North West Coast Clinical Networks

Supporting information

Mental Health for infants and children aged 0-5 years old: a strategy for Lancashire and South Cumbria, March 2025

1 Introduction

This document provides background information to the Lancashire and South Cumbria (L&SC) strategy on mental health for infants and children aged 0-5 years old. In this document, you can read more about existing provision in L&SC and the models of best practice that have been used to inform the strategy development.

2 Understanding current provision in L&SC

Families may access support for their relationships and mental health from conception to age five from a range of services. Details of those that are currently available in L&SC are summarised below and in Table 2.

2.1 Specialist 0-5 Mental Health Services

The only service providing specialist interventions for relationships for this age group in L&SC is the Blackpool Parent and Infant Relationship Service (PAIRS) [1]. The service provides a range of individual and group evidence based interventions for children aged 0-2 years old and group interventions for parents of children aged 2-5. The service also offers consultation and training to services and professionals working in Blackpool. Blackpool PaIRS meets the definition of a Specialised Parent-Infant Relationship Team, as set out by the Parent Infant Foundation [6]. The service is only available to families living in the Blackpool area.

2.2 Children and Young Person's Mental Health (CYPMH) Services

In L&SC CYPMH services are commissioned to provide mental health support from birth to age 25. However, there are not currently any specific teams or pathways in place to support infants and young children under the age of 5.

2.3 Health Visiting Services

Universal Health Visiting Services support all children up until the age of 5, including support to mental health and emotional wellbeing. Across L&SC, the training received by Health Visitors in 0-5 mental health is variable. Health Visiting caseloads have increased over the past decade [2] and as a result the mental health offer available from Health Visiting Services is variable across L&SC.

Specialist Health Visitors for Perinatal and Parent Infant Mental Health can offer an enhanced range of interventions and support to families and provide advice and consultation to colleagues within Health Visiting Services. These roles are not in place in all Places of L&SC and are of limited capacity.

Blackpool has transformed its Health Visiting Service, becoming the first area in England to offer eight visits to all families, instead of the nationally mandated five. Through Blackpool Better Start, the NHS and Local Authority were able to create space for change, focusing on outcomes, relationships and transforming the system. The enhanced health visiting service is provided within the same funding envelope as the previous offer but with an alternative and collaborative delivery. There was a focus on relationships and training Health Visitors to support parent and infant/early years relationships and mental health. All Health Visitors are

trained in NBO, Trauma-informed practice, PIMH Awareness. Some health visitors are also trained in Behavioural Activation.

2.4 Family Hub and Start for Life offer

Since 2022, Family Hubs in Blackpool and Blackburn with Darwen have received funding from the national Start for Life Programme [3]. Through this programme, Family Hubs were required to provide support for Parent Infant Relationships. Family Hubs have also been under development in Lancashire and South Cumbria.

2.5 Early Years Settings

Early Years education settings, such as nurseries and preschools should be aware of mental health and emotional wellbeing for the children under their care. Training of staff in 0-5s Mental Health working in these settings is variable and these settings are not accessed by all children.

2.6 Summary of provision

Support element	Description	Thrive Model
1. Relationships are promoted universally	The importance of relationships is promoted through universal interventions such as antenatal education groups and routine appointments.	Thriving
2. Relationships and mental health are discussed in routine universal appointments	Universal workforce has appropriate levels of training / awareness to recognise relationship needs and signpost appropriately. Specialist consultation on 0-5 mental health is available locally.	Getting advice
3. Targeted relationship support is available through universal provision	Evidence based interventions available through HV / VCSE / other for mild / moderate needs. Specialist consultation on 0-5 mental health is available locally.	Getting help
4. Specialist 0-2 Mental Health support	Evidence-based interventions delivered by parent infant trained staff where there is specific focus on relationships e.g. Specialist PIMH service or pathway within CYPMHS	Getting more help
5. Specialist 2-5 Mental Health support	Evidence-based interventions delivered by specialist trained staff where there is specific focus on the 2-5 age group e.g. Specialist MH service or pathway within CYPMHS	Getting more help
6. Specialist support available during crisis response / risk management	Specialist consultation on 0-5 mental health is available locally e.g. through a specialist team or as part of Children's Social Care.	Getting risk support

Table 1 - summary of support elements within a Health and Social Care system to support mental health of children from conception to age 5.

