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Perinatal and Infant Mental Health Care in the South West: Improving Care Pathways

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1 Foreword

It is widely acknowledged that the impact of mental illness on families can be significant and long term. Mental Health Services in England are a stated priority for the government and are included in the NHS England Business Plan, 2015/16 and the NHS Five Year Forward View, 2014. The South West Maternity and Children's Strategic Clinical Network (SCN) has prioritised Perinatal and Infant Mental Health (PIMH) since the launch of the Network in July 2013. Mental Health services for mothers and children are widely acknowledged to be inconsistent and inequitable across the country.

It was against this background that the South West Mental Health and Dementia SCN and the South West Maternity and Children's SCN agreed to jointly lead a review of perinatal and infant mental health services across the care pathways. We acknowledge the huge contribution to improving our perinatal and infant mental health services from all the organisations, individuals, professionals and clinicians who gave their time, energy and expertise to this review.

During this work we heard stories about the devastating effect mental illness can have on women and their families at a time when they expected to be enjoying life with their new baby. Often it is fathers and partners who bear the brunt of the impact of mental illness whilst they continue to provide support to their family. Sometimes this is made even more difficult by long periods of separation involving an admission to an inpatient service which could be some distance from the family home or admission to an adult mental health bed and separation from their infant.

Professionals have a strong desire to provide better services for women with perinatal mental illness and their families but are often frustrated by real and perceived barriers such as organisational and professional boundaries. Sharing best practice and using the wealth of evidence available informed the development of recommendations for improving service provision along the care pathways in the South West. Throughout the review there was an impressive willingness from individuals and organisations to work together to improve services.

The recommendations presented here have been developed collaboratively between professionals, commissioners, providers and service users and lay the foundations for improved perinatal and infant mental health services in the South West.

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2 Executive Summary

More than one in ten women will suffer from a perinatal mental illness, spanning from adjustment disorders and stress, through to chronic serious mental illness and postpartum psychosis. The price to society is high, both on a human and economic level. The human impact is felt not only by the women suffering from perinatal mental illness, but also by their children, partners and families. Studies have shown an increased risk of child mental health problems in those whose mothers had suffered from anxiety and/or depression.

Improving perinatal and infant mental health services is a recognised priority nationally, being included in the NHS Five Year Forward View and the NHS England Business Plan. The Maternal Mental Health Alliance's Everyone's Business Campaign and the London School of Economics and Centre for Mental Health's report into the costs caused by perinatal mental health problems have increased the focus on the need to improve services.

Perinatal and Infant Mental Health has been a priority for the South West Maternity and Children's Strategic Clinical Network since its formation in 2013. This project has been undertaken as a joint venture with the South West Mental Health and Dementia Strategic Clinical Network, with the aims of gaining greater understanding of the provision of services relating to perinatal and infant mental health within the South West and developing a set of recommendations for improving service provision along the care pathways within the region. Mapping of existing services was undertaken by Ostara Consulting Ltd between February and April 2015 and a set of three stakeholder meetings were held in May and June 2015, resulting in the information and recommendations contained within this report. Opportunities for direct public engagement within this project have been limited due to the tight timescales; however, Bluebell Care in Bristol kindly facilitated feedback on a set of questions via their support group sessions to assist in gaining insight into the care received and the experience of women throughout their journey to date.

Based on the information gathered and conversations held between all three stakeholder meetings and in line with national guidance, the South West Strategic Clinical Networks for Mental Health and Dementia and Maternity and Children have developed the following recommendations:

Clinical Commissioning Groups (CCGs) should:-

- Ensure that a local perinatal and infant mental health strategy is in place, which has been developed with providers and commissioners from all parts of the system, service users and third sector organisations, so that women, their children and their families receive the right care in the right place at the right time.

- Ensure that this strategy results in a local integrated care pathway, which all providers are compliant with, which incorporates the following:
  - Is well-understood by all clinical staff, enabling them to signpost and give information as required
  - Mechanisms to ensure early identification of emergent mental health problems

  - Clear referral processes at any stage during the perinatal period when there is a history of mental illness, a mental wellbeing problem is suspected or there is the sudden acute onset of mental ill health
  - Clarity around availability of services
  - Incorporates a clear definition of who is responsible for a woman's mental health and maternity care once perinatal mental illness has been diagnosed or suspected
  - Follow-up and support post-recovery including promoting sound infant-parent attachment
  - Mechanisms to ensure the straightforward sharing of appropriate patient information between the agencies involved in her care
  - Each local system will have in place a mechanism for providing women and their families with a consistent, validated set of information resources, that are always up-to-date

