Health National Seminar took part in a number of activities including; describing the work currently under way or planned in their area to provide a current picture of perinatal and infant mental health services, and discussing their vision for these services. Six themes emerged from conversations:

1. Commissioning and provision of services
2. Workforce
3. Leadership
4. Data and information sharing
5. Engagement with service users
6. Generating activism

1. Provision of quality services; commissioning a care pathway and specialised commissioning

Successes

Mapping provision was specifically reported to be under way in some areas and completed and reported on in others. Some examples highlighted during discussion include:

- The South West has recently undertaken a review of perinatal and infant mental health care pathways within the region and they are currently working to support the implementation of the recommendations within their report. This was undertaken as a joint exercise between the Maternity and Children's and Mental Health networks and included a service mapping exercise to establish a baseline of current service provision.
- The East of England are using the Healthy Child Programme toolkit to shape local work and to develop a standardised area perinatal and infant mental health care pathway.
- In the East Midlands, which has an established network, the care pathway is being supported by CQuIN in relation to improved data collection and workforce development, which are both themes we report on elsewhere.
- In Yorkshire and the Humber it was commented that there is '*variation in current commissioning of PNMH services. Good engagement from Y&H CCGs and the majority either have a strategy for commissioning PNMH services or are developing one. CCGs are awaiting commissioning guidance*'. The South West is also supporting the 11 CCGs within the network footprint with their local service improvement initiatives and providing regional support and input in to the work.
- London is developing a fact sheet containing a directory of models of good practice and case studies to share learning.
- NHSE have commissioned outreach services in Yorkshire and the Humber. The service covers preconception advice for high risk women and follow up for women discharged from the mother and baby unit.

Challenges

With regard to specialist commissioning, concern was expressed about keeping beds open (East Midlands), in other areas, thinking and planning for mother and baby units has either not begun, or, as in the South West, is in its early stages of consideration with mental health specialist commissioning colleagues involvement.

There is a general recognition that the care pathway needs a means of responding very promptly to women who disclose perinatal mental health issues, and concern about access to services in a timely and appropriate way.

There are issues about thresholds for Improving Access to Psychological Therapies (IAPT) being appropriately set, and links to perinatal psychiatry for advice and referral, which are frequently encountered and need addressing in commissioning of the care pathway. CCGs are in different places in terms of responding to this, depending on the strength of their commissioning arrangements, but one would expect forthcoming commissioning guidance to help.

The ambition and how to deliver it

There was overall support for a complete care pathway to be in place for every woman who requires it, which addresses the whole spectrum of need with high quality

services being as locally based and timely as possible. Within that context delegates noted the following:

- Recognition of perinatal and infant mental health issues and needs across CCGs and providers is important.
- There were calls for CCGs to work more collaboratively, and for there to be improved engagement between CCGs and providers with a named responsible person in each locality, who has the power to act.
- Better integration was a strong theme amongst ambitions expressed. Many areas talked about greater involvement of partners, a continuity of care, and the need to include Child and Adolescent Mental Health Services (CAMHS) in the care pathway as well as IAPT tertiary and secondary care, and social workers.

Suggestions as to what needs to be in place to drive improvement included:

- Adequate funding; sufficient NHSE resources to support SCN networks, and ensuring that funding is recurrent in order to implement changes in the long term.
- SCN area bids for funds based on evidence and stakeholder endorsed strategies. Some delegates advocated that funds resulting from such bids ought to be disseminated according to need, with CCGs being held accountable. It was suggested that SCNs could have a role in reviewing bids.
- Co-commissioning was also cited as being important to achieving the vision. General suggestions around how to achieve better integration and strengthening of services included; negotiation, identifying the right people locally, robust provider agreements, and consistency of agreed clinical pathways.
- A national CCG group and improved guidance to CCGs.
- CCGs having clear perinatal priorities and strategies embedded in their services specifications.
- SCN's being able to share good practice, and in carry out practical support tasks such as gap analysis.
- To sustain momentum it was felt to be important that SCNs develop an organisational culture of striving for improved quality and the ability to reflect and recognise achievements made.
- Services offering Parent Infant Psychotherapy to address difficulties in the parent/infant relationship are vital but they need to work in tandem with Perinatal Psychiatry teams that assess and treat maternal mental illness and should not be seen as a substitute for specialist Perinatal Psychiatry services, both community and inpatient.
- Tracking the progress on the commitment in the NHS mandate to have a Specialist Mental Health Mandate in every birthing unit, ensuring the commitment becomes a reality.