Support element	Blackpool	Blackburn with Darwen	Lancashire	South Cumbria
1. Relationships are promoted universally				
2. Relationships and mental health are discussed in routine universal appointments				
3. Targeted relationship support is available through universal provision				
4. Specialist 0-2 Mental Health support				
5. Specialist 2-5 Mental Health support				
6. Specialist support available during crisis response / risk management				

Full provision (Green)	Concordant with national or best practice guidelines and funding is stable.
Some provision (Amber)	Some provision, but does not meet best practice guidelines, is limited in capacity and/or has short-term funding.
No provision (Red)	No provision.
In development (Purple)	Services or initiatives are currently in development at time of writing (March 2025)
Unknown (White)	More data required.

Table 2 - overview of relevant service provision for Lancashire and South Cumbria by ICS Place.

3 What do families think of current provision?

From our engagement work to support this project and the PIER Best Practice Service Model [4] we have learned that parents are aware of this topic and are often comfortable talking about it, however stigma and taboo still exist, and the more parents worry about their relationship with their child, the less comfortable they are to discuss it. The symbiotic link between maternal mental health and infant mental health was strongly acknowledged by parents, leading to mothers feeling unfeasible levels of personal responsibility for their children's development.

Parents would value professionals leading conversations about their relationship with their child throughout the 0-5 period, but especially during the first year and at developmental checks [5]. Capacity building training into the workforce must prioritise those professions that have most contact with young families. GPs, midwives and health visitors remain the 'go to' professionals for the families we worked with, despite mixed experiences of care within these services.

The lack of current support within the L&SC means that informal sources of parenting support (advice from family and friends, internet, etc) are highly utilised, but not necessarily by preference.

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

Group activities, when accessed, are highly valued, for the benefits that come from accessing peer support for parents and for providing families with an opportunity to spend joyful time with their child.

"At the group… you could see how other people were… you could see that everyone was struggling with the same thing" – conversation participant.

The complexity of caring responsibilities in modern family life can work against the building of meaningful connections, especially with subsequent children in larger and /or multi-generational families. These spaces can also facilitate peer to peer relationships for both parents and their children. Infants and young children also value the opportunity to spend time with their peers and gain great benefit from doing so.

In terms of who parents would like support from, peer support is viewed as valuable, offering a different and potentially more accessible alternative to clinicians. Formal and informal peer support helps to build bridges between potential service users and services. This is relevant for all parents, but especially so for families facing additional barriers to access. Those in peer support roles need to be able to provide relevant, attuned support and therefore should have a significant degree of commonality to the communities they serve.

Families must have trust in services in order to access them, and relationships need to be built with the service provider to ensure this trust exists. Everything we were told highlighted the need to work with local populations to first understand the cultural context of local communities

and then to identify how these may facilitate or hinder access to services, co-producing alternative pathways where necessary in order to build this trust.

"You need a bridge person" – conversation participant.

Parents have reported a strong link between confidence in the practicalities of caring for children with increased levels of bonding and attachment. Every conversation facilitated in support of this work took a broader turn into topics including physical health, parental mental health and relationships, practical parenting issues, support (or lack of) from community and family and the role of educational settings. It was impossible to maintain a narrow focus on 0-5's mental health without also discussing these, and other, wider concerns. These conversations can be seen to mirror the complexity of family life in the early years and the wide-ranging support that families need to thrive.

The interrelations between everything a family experiences cannot be separated from the relationship a parent has with their infant. This is a highly complex time in a child's life which requires an intricate network of systems to provide the right assistance in the right way at the right time. What families are challenging us to create is a 0-5's mental health strategy which can cope with this complexity whilst providing services that remain holistic, effective and accessible to those in need.

Read more about the engagement approach that supported this strategy in the accompanying document: *Lancashire & South Cumbria 0-5 Mental Health Strategy, Listening to our communities*.

4 Health inequalities

It is important to acknowledge and consciously address the health inequalities that exist for the population of L&SC. Vulnerable groups in L&SC include ethnically and culturally diverse communities, LGBTQ+ communities, parents with learning disabilities and/or Autism/neurodevelopmental conditions, families in areas of high deprivation, families with low educational attainment and potentially others.