- Ensure that within the pathway there is access to specialist community services that provide an alternative to hospital care where safe and appropriate, and through which clinicians in other parts of the system can access specialist advice and support

- Provide systems leadership, either directly or commissioned through a local provider, which provides a regular forum for providers to communicate, collaboratively innovate, and collectively address issues and challenges which impact upon the experience of women and their families

On a South West basis:-

- A co-commissioning exercise between CCGs and NHS England Specialised Commissioning be undertaken to scope the need for in-patient beds in the South West, leading to the identification and commissioning of the in-patient capacity required. Central to this scoping exercise will be the role of specialist community services, and the opportunities for co-commissioning alternatives to hospital admission

- In collaboration with Health Education South West (HESW), a perinatal and infant mental health workforce plan be established which describes the knowledge and capabilities required by staff at every stage of the PIMH pathway, and identifies training and education routes through which staff can gain these skills and capabilities

- The experience of women and their families will be systematically captured and used to inform service development

- Data is identified, collected and reported on a routine basis to monitor service provision and drive improvement

The South West Maternity and Children's Strategic Clinical Network is currently undertaking a project to develop a set of patient centred outcome measures (PCOMs) for those suffering from perinatal mental illnesses. This will take the form of a simple set of questions regarding women and their families' experience of perinatal and infant mental health

services, with the aim of providing a clear reflection of the outcomes/experience of women and their families across the South West. The measures will provide a basis for reviewing current service provision and the impact of future changes.

3 Background

It is estimated that over one in ten women will suffer from a perinatal mental illness. A range of services is required to ensure the early identification and expert management of these illnesses in order to reduce the impact not only on the women, but on families as a whole, including their children.

In 2012 the Joint Commissioning Panel for Mental Health published 'Guidance for Commissioners of Perinatal Mental Health Services'. The incidence rates from this document, together with extrapolated national figures and those for the South West, appear in the table below.

Estimated incidence of Perinatal Mental Illnesses			
Disorder	**Estimated rates per 1000 maternities** (JCPMH, 2012)	**England figures** (Based on ONS 2013 live birth data – 664,517)	**South West figures** (Based on ONS 2013 live birth data - 58,710)
Postpartum psychosis	2	1329	117
Chronic serious mental illness	2	1329	117
Severe depressive illness	30	19,936	1,761
Moderate depressive illness and anxiety states	100 – 150	66,450 – 99,675	5,871 – 8,807
Post-traumatic stress disorder	30	19,936	1,761
Adjustment disorders and distress	150 - 300	99,675 – 199,355	8,807 – 17,613

The impact on the children of women suffering from perinatal mental illnesses can be seen even before they are born, with studies having shown that many perinatal mental illnesses can increase the risk of both early delivery and low birth weight of the infant (Hogg, 2012).

Unless appropriate treatment is received, infants of mothers who are suffering from perinatal mental illnesses are at risk of not being provided with the sensitive, responsive care that they need to fulfil their potential in life. Recent studies suggest a strong link between the mental health of the mother during the perinatal period and that of the child, often having a detrimental effect on the parent-infant relationship and causing an increased risk of child mental health problems in those whose mothers had suffered from anxiety and/or depression (Pawlby et al., 2009).

It should be noted that perinatal mental illness impacts fathers also, with 25-50% of fathers with depressed partners suffering from depression themselves. This has been shown to affect not only the relationship of the couple but the developing infant also (Hogg, 2012).

In addition to the human impact incurred by inadequate perinatal and infant mental health care, there is also the economic impact, as highlighted by the London School of Economics and Centre for Mental Health's recent report, which estimates that perinatal mental health problems cost the UK £8.1 billion each year.

There has been an increasing national focus on the importance of perinatal and infant mental health within recent years, with campaigns such as the Maternal Mental Health Alliance's Everyone's Business campaign highlighting the need for every woman experiencing a perinatal mental health problem to receive the care that they and their families require. A wide range of evidence based guidance and best practice is available to inform the design and development of perinatal and infant mental health services. Two of the most comprehensive are the NICE guidelines for antenatal and postnatal mental health (CG192) and the NSPCC's Prevention in Mind report.

In addition to the clinical guidance on offer, all local NHS systems in England are aware that services must be shaped by the priorities of the NHS Five Year Forward View. This includes a review of perinatal mental health services, as part of the Maternity Services Review, by Autumn 2015 and new waiting time standards for people entering a course of treatment in adult Improving Access to Psychological Therapies services. The NHS Outcomes Framework 2015/16 includes improving the patient experience of community mental health services. The NHS England Business Plan 2015-2016 commits to the development and implementation of access and waiting time standards for perinatal mental health, with the policy document Mental Health Services: Achieving Better Access by 2020 clearly stating the aim of achieving parity of esteem between physical and mental health by 2020. National funding for perinatal mental health services has recently been announced, with £75 million being made available nationally over the next five years.