Summary

The ambition is for a complete care pathway to be in place for every woman who requires it, which addresses the whole spectrum of need, with high quality services being as locally based and timely as possible.

Much work has been done to improve CCG engagement with perinatal commissioning, though progress is uneven, and there is still a very long way to go to get the message across both within SCNs and the wider CCG audience. SCNs are acting both as practical enablers and in a more strategic role.

Progress is seen as being dependent on stable funding, good central guidance and winning hearts and minds.

2. Workforce and training

Successes

The training of primary care professionals and first line of contact staff in understanding the frequency of perinatal mental health problems and being able to respond and refer onwards appropriately is a widespread focus of activity and concern reflecting the passion for prevention and early identification. Examples of current activity include:

- Many areas are still at the point of scoping and mapping what training is taking place and where. However Yorkshire and the Humber Children's and Maternity SCN have completed a scoping review into what training is currently available. Work in this area has also included connecting with the local Health Education England (HEE) representative who is looking at training for midwives, nurses and non-registered staff, and who is currently scoping the work required.
- Thames Valley has identified GP training as an area of concern and is delivering perinatal training to these professionals alongside training in diabetes and epilepsy.
- In London there are 3 major pieces of work taking place in relation to specialist health visitor and mental health worker training, though concerns were raised about their coordination and sustainability. Local Education and Training Boards (LETBs) have identified this topic as an area of work; however they do not appear to be working in a co-ordinated or joined up way with adjoining LETBs.
- In the East of England the area is supporting the training of health visitors in identification and early intervention.
- In the East Midlands there is a focus on providing the IAPT workforce with the training they need to enable them to respond effectively to mothers with mental health issues which do not require a specialist service.
- The South West is establishing an educational reference group with Health Education South West with the aim of developing an appropriate workforce and education plan to support improvements in the regional care pathways.

Challenges

There is little shared understanding or agreement as to what the national approach to workforce and training is or should be, and in most cases clinical networks are identifying their own routes, or supporting work which is already taking place.

We heard praise for the skills of health visitors and midwives with specialism in mental health, but also caution that currently, as the specialism emerges from an individuals experience and interest and is not formally accredited, it leaves professionals vulnerable in Serious Case Reviews to having their credentials questioned. It was also noted that there are currently very few specialist health visitors in perinatal and infant mental health.

There was also particular concern expressed about the engagement of GPs and obstetricians.

The ambition and how to deliver it

The need for improved, accredited, multi agency, training opportunities was highlighted universally with calls for '*quality continuous professional development for perinatal mental health skills and competence*' for a broad range of professionals.

Suggestions as to how this could be achieved included:

- A list of existing nationally recognised and quality-checked tools, resources and training; with the development of new materials as required to address gaps in the national package.
- Some delegates felt that a new national workforce training programme is required, accessible to a range of professionals, which addresses issues around; training standards, minimum content, accreditation, competency frameworks and offers conversion and top up course options.
- There was a general sense that Health Education England should be providing guidance to LETBs and SCN leads.
- Influencing the content of current training: including specialised perinatal health training in IAPT.
- Maximising the support of tertiary academic institutes.
- Most SCN areas identified existing staff capacity as the main resource available to work towards their vision. However the huge variation in the roles and capacity across SCN areas was noted. Some identified project managers as the key influencers and others identified clinical leads, some areas also noted that programme leads may only be appointed on a fixed term basis.
- Access to some specialist health visitors, midwives, clinicians, strategic leads and trainers as a conduit for achieving ambitions for improvements. It was the view of some delegates that posts are needed in each locality to provide specialist clinical interventions to targeted families, consultation & training to the wider health visiting workforce.

Summary

A broad range of activities by SCN leads is identified but lack of clear direction centrally seems to account for there being little in the way of a clear common process or methodology, or set of outcomes to work to.

Information about activities is not shared widely across /between SCNs.

The importance of a national training programme to develop leadership is identified. So is the need for engagement from tertiary education to support the development of strong local interest groups and local expertise.