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

Research estimates [6] that 34% of infants born into low-income families experience disorganised attachments styles, whereas this decreases to only 15% for middle-class families.

Services must work to actively address these health inequalities through targeted engagement with at-risk communities and the development of trusting relationships with these populations

and the groups and leaders working amongst them. It is acknowledged that marginalised and more vulnerable families will need additional support to access services.

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

5 Understanding best practice

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

A visual representation of the PIERS model concept and how it strengthens and supports the community and individuals around a child and its family is presented in Figure 1 below.

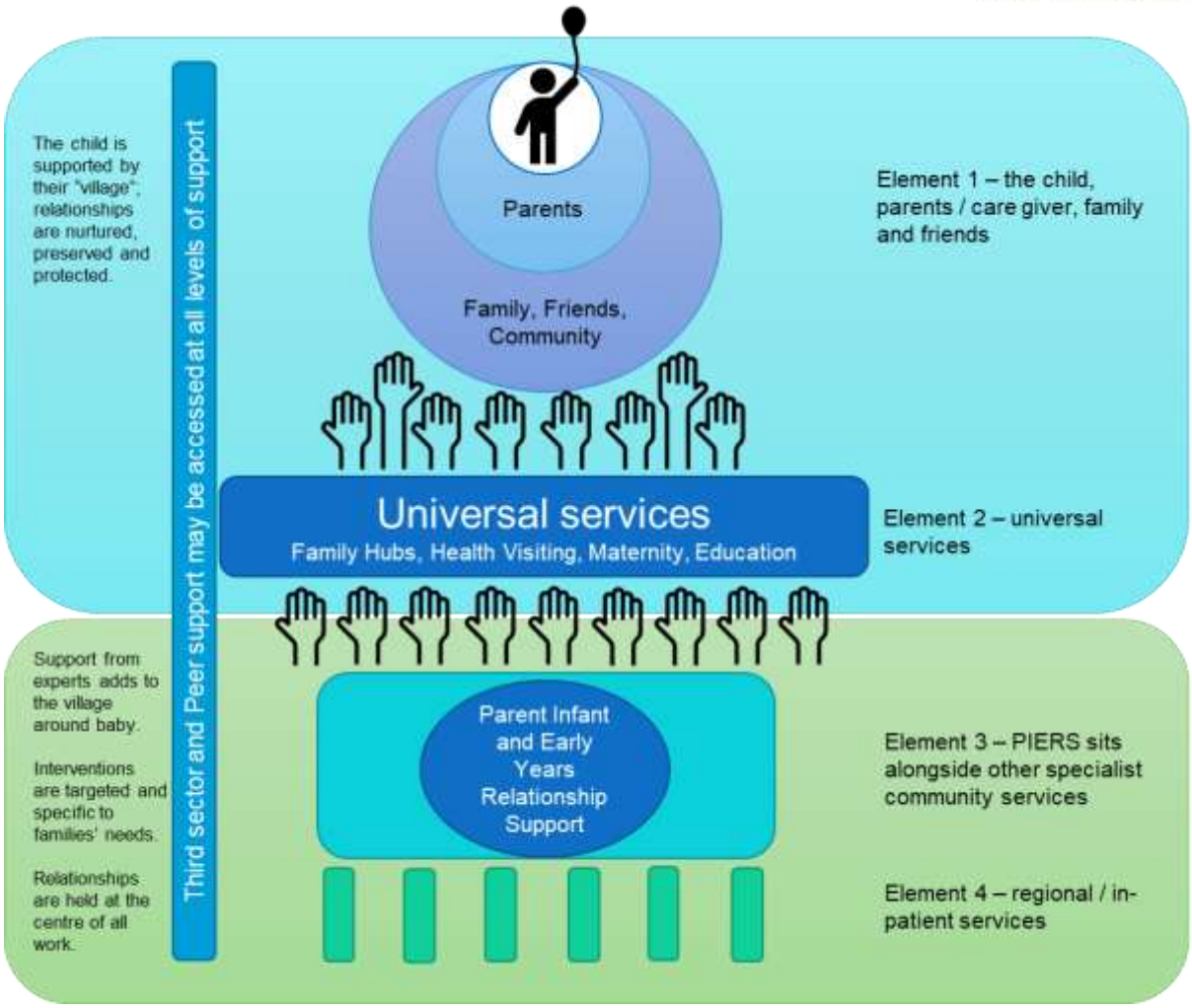

Figure 1 - a visual representation of the system of care surrounding a child with specialist 0-5 relationship support as a component.