Perinatal and infant mental health has been a priority for the South West Maternity and Children's Strategic Clinical Network since its inception in 2013. The Network's Perinatal and Infant Mental Health Working Group consists of a wide range of members, both professionally and geographically, informing the development and leading the delivery of the Network's work programme.

There has been a growing momentum across the South West to consider the development of perinatal and infant mental health services, to improve outcomes and experience for women, their infants and families. As a consequence of this, a joint piece of work was initiated by the South West Mental Health Strategic Clinical Network and the South West Maternity and Children's Strategic Clinical Network to jointly lead a review of perinatal and infant mental health services across the care pathways.

4 Project Outline

The Strategic Clinical Networks for Maternity and Children and for Mental Health and Dementia have jointly facilitated a project; the aims of the project were two-fold:

- To carry out a mapping exercise to understand what services are provided in each of the 11 CCG areas in the South West
- To develop recommendations for improving service provision along the care pathways in the South West

The service mapping was undertaken by Ostara Consulting Ltd. between February and April 2015. The Strategic Clinical Networks held three meetings of a stakeholder group between May and June 2015 to consider the results of the service mapping exercise, to undertake a review of the existing care pathways in the South West and to develop the recommendations detailed in this report. This stakeholder group consisted of a wide range of participants from across the region, including clinicians, commissioners and third sector organisations.

5 Mapping Perinatal and Infant Mental Health Services in the South West

The detailed service mapping carried out in early 2015 is included as Appendix 1 of this report. Key stakeholders were identified in each CCG area. These included:

- Children and Young People's Commissioners
- Child and Adolescent Mental Health Services (CAMHS) Commissioners
- Heads of Midwifery
- Health Visitor Leads
- Maternity Commissioners
- Mental Health Commissioners
- Mental Health providers, accessed via Medical Directors
- New Horizons Mother and Baby Unit (MBU), Bristol, as a regional resource

Service-specific surveys were sent to each Head of Midwifery and Health Visiting Lead. A focus was placed on pathways of care, interfaces between services, and non-NHS community support services. Interviews were set up with commissioners and service providers to add to the detail gathered via the surveys. The majority of these were telephone interviews, with some face-to-face meetings being held. All findings were collated and presented within a consistent template format. Although New Horizons has a remit across all South West CCGs, the findings from that interview are also presented in template format. The full report is available separately as 'Perinatal Mental Health Services South West Mapping'.

The strongest headlines from the Mapping Report included:

- Only two CCGs (Northern, Eastern and Western Devon CCG and South Devon and Torbay CCG) in the South West commission a full Specialist Community Perinatal Mental Health (SCPNMH) service which meets the level 5 requirements in the Maternal Mental Health Alliance's 'Everyone's Business' national mapping. A further CCG (Kernow) commissions a service that ranks at level 3 within this mapping. Details of the criteria involved can be found via the Maternal Mental Health Alliance's website, listed in the references section.
- Many staff are working extremely hard, within existing resources, to generate as much service improvement as possible without additional investment. Where this is most successful, the effort has been driven by a committed individual who has been able to demonstrate strong leadership.
- Even where services are better developed, concern was expressed about the significant gaps in support for women with perinatal mental health issues – the most common concern being about gaps in service for women with moderate needs.
- Where services are operating without an agreed care pathway or a service-specific set of standard operating procedures, the clinical response to vulnerable women is inconsistent. Responses from these services are based solely on the level of knowledge and awareness of each clinician along the route. Examples were given of where this has resulted in sub-optimal care.

6 Summary of Information Gathered through the Stakeholder Group Meetings and Service Mapping

The collaborative vision for perinatal mental health support for women and their families in the South West developed throughout the stakeholder meetings is:

> All women will receive perinatal mental health support that is timely, easy to access, and delivered by skilled and knowledgeable professionals. The service response to these perinatal mental health needs will enable each woman, her baby and the rest of her family to have the best possible short and long-term outcomes.