3. Local and national leadership

Successes

At an SCN area level perinatal and infant mental health networks are seen as an important contributing factor to the success of local leadership driving change. There is a wide spectrum of development of such networks in different parts of the country. Investment in capacity is varied with some areas funding leadership in an ongoing way, others on a part time and short term basis, or not at all. Those areas that are most developed have resourced leadership, and at least some commissioned services providing clinical leadership, support and expertise. Examples of activity include:

- The East Midlands described themselves as having a '*well-established network and strong links with Maternity, Children and Young People and Specialist Commissioning*'.
- London has merged 3 perinatal mental health networks into one, developed a protocol, care pathway and holds an annual London conference. The network comprises 183 members is multi-agency and funded by London Mental Health SCN.
- The South West has had perinatal and infant mental health as a priority since its launch in 2013 and has developed a well-established work programme through its provider, commissioner, third sector and public membership.
- South East Coast describes good engagement from commissioners, but limited capacity and is currently scoping a network perinatal work programme from baseline survey work.
- East of England has just established an area network and held its first meeting.
- Yorkshire and the Humber SCN established a perinatal mental health Task and Finish Group in April 2015. The Group includes Maternity and Mental Health providers and Commissioner and service users.

Challenges

Ownership of the perinatal and infant mental health agenda was discussed. Opinions varied on preference between joint ownership across Mental Health and Maternity, Children and Young People SCNs or sole ownership by either. It was suggested that success may heavily depend on the leadership and individuals involved.

Communication was another challenge cited during discussions. '*Communications need to be cascaded via mental health AND maternity and children's networks. Each can't be relied upon to share information with the other*'. Some areas, such as Yorkshire and the Humber, reflected that the Maternity Children and Young People SCN and the Mental Health SCN communicate well together. Universally there was a desire among delegates to hear from others, to learn from them and take actions back to areas to work through together across both Maternity and Children and Young People's SCN programmes and the Mental Health.

Some SCN leads felt that they have limited power locally and that CCGs especially need to hear messages about driving this agenda forward from a national level too.

The ambition and how to deliver it

NHS England was seen as fundamental to supporting SCN areas in moving the agenda forward. Dedicated resource at national level was crucial. Some delegates wanted more defined national direction providing independent leadership and improved

national guidance, strategic thinking and planning, to bring more consistency to SCN approaches, which currently reflect different ways of working.

Suggestions on strengthening local leadership included:

- Steering groups, specialist interest groups and the establishment of perinatal and infant mental health area networks with adequate funding, capacity and capability are key assets for driving change locally. Having a programme lead locally as the 'go to person' was also seen to be beneficial.
- Developing innovations such as:
 - A monthly or six weekly practice sharing webinar, perhaps underpinned by regular national meetings of project leads.
 - A national map, similar to the crisis care concordat map, showing CCG action plans for perinatal mental health with a 'get inspired' section.

Ideas for improving national leadership included:

- More strategic joining up; for example ensuring perinatal and infant mental health is on the agenda of the National Information Board (NIB). *N.B: The NHS England Expert Reference Group agreed to produce a summary paper for NIB which will be shared back with delegates who attended the Perinatal and Infant Mental Health National Seminar.*
- National coordination of SCN networks through a national implementation team working within NHS England with the budget to create necessary resources. Suggested support they could provide includes:
 - financial mapping
 - risk analysis
 - development of a national group of mothers with lived experience to act as change agents
 - research and development of liaison psychiatry and liaison IAPT models
 - providing action learning and support to win hearts and minds among the wider workforce
 - linking the workforce together with regular webinars
 - liaising with other arm's length bodies such as HEE
 - drawing in the expertise from a range of organisations and supporting the development of long term plan for the health system partners which creates the context for success.

Summary

Geraldine Strathdee made it clear that National Clinical Directors see PIMH as a national priority. The remit to individual SCN leads seems diluted by the time it reaches them.

Dedicated resource at a national level is crucial. Many SCN areas reflected on the potential for a more defined national direction to bring more consistency to local approaches.

Leads struggle with a lack of authority, and in a good many cases lack of awareness and enthusiasm at both SCN and CCG level amongst broader stakeholders.

Suggestions for strengthening local leadership centred on creating opportunities for practice sharing and investing in appropriately resourced networks.