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

The child is at the top. They are supported by all the layers below them and the closeness of the layers to the top tier represents how close those people are to the child – parents or caregivers next, then family and friends. This is the kinship village that is helping to raise this child. This may also include faith and community groups. The value of this support is recognised and nurtured by the whole system.

Element 2: universal services

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

Families will also link with their local Family Hub, to supplement the support from health care and to connect with other parents in their area. Family Hubs facilitate a "one stop shop" that

can provide for all needs of the new family without separating service types or need such as mental and physical health, behaviour, relationships, finances, education etc.

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

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

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

Staff in element 2 (universal) and 3 (specialist) would meet and discuss the concerns, understandings, connected emotions and plans for the family. These conversations would be made easier by the training and shared learning that they do together, having shared frameworks, models and language. This might result in the universal staff continuing to support the family, maybe in the way they were doing before but with more confidence, maybe in new ways. Families would experience continuity and useful developments in the relationships and work they are completing with these staff. Or staff in elements 2 and 3 might agree to see the family together. The family would experience this as an open and less formal enlargement of their 'village of support'; a 'warm inclusion' rather than a referral to a strange person and service.

Element 4: regional / inpatient / tertiary services

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

Key points of the model:

- Infant or child is supported by their village – PIERS model explicitly serves to support, preserve and nurture relationships.
- When specialist services are needed to offer support, advice or therapy to a family they should not do this in isolation. Specialist knowledge and skill is 'added into' the system around a infant or child, not separate from.
- The PIER Service temporarily joins the child's village when needed, as such it's vital that these specialist teams are physically located in communities.
- Professionals working within this system are offered a robust structure for both clinical and managerial supervision. This enables psychological safety for the professional so that they can successfully hold the infant in mind when supporting families.

5.1 What does good feel like?

5.1.1 Infant's perspective

An imagined account of an infant's experience of relationship support.

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

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

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

5.1.2 Young child's perspective

An imagined account of a three year old's experience of their relationships and mental health and how this changed with support.

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

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

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

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

5.1.3 Parents / carers

An imagined account of a parent's experience of accessing specialist parent infant relationship support. Based on and quotes taken from the Blackpool PaIRS Caring Connection video [1]:

I was in a really dark place when I started working with Lucy on my relationship with my infant. I don't do very well with new people at first but she's like a friend, she will come around she'll have a brew there's never a rush. I feel really at ease with her and that she really cares.

We worked on recognising which cry was which. I was quite proud that I made that step, and I saw then that little brain is developing because of me. I realised I am doing a good enough job. Part of it is adjusting to being a parent; you find a new version of yourself, Lucy helped me to see that.

I think I'm not my mother and I'm not my parents and I am good enough.

It's nice to have that bond, I feel really confident to be around her. I don't know where I would be now if I hadn't have said I need some help and got the help that I've got. It was the best thing that could have happened for me and my infant I feel like she's got a better mum.

An imagined account of a parent's experience of accessing community based, relationship informed support based on conversations with families that informed this strategy:

When I found out I was pregnant it was a bit of a shock. Life was already quite chaotic; we had not long been living in the area, and I had moved away from my friends, family and job to be closer to my husband's relatives. I wasn't sure how I would cope with being a Mum on top of all the other changes going on in my life. I felt very isolated.

Through my midwife I was told about our local Family Hub. At first, I didn't believe her when she said that the council put on free stuff for parents and families. I didn't go for ages because I thought that no-one there would be like me. I didn't want to be judged. But then I met a peer connector from a local charity when I was waiting for one of my routine appointments and they offered to go along with me.

I'm so glad I took that step. The antenatal support group leaders helped me understand how my baby was developing and what I could do to start to bond with her, even before she was born . I met some other first-time Mums, including one who lived just around the corner, and started to make friends.

By the time my daughter was born I already felt like her Mum. Although the first few weeks after her birth were really hard - my husband is self-employed and so I was on my own a lot of the time - I knew it would get better. When the Health Visitor asked me about my relationship with my baby, I told her that I felt like my daughter and I were a little team learning how to do this together. The skills I had learned in parentcraft classes also came in very handy, let's face it babies don't come with an instruction book!