The information collected through the three stakeholder meetings has been collated and presented in Appendix 2. The information has been structured to reflect the woman's journey through her pregnancy. The stages were agreed as:

- Pre-conception
- Booking and early pregnancy
- Later pregnancy
- Birth
- Postnatal

Within these stages of pregnancy, the following distinctions in mental wellbeing were made:

- Is well, with no known mental health issues

- Has no history of mental health problems but mild/moderate issues are identified in pregnancy
- Has an active mental health plan in place. She has a known condition that may deteriorate in pregnancy or post-partum
- Is currently well and not accessing mental health services. She has had previous mental health problems and is at high risk of relapse
- Has no history of mental health problems but suddenly becomes severely unwell

These distinctions in mental wellbeing do not indicate a hierarchy, or a sequential escalation of need. The stakeholder group strongly recognised that a woman can present with any level of need at any time during her pregnancy, birth or postnatal period. There was also recognition that progress to recovery is not necessarily continuous. There is, however, an opportunity through routine pregnancy screening to identify issues early and to intervene quickly, in order to prevent escalation.

The tables within Appendix 2 represent the views of the stakeholder group regarding the support that should be offered at each stage of pregnancy and at each level of need.

The information has informed the development of the recommendations within this report, as well as being made available for planning purposes by organisations involved in the commissioning and provision of perinatal and infant mental health services across the South West.

The following high level messages emerged from the stakeholder meetings in relation to common shortfalls in service provision across the South West:

- Services are inconsistent and inequitable across the South West – both for women and their infants
- Many clinicians report concern about holding risk, with no clear routes for escalation of identified issues
- There is a lack of awareness and skills around perinatal and infant mental health in the wider workforce, including within mental health services
- Skills in enabling conversations with women are not consistent
- Insufficient training is available to support best practice in perinatal mental health
- Contractual arrangements for mental health services inhibit their ability to be sufficiently responsive to the rapidly changing needs of pregnant women
- There are structural barriers to co-ordination between services, e.g. information sharing systems
- Lack of data availability across all services is hampering service development
- Funding constraints are limiting the pace at which implementation of best practice can be achieved

The participants of the stakeholder meetings highlighted that any care pathway needs to include the following core principles:

- Women, their babies and partners are central to all discussions
- The strong development of the mother-infant relationship should be supported
- Service responses to women’s perinatal mental health crises should be comparable with those for physical crises, e.g. post-partum haemorrhage

- Universal and targeted services must be able to access specialist perinatal mental health advice systematically, not based on goodwill or personal relationships
- Services need to be available seven days a week
- There must be effective communication between local services in order to develop strategic direction, models of care and investment plans

Because the support network for women with perinatal mental health issues is complex and involves many agencies, there is an even greater need for each agency to be constantly alert to the safeguarding needs of the unborn child or infant. This thread should run through all care planning, bearing in mind that:

"All agencies in contact with children and their families have a responsibility to act if they become worried about a child's welfare or a parent's ability to care for a child safely and adequately. The welfare of the child is the paramount consideration. If a child is at risk of harm this must override concerns about the parent's wishes or welfare. If there is a risk of, or there are concerns about, suspected child maltreatment, follow local safeguarding protocols.

All professionals should carry out a risk assessment in conjunction with the woman and, if she agrees, her partner or family member, that focusses on areas that are likely to present possible risk such as self-neglect; self-harm; suicidal thoughts and intent; risks to others (including the baby) smoking, drug or alcohol misuse; and domestic violence and abuse. If any risk is identified actions should be taken in-line with relevant local pathways."
Draft Swindon Integrated Perinatal Mental Health Pathway and Implementation Strategy 2015, Swindon Borough Council/Swindon CCG

The following positive messages were felt strongly throughout the process of stakeholder meetings:

- There is a strong impetus across the South West to make improvements
- Momentum within local areas to resolve issues has generated creative solutions
- The ability to only take small steps does not need to hamper aspiration
- The quality of local inter-agency relationships is a strong enabler to progress in challenging environments
- Including the voice of lived experience in service design, development and delivery is powerful in shaping progress
- There is a strong economic argument for getting the right response to women the first time

7 Public Engagement

Tight timescales for this project meant that the opportunities for direct public engagement have been limited. However, the SW SCN for Maternity and Children undertook service user engagement via Bluebell Care in Bristol, who kindly facilitated feedback via several of their support group sessions for women suffering from perinatal mental health issues. Feedback was gathered via a set of questions, which were developed to gain insight into the care received and the women's experience throughout their journey to date.

Headlines from the feedback received included the following:

- The majority of first contacts were with General Practitioners (GPs) or Health Visitors
- More antenatal information, advice and support is required
- Many felt that professionals' knowledge of the services available could be increased
- The importance of professionals listening and taking women's concerns about their mental wellbeing seriously
- Many women felt unhappy with the support that they had received during parts of their journey

Below is a small sample of comments made by the women who responded to the questions:

'Felt judged – booked to see an alternative GP'

'Health Visitor told me to see GP and get out of house everyday – no further follow up unless at weigh-in'.