4. Data and information sharing

Successes

Some specific SCN activity at area network level was identified:

- Agreement of data collection across an area linked to national dataset.
- Mapping data collection.
- Development of improved data collection and information for CQuIN purposes.
- In Thames Valley the area lead has set up a moderated social media platform to enable professionals to share information on provision and practice.

Challenges

There is a lack of a comprehensive national minimum dataset for perinatal and infant mental health.

Also challenging is the paucity of data about women being treated for perinatal mental illness in mental health, primary care and acute non-mother and baby unit settings. This was seen as a potential block to making a clear case for commissioning based on local needs.

Other key missing information included

- Data from mental health trusts about the numbers of perinatal cases (male and female) had been seen by them in the previous year.
- The lack of a perinatal indicator for outcomes.
- The lack of linkage between maternity, child and mental health datasets meaning that deciding which proxies to use and how to bring them together was a task beyond the resources of most localities.

The ambition and how to deliver it

Utilising data and outcomes to drive the work was regarded as important to sustaining momentum. Improved data collection, sharing and use from all localities was cited as a universally important aspiration. Data flows needed to come from acute, mental health and community settings in order to cover the issues comprehensively.

Delegates suggested the following measures to drive improvements to data and information sharing:

- NHS Benchmarking data supplied by SCNs could usefully be fed back to them so that they could get an idea of how each area is doing relative to others.
- Development of a minimum mental health data set for perinatal, maternity, health visiting and mental health which would include information on women admitted to acute mental health units as well as mother and baby units.
- Creation of a central resource website or online forum, accessible to all, where all perinatal and infant mental health delivery plans could be stored and shared.
- Improved IT systems.
- Measuring quality:
 - Through better use of existing quality standards and links to bodies such as the Care Quality Commission (CQC).
 - Introducing a national data code, and using a pregnant women ID in mental health trusts.
 - Clarifying what good outcomes for mothers and infants look like. Is there a need to develop patient experience and or wellbeing

- measures? Is it possible to measure early identification and the overall level of perinatal and infant mental health problems?
- One area advocated establishing a rating scale to use when gathering feedback on services. One option that could be utilised to do this is the [Friends and Family Test](#) for NHS organisations and services. However SCN areas could also look to develop their own more specific tools applicable to services beyond the NHS; as the South West SCN area is doing in developing its service user outcomes and experience measures survey.

Summary

In most areas information about the collection and use of soundly based data and information about services and training is still being collated. The exceptions are London, East of England and the South West where these processes seem to have been completed.

There was much discussion about the need to use data to drive change, through improved data collection, sharing and use.

The lack of national data collection about perinatal episodes is well known, and is clearly seen as a significant problem.

There was no discussion of data around financial mapping, or of the cost of services supporting mothers and babies provided under the auspices of the Healthy Child Programme, or by local authorities. That is not to say that this is not taking place merely that it was not mentioned, perhaps because not specifically asked for in the seminar.

5. Engagement with service users

Successes

Many SCN areas shared information about how they engage with service users locally. Some examples of practice include:

- London describes how they co-produce products with service users – all work currently under development involves mums and dads with lived experience.
- Cheshire and Merseyside have two expert users on their multi-disciplinary development group at least one of whom (Elaine Hanzak) is nationally well known.
- Yorkshire and Humber have undertaken a scoping exercise to ascertain current service user groups and involvement. Two service users have been invited to join the Y&H PNMH Task and Finish Group.
- The South West recognises service user engagement as critical within its core activities and has embedded this within its perinatal and infant mental health work programme. The network is developing a service user outcomes and experience measures survey that is intended to be piloted within the network from November 2015.

Challenges

Involving service users in the design, delivery and improvement of services is generally considered not to be reaching its full potential in every locality.

The ambition and how to deliver it

There was a desire for engagement of service users to be embedded consistently across the country in order to maximise the success of services and to drive change.

Suggestions about how this could be achieved included:

- Sharing of practice and experience among professionals working at SCN and service delivery level.
- Services to consistently and systematically ask users for feedback on their views and experiences of the services they engaged with; analysing the information gathered and using it to inform service improvement.

Summary

It is not clear whether the opportunities presented by co-production and engagement with service users are being well exploited, generally speaking, and this probably reflects restricted resource/capacity at area level.

Investing in thoughtful engagement will be crucial to inform the development of quality services and to improve the experiences of mothers and families.