Now my daughter is 6-months old and I still go to the Hub regularly for feeding support and to attend a baby activity group. It's lovely to have that time together, having fun and not worrying about the pile of washing sitting in the corner… I can see that my daughter enjoys it too. She has her favourite toys at the group and she does this big smile when she sees other babies that she knows! I value seeing the other Mums too, we share our worries as well as our baby's milestones and I always know one of them will understand what I am going through.

I don't like to think what mine and my daughter's life would look like if I hadn't gone along to that first group. I don't think I could do the job of being her Mum without the support of others. The days are so long, and the worry that you are getting it wrong is massive. Having

somewhere to go where you know you will get good advice and meet people going through the same stuff as you makes all the difference in the world.

5.1.4 Professionals

An imagined account of a Mental Health Professional working to support relationships for infants and young children:

To me, good looks like putting relationships at the heart of everything we do. I feel privileged knowing that I'm part of an early years system that truly values the power of relationships. It's a place where infants, young children and relationships are at the heart of everything we do, and where everyone is committed to making a positive impact.

I feel like I am a part of a developing and growing system that is working to improve services for families in L&SC. I can see that 0-5 relationship support services are not just a standalone entity; they are part of a pathway of support across our local area. Our services are integrated with others locally that makes moving between services feel like a seamless transition for families, creating a holistic network of support. Families are no longer at risk of falling between cracks or disengaging between referrals.

I know that I have a strong support network of colleagues who understand the difficulties of the work that we do. I know that I can access meaningful supervision when I need it and feel like others are able to hold me in mind so that I can continue to hold our vulnerable infants and children in mind. I feel like my own wellbeing is a priority within my workplace and I feel well-supported, both in terms of resources and professional development. I have access to ongoing training and supervision, which helps them stay updated with the latest research and best practices and makes me feel optimistic about my career progression in L&SC.

Within my role I can be flexible and innovative, this makes it possible to work collaboratively with colleagues across organisations and sectors which is in the best interest of families. As a team, we can offer a range of services such as parenting programmes, parent-infant relationship support, mental health support and community activities, all designed to strengthen the parent-infant relationships.

I get so see the positive impact that 0-5 relationships support is having on families. When parents feel supported and understood, it creates a ripple effect that benefits infants, children, families, the wider community and the whole early years system.

6 Principles of the strategy – in more depth

6.1 Understanding the voice of the infant, young child and caregiver

0-5 Mental Health Services exist to support infants and young children. It is essential that their views and experiences are prioritised in this strategy and during the development to support their needs. Infants and young children may not have the language to contribute directly to conversations around service development but they have the ability to communicate their needs and preferences about aspects of their lives and equal rights to express these.

To support the mental health of infants and young children, services must also work with the parents and care givers who look after them. It is important that the voice and opinions of these family members are also included throughout developments.

For infants, young children and families to make meaningful contributions, their voice should be considered and represented in strategic and decision-making processes in their local communities, actively shaping neighbourhood assets, pathways and provision. The North West Clinical Network prioritises asset-based co-production with families, undertaken as a continuous and iterative process, as illustrated in Figure 2.