'The GP I saw for my postnatal check didn't ask about my mood/how I was coping despite my history of anxiety and depression.'

'(I didn't feel…) very safe – was really worried about social services getting involved'

'Mother focus (needed) rather than just baby focus'

'(I wish I'd…) known more about antidepressants, known more about accessible help, had someone to talk to.'

8 Recommendations

Based on the information gathered and conversations held between all three stakeholder meetings and in line with national guidance, the South West Strategic Clinical Networks for Mental Health and Dementia and Maternity and Children recommend the following:

CCGs should:-

- Ensure that a local perinatal and infant mental health strategy is in place, which has been developed with providers and commissioners from all parts of the system, service users and third sector organisations, so that women, their children and their families receive the right care in the right place at the right time [1]

- Ensure that this strategy results in a local integrated care pathway, which all providers are compliant with, which incorporates the following[2]:
  - Is well-understood by all clinical staff, enabling them to signpost and give information as required
  - Mechanisms to ensure early identification of emergent mental health problems.
  - Clear referral processes at any stage during the perinatal period when there is a history of mental illness, a mental wellbeing problem is suspected or there is the sudden acute onset of mental ill health
  - Clarity around availability of services
  - Incorporates a clear definition of who is responsible for a woman's mental health and maternity care once perinatal mental illness has been diagnosed or suspected
  - Follow-up and support post-recovery including promoting sound infant-parent attachment
  - Mechanisms to ensure the straightforward sharing of appropriate patient information between the agencies involved in her care

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Evidence

[1] Ensure that a regional perinatal mental health strategy is present and that all providers of care for perinatal mental health problems are participating. (JCPMH) p.3

A comprehensive perinatal mental health strategy should encompass all levels of service provision no matter if those services are commissioned by the NHS Commissioning Board or Clinical Commissioning Groups. Robust care pathways, education, training and resourcing of non-specialists is essential to ensure that "the right patient reaches the right service where they are seen by the right professional at the right time." (JCPMH) p.5

[2] Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care
services) should ensure that:
- there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways. (NICE) p.43

Ensure that there is a perinatal mental health integrated care pathway in place which covers all levels of service provision and severities of disorder. All service providers should be compliant with this so that there is equitable access to the right treatment at the right time by the right service. (JCPMH) p.3

GPs and other primary care staff being made familiar with the perinatal mental health integrated care pathway. (JCPMH) p.3

  - Each local system will have in place a mechanism for providing women and their families with a consistent, validated set of information resources, that are always up-to-date

- Ensure that within the pathway there is access to specialist community services that provide an alternative to hospital care where safe and appropriate, and through which clinicians in other parts of the system can access specialist advice and support[3]

- Provide systems leadership, either directly or commissioned through a local provider, which provides a regular forum for providers to communicate, collaboratively innovate, and collectively address issues and challenges which impact upon the experience of women and their families[4]

On a South West basis:-

- A co-commissioning exercise between CCGs and NHS England Specialised Commissioning be undertaken to scope the need for in-patient beds in the South West, leading to the identification and commissioning of the in-patient capacity required. Central to this scoping exercise will be the role of specialist community services, and the opportunities for co-commissioning alternatives to hospital admission

- In collaboration with Health Education South West, a perinatal and infant mental health workforce plan be established which describes the knowledge and capabilities required by staff at every stage of the PIMH pathway, and identifies training and education routes through which staff can gain these skills and capabilities

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Evidence

[3] A specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services;
access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding (NICE) p.12

Women with serious mental illness complicating childbirth need specialised knowledge and skills on the part of the professionals who care for them. These include specialist knowledge of the risks and benefits of medication in pregnancy, the skills to manage and nurse seriously mentally ill women, at the same time as enabling them to meet the emotional and physical needs of their infants. (JCPMH) p.7

Good perinatal mental health services will include a range of services including:
- specialised community perinatal mental health teams (JCPMH) p.14

A good specialised community perinatal mental health team will be a member of the Royal College of Psychiatrists' quality network. It will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately managed by primary care services. (JCPMH) p.15

[4] Good perinatal services should be part of a clinical network. With so many different agencies and services, providers and differing commissioning arrangements in the pathway of care from early pregnancy through to the postpartum period, it is essential that systems are in place to maintain the integration and collaboration of these agencies. Part of the perinatal mental health strategy should include a managed (strategic) network made up of all stakeholders, including patients' representatives, to ensure the functioning of the whole service pathway and to allow for development and innovation as new evidence arises. A clinical network also has the important function of advising both commissioners and providers. (JCPMH) p.14

- The experience of women and their families will be systematically captured and used to inform service development

- Data is identified, collected and reported on a routine basis to monitor service provision and drive improvement

9 Measuring Outcomes – Developing Patient Centred Outcome Measures

The South West Maternity and Children's Strategic Clinical Network is currently undertaking a project to develop a set of patient centred outcome measures (PCOMs) for those suffering from perinatal mental illnesses. This will take the form of a simple set of questions regarding women and their families' experience of perinatal and infant mental health services.