6. Generation of interest and activism

Successes

Geraldine Strathdee, in her address to the seminar, praised the increased public interest in and awareness of mental health in recent times.

Generally delegates wanted to hear from others, to learn from them and to take actions back to their own areas of work.

Challenges

Geraldine Strathdee also described continued resistance and criticism from 'body part' colleagues; demonstrating a lack of understanding or appreciation of the issues, the evidence around it, the services available to address it and the spending that it requires, reflecting the enduring wider stigma in society.

The ambition and how to deliver it

Geraldine went on to describe an ideal 'functional family' of people interested and invested in improving perinatal and infant mental health and called for more activism.

Contributions from delegates supported a strong case for perinatal and infant mental health. Delegates felt CCGs shouldn't underestimate its importance relative to other high priority clinical areas. Educating people about the biological and physical consequences of poor perinatal mental health for families was seen as a way of improving the prioritisation of commissioning of the pathway by CCGs, and combating difficult CCG constraints of limited resources and strict prioritisation processes.

One area in particular highlighted the need to raise awareness among consultant obstetricians, and to have an ambition that these professionals make time for perinatal and infant mental health.

Delegates highlighted the following issues in discussion about how to deliver on these ambitions:

- The Voluntary and Community Sector (VCS) make a valuable contribution to this agenda; particularly in terms of understanding, relating to and listening to mothers and their families, and providing a mechanism for the powerful lived experience voices to be heard.
- Conversations at ministerial level are needed – getting perinatal and infant mental health onto the planning guidance agenda.
- The potential impact of an *Early Years Collaborative* style series of events.
- Suggested delivery of an action learning programme
- Increasing use of social media to discuss the agenda among professionals.

Summary

There appears to be universal understanding of the need to improve the wider workforce appreciation of the issues surrounding perinatal and infant mental health; however uncertainly about the best methods, capacity and resource needed to do this.

The potential to harness the momentum of all relevant Royal Colleges taking up the issue as a priority is yet to be realised.

Twitter was acknowledged as an incredibly useful tool to generate conversation that is watched closely by decision makers.

Conclusions

These are the conclusions of the seminar organisers and do not necessarily reflect the views of all the delegates.

- The range of different issues highlighted in this report are fundamentally linked by an emerging narrative that more integrated support is needed from the centre to SCNs and CCGs to achieve commissioning at scale, and for the leads to be in a better position to support and learn from one another.
- We collected a wide range of responses on work currently under way or planned, reflecting progress in different parts of the country and in the leadership provided. There is a lot of good work going on. This is not necessarily coordinated across each region, never mind nationally. Despite this there is continued progress in many local areas.
- Commissioning guidance will be issued soon by NHS England. However, without funding to support it, it is felt that guidance alone will not achieve its potential. The commitment of £75M over 5 years is very welcome. Those working in the sector are concerned that this money is not wasted in un-coordinated development work which re-invents the wheel.
- Data collection is still not comprehensive and there are some significant gaps. What data exists is difficult to use in a way which strongly supports commissioning, and it appears that the research evidence to join up the data and agree reasonable proxies is lacking.
- Aspects of workforce and training have been addressed centrally, but this is felt to be a somewhat piecemeal way; with the development of Health Visitor Champions, a training programme for midwives, and some guidance issued to GPs. The development of a set of key perinatal competencies for the whole Mental Health/Maternity, Children and Young People workforce with different levels of training and the funding to achieve these is necessary. HEE should communicate more clearly what their programme for workforce training in this area is.
- SCNs are working in the absence of a clear national long term plan for perinatal and infant mental health underpinned by coherent commitments to achieving this made across the whole delivery system. The development of such a robust plan is likely to require significant further national leadership probably including ministerial sign-up.
- Developing engagement with service users at a local level and as a collective group of change agents is not currently being pursued to its full potential. Investing in such participation could not only improve individual's outcomes, but the quality of services and contribute to the wider agenda of generating public and professional interest. There persists strong unmet need to improve the wider workforce appreciation of the issues surrounding perinatal and infant mental health.
- This landscape, and financial constraints within the NHS as a whole, makes for a difficult climate in which to achieve coherent and consistent local development. It is in this context, against a back-drop of increasing multi-agency momentum for making improvements that we face an exciting opportunity to make a step change in moving things forward for perinatal and infant mental health.