Lancashire Health and Wellbeing Board

Delivering the Health and Wellbeing strategy – Intervention planning

<table>
<tr><td colspan="2">Priority :
• Joined up support for vulnerable families (first pregnancy)
Priority shifts:
• Build and utilise the assets, skills and resources of our citizens and communities
• Shift resources towards interventions that prevent ill health and reduce demand on acute services</td></tr>
<tr><td colspan="2">Outcomes:
• Maternal and child health
• Mental health and wellbeing</td></tr>
<tr><td>Current reality:
What have we uncovered so far?
What is working well?
What is not working so well?</td><td>An initial consultaion discussion session involving representatives from public health, health commissioners, health providers, and local authority highlighted the following:
✓ Wide range of existing strategic commitments to the issue of maternal health and wellbeing e.g. Public Health outcomes framework, NHS outcomes framework, Children & Young People Plan outcomes;
✓ A number of working groups and programmes of activity linked to the strategic commitmenets and with specifc action plans in place to address aspects of maternal health e.g. healthy child programme, infant mortality group, healthy weight group, infant feeding group, sexual health and substance misuse group, early years group – many of which have strands of actvitiy associated with vulnerable groups. In addition there is a wide range of work focussed on improving adult health to include (as examples) smoking, adult healthy weight.
➢ Less evident is the work around (adult) mental health and wellbeing associated with pregnancy, particularly lower level mental health issues (although there was stronger evidence of CAMHS mental health work). In part this may be due to lack of knowledge of, rather than lack of , service provision – maintaining a comprehensive and consistent knowledge of service provision across Lancashire is challenging;
➢ Consistency of provision across geographies, and across organsiations cited as an issue. Good practice 'in pockets' rather than widespread and no readily available assurance that what is available meets evidenced needs. Lot of work done in North Lancs to define a specification for Perinatal Maternal Health but patchy implementation, partly due to problems achieving service change without resources, and partly due to varying commitment from a range of partners. In</td></tr>
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	some areas midwifery teams are not currently coterminous with Health Visiting teams and children's centres which limits opportunities for genuine **integrated team working**. ➢ **Awareness and use of established guidance** i.e. 'Improving Outcomes and ensuring quality – a guide for commissioners and providers of perinatal and infant mental health services' - published 2011 and NICE commissioning toolkit for Perinatal Maternal Health. Established evidence around how maternal mental ill health can adversely affect the mother-baby relationship with ongoing term impacts for the child's development. Strong attachment between a mother and baby during the first year of life is crucial to support brain development and future resilience. ➢ **No definition of 'vulnerable family'** – but the existing criteria for identifying families through the Working Together With Families (Troubled Families) programme may provide a starting point. Is vulnerability defined by physical (long term conditions/morbidity, etc), mental or social/emotional health (domestic violence, etc) criteria? Links with early parenthood (teenage pregnancy); ➢ The balance between health and social care needs to be understood to ensure the appropriate support is provided – are support **pathways clear, evidence-based and consistent**?; ➢ **Workforce development** an issue in terms of the ability for practitioners to support vulnerable individuals and to work in the context of (often challenging) family circumstances. Potential to examine the role of specialist midwives (capacity, expertise, allocation, etc) and other professionals across Lancashire alongside the scope to enhance the role of community support for vulnerable families (peer support, etc); ➢ The **cohort of individuals who do not access any midwifery or antenatal services** throughout their pregnancy or access at a late stage – how do we identify, track and support these individuals? ➢ Some existing 'technical' issues regarding the **consistent supply of data** assist in identifying vulnerable individuals exemplified by the provision of early notification of pregnancy and live birth data to children's centres to enable the timely provision of support to families who do not currently use the centres, particularly in the most deprived areas. ➢ **Engagement of appropriate clinical and technical leads** is critical - Heads of Midwifery and dedicated Public Health Midwives (now established in some Maternity services) will have significant information to add to this stocktake. ➢ Need to be aware of **developments in UHMB** where there is a very intensive workstream to address problems identified by Monitor and CQC, which includes issues around how vulnerable families needs are met and ensure that HWB requirements are reflected within the work programme.

	➢ Number of concerns about the extent to which **Higher Education providers** (HEIs) are responding to the changing requirements e.g. how much are they preparing future workforce for integrated working, responsive to vulnerable families, lead professional role, etc. ➢ Variable progress with **Health Visitor Implementation plan** – e.g. extent to which Health Visitors are currently working ante-natally will vary significantly between CCGs. Opportunity to shape from the beginning what Health Visitors do ante-natally – rather than having to change practice retrospectively?			
Results: What does success look like?	• Consistent and safe supply of appropriate data across organisations to assist in the identification of vulnerable families where maternal health may be at risk • Targeted and coordinated support for vulnerable families which delivers improvements in maternal and child health and mental health and wellbeing • Measures: ? - to improve the % of women accessing midwifery services by 12 weeks (with the potential to reduce this to 10 weeks); ? – to reduce smoking in pregnancy; ? – to increase breastfeeding rates at initiation and 6-8 weeks; ? – to increase uptake of parenting programmes.			
Response: Programme of work	**Knowing:** a) Work to improve the consistent and safe flow of data regarding early notification and live births across Lancashire – minimum standard defined and % provision agreed b) Work to identify the number of	**Understanding:** a) Work to understand the current balance between health and social needs and the pathways for both. Links to the wider work around access to early support via Children's centres. b) Work to identify the opportunities	**Delivering:** a) Work to identify a cohort of individuals/ families through the Working Together With Families programme where first (and subsequent) pregnancy is present – undertake a patient	**Sustaining:** a) Work to examine the current role of, and commissioning arrangements for, specialist midwives – number, allocations, thresholds, impact, etc – and future potential versus the role of midwifery

	women who do not access midwifery services by 12 weeks – who, why, where – and how can we improve?	presented by existing programmes of work e.g. healthy weight, healthy child, infant mortality, Clinical Strategy workstream at UHMB, U18 conceptions, Solihull approach, to define vulnerability and target support. c) Work to identify the opportunities presented by the Health Visitor expansion programme (particularly around ante-natal work).	walkthrough comparing 'as is' to 'as should be'. Cohort in 3 selected districts – 1 per cluster area. b) Potential involvement of academic establishment (UcLan) to undertake walkthrough and examine the role played by the lead professional.	workforce overall. b) Work to examine the scope for community asset building around vulnerable families where a vulnerable pregnancy is identified (peer networks, etc) c) Work to engage HEIs in dialogue regarding the future working context for professionals e.g. integrated working, etc
Timeframes	a) By October 2012 b) By December 2012.	a) By March 2013 b) By October 2012 c) By October 2012.	a) By October 2012 and throughout 2013.	a) By March 2013 b) By October 2012 and throughout

			b) As above.	2013 c) Throughout 2012/13