The aim of this project is to provide a clear reflection of the outcomes/experiences of women and their families across the South West in relation to perinatal and infant mental health services throughout the care pathway for the providers and commissioners of these services.

It aims to reach a wide range of women, including those with disabilities, those who are disadvantaged and other minority groups, ensuring that equality and diversity are central to the project. It will be available both digitally and on paper to facilitate completion by a wide range of individuals throughout the perinatal period.

The survey will be developed by November 2015 and will be piloted by Kernow CCG during March 2016. The eventual aim of the Network will be for rollout of the survey across the South West.

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Appendix 1 - Area Mapping Templates

This appendix contains detailed information, gathered as part of a mapping exercise carried out across the South West between February and March 2015.

The templates are presented to match the CCG geographical footprints, with an additional template that relates to the region's Mother and Baby Unit, located in Bristol.

Name of CCG	Bath and North East Somerset
Maternity Service Provider(s)	Royal United Hospitals Bath NHS Foundation Trust
Health Visiting Service Provider	Sirona Care and Health
Mental Health Provider(s)	Avon and Wiltshire Mental Health NHS Trust Oxford Health NHS Foundation Trust (CAMHS)
Population: women 15-45	36,600
Total Fertility Rate[5] (ONS 2013)	1.74 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	In development RUH has an internal Policy
Care Pathways in place?	No pathways in place
Pre-conception planning	No formal service in place
Midwifery Input	• Some ad hoc training provided by New Horizons Unit • Mental health assessed at booking and every contact, using Whooley questions, with plan to introduce anxiety scales • Midwife with specialist interest (0.5 WTE) runs joint Perinatal Mental Health Clinic with Liaison Mental Health Nurse at RUH. Additional midwife has undertaken further training in her own time, to support community clinic • Information shared via the Health Visitor / Midwife Liaison Pathway
Health Visiting Input	• Antenatal and Postnatal Promotional Guide training plus Neonatal Behaviour Observation • Mental health assessed routinely at universal contacts and pre- and post-HV interventions • Tools used are Whooley questions, EPDS, HAD / CORE, PHQ9 / GAD7, NBAS • Standard Operating Procedure not in place for identification, assessment and management of women with mental health issues • No Specialist HV in post, but a designated perinatal mental health lead within the service • Information is shared via the Health Visitor / Midwife Liaison Pathway • Support options and pathways into those options clear and well-understood by all staff • Specific HV inputs include: Listening Visits, Baby Feeding Hubs, Moving On Up (movement and dance therapy)
GP Input	• Consistent support to women across area, with quick response on individual basis • Routine 6 week postnatal check

[5] The total fertility rate (TFR) is the average number of live children that a group of women would each have if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lives. The TFR provides an up-to-date measure of the current intensity of childbearing. TFRs for subnational areas (that is regions, counties, unitary authorities and health authorities/boards) are calculated by summing five-year age-specific fertility rates over all childbearing ages and then multiplying by five (this method gives more robust TFRs for areas with smaller populations). Source: http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2013/stb-births-in-england-and-wales-2013.html#tab-background-notes

Community Support	• Children's Centres offer variety of groups and individual support, fathers included
	• Access to Children's Centres support worker via allocation meetings, if receiving secondary mental health services
	• Wide variety of individual support and community groups but not necessarily BANEs-wide. Include:
	  ○ My Time, My Space (arts based therapy)
	  ○ Bright beginnings (specific postnatal group)
	  ○ Dramatherapy
	  ○ NCT Groups
	  ○ Baby massage – one to one or group
	  ○ Family Information Service website
	  ○ Yoga
	  ○ La Leche Leagues
	  ○ Voluntary Support Groups

Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Self-referral • Perinatal women prioritised, usually seen within 7 days subject to timing and location of appointment
IAPT Offer	LIFT Psychology Service – Individual and group interventions
CAMHS Input	• Primary Infant Mental Health Service in place, with plans to provide consultation to staff on New Horizons • Limited referral criteria i.e. teenage parents • Consultation offered to HVs BANES-wide: valued and uptake good
Mental Health Service Provision	• Joint clinic at RUH with specialist midwife and Mental Health Liaison worker – medication advice • Primary Care Liaison Service • Recovery service that incorporates Assertive Outreach • Mental Health Reablement Service • Intensive services
Management of Crises / Prevention of admission	Community support provided by intensive services
Access to beds	Mother and Baby Unit (New Horizons) in Bristol, or via Out of Area processes
Data to inform commissioning	• HVs have an issue with data provision whilst SystmOne beds in • Manual collection of data by midwife with specialist interest
MMHA Ranking	Level 0
Current Gaps and areas of concern	• Lack of opportunities of early intervention and effective communication pathways across all services • Insufficient access to evidence based first line interventions for parents with mild-moderate low mood, which are both timely and accessible for parents

Name of CCG	Bristol
Maternity Service Provider(s)	North Bristol NHS Trust Royal United Hospitals Bath NHS Foundation Trust University Hospitals Bristol NHS Foundation Trust
Health Visiting Service Provider	North Bristol NHS Trust (NBT)
Mental Health Provider(s)	Avon and Wiltshire Mental Health NHS Trust North Bristol NHS Trust (CAMHS)
Population: women 15-45	107,100
Total Fertility Rate (ONS 2013)	1.81 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	Not a current version, but will be updated within work plan of newly established Perinatal Mental Health Integration Team
Care Pathways in place?	Antenatal pathway in development
Pre-conception planning	Women with known issues offered early Obstetric Consultant appointment when planning subsequent pregnancy
Midwifery Input	• Mental health assessed routinely at booking, 36wks and Postnatally, using Whooley questions • Section in hand held maternity notes to review mental health • UHB Midwives use at risk notification form and refer to weekly Consultant Obstetrician / Midwifery matron clinic for triage and onward referral. This is pilot work. • NBT midwives refer directly, or advise women to self-refer, to IAPT • Specialist Midwife post out to advert • Information is shared via the Handover Tool
Health Visiting Input	• Solihull training provided by PIMH Team • Some ad hoc training provided by New Horizons. One HV has undertaken Primary Infant Mental Health Master's degree • Mental health assessed at Family Health Needs Assessment and each contact, using Whooley questions • No Specialist HV in post, but Perinatal Champions in place • Information shared via the handover Tool and at monthly GP / HV meetings
GP Input	• Mental health referral letters copied to GP • Midwives and HVs can recommend a woman to see her GP but there is no mechanism in place to check compliance • Routine 6 week postnatal check

Community Support	• Bluebell in South Bristol offers:
	  ○ Mum's Comfort Zone
	  ○ Bluebell Buddy Service
	  ○ Dad's Zone
	• Mothers for Mothers- restricted delivery due to funding issues
	• Southern Brooks Community Partnership, North Bristol
	• Off the Record for 11-25 year olds
	• Pockets of good voluntary sector provision, but not Bristol-wide

Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Self-referral, but midwives and HVs can also refer • Perinatal women prioritised • Usually seen with 7-14 days, subject to timing and location of appointment
IAPT Offer	• Delivered by network of 14 providers – individual and group therapies • Single point of access followed by triage, assessment and signposting where relevant • Support for PTSD and sexual abuse • Psychosocial and Psychoeducation support • Looking to develop online forums
CAMHS Input	• Primary Infant Mental Health Service in place, provides training, advice & consultation, and direct care • Also provides consultation to staff on New Horizons • 5 day training in Social and Emotional Development offered to staff in universal services • Referrals from HVs, Community Nursery Nurses, GPs and occasionally Paediatricians
Mental Health Service Provision	• Primary Care Liaison • Early Intervention in Psychosis • Assessment and Recovery • Complex Psychological interventions • Crisis care New protocols and pathways being implemented
Management of Crises/Prevention of admission	• Crisis Team will support in conjunction with other • No option for intensive community support
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Data is not systematically or consistently offered to commissioners in order to support development and planning of services
MMHA ranking	Level 0
Current Gaps and areas of concern	• Lack of specialist Perinatal Mental Health Consultant support for maternity and adult mental health services • Links and co-ordination across services could be improved • There is evidence that universal services identify issues but do not refer early enough or often enough • Inconsistency in practice – one Trust has a (pilot) triage system in place, the other relies on midwives making onward referral • IAPT Postnatal groups have not been well-attended – women appear to prefer 1-1 support • There are some issues with the range of culturally sensitive services • Lack of services for mild-moderate anxiety and depression • No option for intensive community support to prevent admission