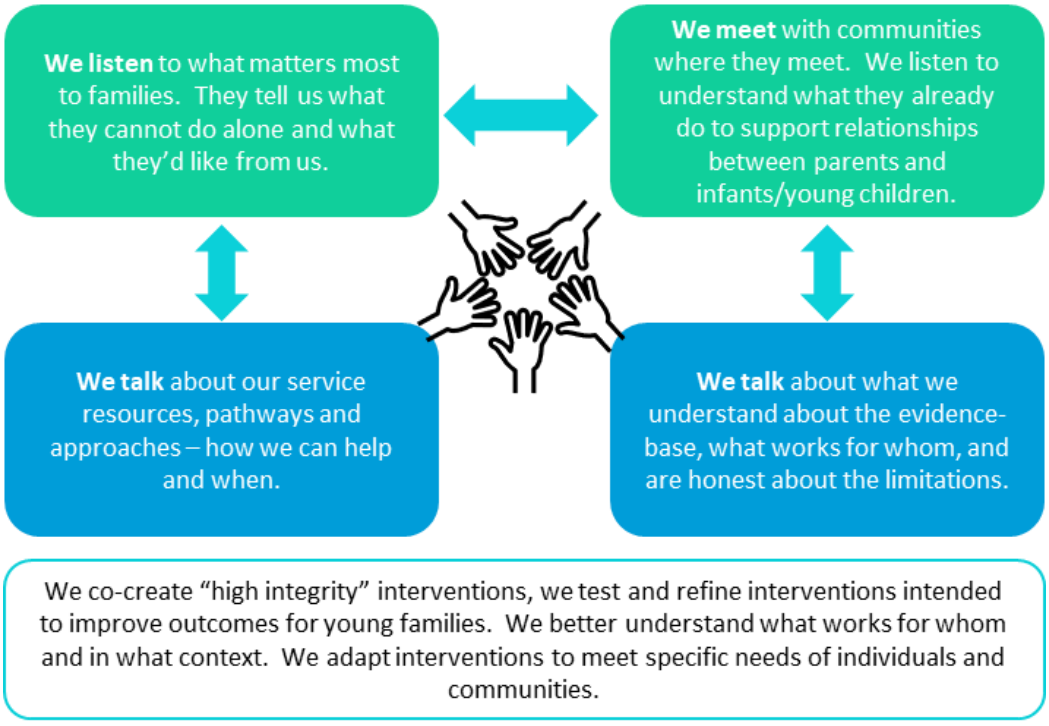

Figure 2 – The North West Coast Clinical Network approach to community engagement for the purpose of designing and developing appropriate and responsive services.

It is intended that engagement activity will continue as part of this strategy throughout and beyond the timeframes described. This is especially important in understanding the specific needs of local populations at a neighbourhood scale and the barriers to accessing services experienced by marginalised groups. Members of already marginalised populations often face double or triple exclusion owing to their gender, age, ability, ethnicity or other characteristics. This can result in differing priorities and make it difficult for parents to achieve consensus and

take collective action. Thus, locally driven approaches to developing services are essential, where parents and leaders at Place can centre their focus on local neighbourhood assets, structures and unique population needs.

When working infants and children under 5 years old, it is important to take a proactive approach to listening to and responding to their voice. It is vital that all stakeholders acknowledge the importance of this and commit to considering the infant/young child's perspective in all levels of decision making [7]. As a system, we can then start to conceptualise and consider the experience of infants/young children as part of business as usual, for example through inclusion in a family's records or in routine outcome measures and build a system that is meaningfully child-centric.

6.2 Valuing relationships

In alignment with the NWC PIER Best Practice Service model, this strategy describes services and systems that focus on relationships between infants/young children and their parents or care givers as opposed to the mental health of individuals. This is essential to deliver meaningful interventions in the early years.

This strategy strives to develop systems in which services and professionals are encouraged to take a "think family" approach. Through this approach, the mental health of all family members around an infant or child are considered in the context of their relationships. Within this approach, individuals are recognised and supported in their roles as parents, grandparents, siblings and care givers.

This ethos of valuing relationships extends beyond the infants, children and caregivers who might be using 0-5 mental health services to all of those working within this system. It is vital that trusting relationships exist between parents and professionals, as these relationships often facilitate access to support services.

Equally, across the system, relationships will be valued between professionals. This will support integration of 0-5 mental health services within the local system and will support joint working in the interest of infants and young children. A system that values relationships will promote trauma informed approaches throughout and help to ensure that families receive warm transfers of care, during which they are introduced, not referred between service providers.

"Change moves at the speed of trust." – Stephen M.R. Covey

This strategy is also intended to support a shared ethos and common approach across the L&SC system in which relationships are valued, supported and invested in. This will support a consistent, trauma informed approach to care and will support our system to evolve with infants, young children and families held central.

Valuing relationships through all elements of this strategy will support our system to adopt this consistent approach at both Scale and Place and will be embedded within workforce training, awareness raising, supervision and the interventions offered by services.

6.3 Developing concurrently at Place and at Scale

6.3.1 Place

This strategy recognises that the local Places within L&SC are unique and distinct from one another. The Blackpool PaIRS team has been developed with the Blackpool community and population in mind and for this reason cannot be exactly duplicated in other communities of L&SC and expected to thrive. Across L&SC there is significant variation in demographic measures such as deprivation, population health outcomes, age and ethnicity.

The development of both specialist and universal support needs to be place based to promote:

- Understanding of local populations and their needs, challenges and culture
- Understanding of local services, structures and systems
- Positive working relationships across the system

For this place-based approach to succeed, community powered co-production will be essential, where parents and leaders at Place can centre their focus on local neighbourhood assets, structures and unique population needs to build systems that are relevant to and sustainable for the populations they serve.

A key element of this will involve working closely with local Family Hub development workstreams. Local systems should be designed to align with these services and assets as they currently exist and as they are planned to develop in the future. Equally, an understanding of and alignment with the Voluntary, Community, Faith and Social Enterprise (VCFSE) offer at place will be required. VCFSE organisations can provide an alternative support option to statutory services that can be perceived as being more accessible, less risky and with reduced stigma attached. Working closely with VCFSE groups can offer insight to a community and routes to link in with local populations to support service development and awareness locally.

Developments at place should include stakeholders from the following local services and organisations:

- Local service user groups, this may include (but not limited to): Family Hub parent/carer panels, Maternity and Neonatal Voices Partnerships, user groups from other statutory and VCFSE organisations.
- Health Visiting
- Maternity
- CYP Mental Health
- Relevant VCFSE organisations
- Family Hubs
- Primary Care Network
- Early Years Education
- Social Care

Other relevant organisations might exist at each Place.

6.3.2 Scale

In parallel with developments at Place, this strategy offers a unique opportunity to monopolise on the benefits that can be reaped from developing systems offer at scale. One of the key challenges for the PIER offer in L&SC at present is the significant variation in service offer across the area. This strategy presents an approach that will address this inequity by implementing the learning from the Blackpool PaIRS development.

Developing concurrently at scale could facilitate equitable service offer across the geographical area, ensuring that no areas or populations are left behind. The ICS was recently established as an agency to improve health and reduce health inequalities, a structure that should support a system wide development such as this.

Specialist PaIR Services are small teams with highly specialised skillsets. When working with a Place based population, these teams can be limited by difficulties in recruiting and capacity, especially for elements such as the provision of clinical and managerial supervision which requires highly qualified professional skills. Additionally, these small teams can be stretched when required to deliver all core elements of the service, i.e. offering consultation and training alongside direct interventions. A service that operates across the whole ICS area could offer a centralised regional team. This team would be well placed to offer clinical and managerial supervision across all the Place based teams, as well as increased capacity for training and consultation. These approaches have become more feasible with the introduction of remote working practices.

Place based teams within a L&SC wide service would also benefit from working at scale through increased opportunities for peer support and shared learning, as well as increased opportunities for career development without losing talent outside of the area.

For the universal workforce and the development of the system around the specialist service, benefits of working at scale would include greater access to training offer which would support the development of the workforce.

With this approach, resources could be shared between more professionals and teams, across both the specialist and universal workforce.

By approaching this system of development at an ICS scale, each iteration in the development of the hub and spoke model would allow learning to be captured and implemented. Approaches to service development and deliver could be standardised across the area, allowing each team established to learn from those preceding it.

Developing at scale could also facilitate the implementation of consistent values and principles and could inform a coherent ethos around user voice and relationship-based approach, as described below.

6.4 Data

In this strategy, we recognise the vital role that data and data systems can play in developing services that are efficient and responsive to the needs of both populations and health care professionals.

- The development of this strategy will be informed by data from across L&SC and will encourage evidence-based development of services and systems in the future.
- Services will be designed to collect, understand and act on data from inception as part of standard operating procedures.
- The data collected during service delivery will be used for routing service evaluation.
- As part of this approach, outcome measures that consider the goals of both the infant and the parent will be standardised across the system to allow comparison and consistency between sectors and providers.
- The data collected should consider the representation of the infant or young child's voice and should reflect their experiences of services.
- Both qualitative and quantitative data should be collated throughout service design and delivery and should be relevant to the evaluation.
- Agreements and procedures should be established to ensure consensual data sharing is enabled across the system, for example between service providers and organisations working across sectors. Data collection should be consistent at Scale across L&SC.
- To accurately monitor and consider equity of access, the service will routinely record quality ethnicity and social deprivation data for families who use services. In turn, data will inform how to best target resource and outreach activity to communities or neighbourhoods.

7 Return on investment

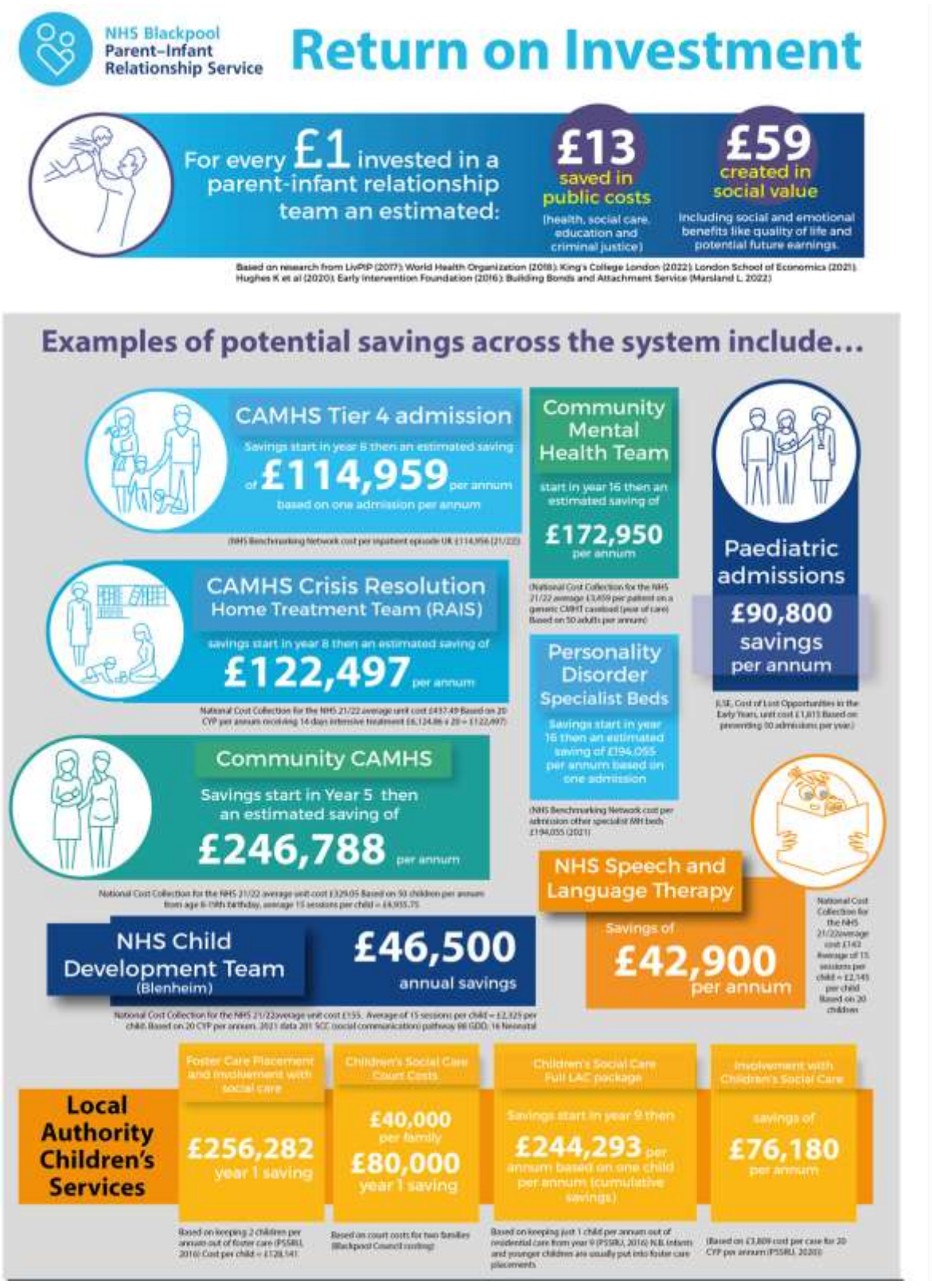

Figure 3 - infographic to describe the economic impact of parent-infant relationship support interventions. Developed by Blackpool PaIRS, 2024.

8 References

1. More information about NHS Blackpool Parent-Infant Relationship Service (PaIRS): https://www.blackpoolteachinghospitals.nhs.uk/services/parent-and-infant-relationship

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