Name of CCG	Gloucestershire
Maternity Service Provider(s)	Gloucestershire Hospitals NHS Foundation Trust
Health Visiting Provider	Gloucestershire Care Services NHS Trust
Mental Health Provider(s)	2gether NHS Foundation Trust
Population: women 15-45	111,200
Total Fertility Rate (ONS 2013)	1.89 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	In development, led by a multi-agency Perinatal and Infant Mental Health Network Group
Care Pathways in place?	Maternal Mental Health Pathway
Pre-conception planning	• No formal service but women can be referred to Mental Health Services • Pathway allows for women with known mental health issues to access support but response may not be consistent
Midwifery Input	• Dedicated psychiatric input on annual generic mandatory training • Mental health assessed at booking, 36 weeks and postnatally, using Whooley questions. More frequent assessment if concerns • No Specialist Midwife in post • Information shared with midwives via Midwife / Health Visitor Liaison Form and verbal handover – work underway to improve communication
Health Visiting Input	• Mandatory 1 day training on perinatal mental health conditions • In house Infant Mental Health training being delivered to all HVs and Nursery Nurses. Focuses on antenatal relationship development • Perinatal and Infant Mental Health conference scheduled for April, invitations include Social Care and Children's Centre staff • Mental health assessed routinely at all universal contacts, using past history, Whooley questions, PHQ9 and GAD7 • Standard Operating procedure in place for identification, assessment and management of women with mental health conditions • No Specialist HV in post but Locality Lead with portfolio responsibility • Mental health clinical supervision being rolled out • Information shared with midwives via Midwife / Health Visitor Liaison Form and verbal handover – work underway to improve communication • Support options and pathways into those options clear and well-understood by all staff
GP Input	• GPs involved in perinatal event planned for April • Regular joint GP, HV, Midwife meetings in some practices to highlight at risk women • Routine 6 week postnatal check
Community Support	• Children's Centres offer free counselling and support groups, but provision not consistent across the county • Courses run jointly by Children's Centres, IAPT and HVs • Home Start in Stroud • Postnatal depressions groups, not equitable around county

Specialist Perinatal Mental Health Service	No formal specialist service Consultant Psychiatrist in post with protected time to support the current service
Access to IAPT	• Self-referral to Let's Talk, or referral by a health professional • Women who are pregnant or up to 1 year postnatal are prioritised • Usually assessed within 14 days
IAPT Offer	• Specific pathway for women who are anxious about pregnancy or giving birth, or requesting caesarean section with no medial indication. Usually referred by the maternity staff and can be offered telephone assessment for brief face to face therapy • Psychoeducational groups • Individual telephone guided self-help • Individual or group therapy • Emotional wellbeing groups are offered in partnership with some children's centres, which provide crèche for pre-school children. This group also has access to a range of disorder specific therapy and psychoeducational groups
CAMHS Input	• Infant Mental Health Service in place
Mental Health Service Provision	• Perinatal service is part of generic mental health services and includes CMHTs, Community Recovery Teams, Assertive Outreach & Crisis Teams • One Psychiatrist has 1 hour / week allocated time • Internal perinatal network within provider – looking at data capture and auditing of pathways and staff skills • Assessments and plans of care shared with GP, HV and midwife
Management of Crises/Prevention of admission	• Support provided by Crisis Team and / or Recovery Team • Some women may choose to be admitted to a local bed, without their baby, in order to stay closer to home • Sourcing of beds is managed by the provider
Access to beds	• Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Not all providers are able to supply commissioners with data that supports development and planning of services
MMHA Ranking	Level 0
Current Gaps and areas of concern	• Absence of specialist perinatal mental health service, with a Specialist HV and Specialist Midwife able to refer to team • Women don't always feel comfortable in talking to HVs about mental health in open clinic sessions • There is a gap around identification of anxiety • Would like to see consistent levels of skill and knowledge across all services providing Early Years support • Better links are needed between all agencies supporting women e.g. mental health services, maternity services and CAMHS • Would like to see a regional service that can function as a resource, to provide advice and consultation to local provision, to share cases of concern, and to jointly plan intensive support • Would like to see short-term beds to step up / down quickly • Would like to see consistent robust conversations for woman in pregnancy

Name of CCG	Kernow
Maternity Services Provider(s)	Royal Cornwall Hospitals NHS Trust Plymouth Hospitals NHS Trust Northern Devon Healthcare NHS Trust
Health Visiting Provider	Cornwall Partnership NHS Foundation Trust
Mental Health Provider(s)	Cornwall Partnership NHS Foundation Trust
Population: women 15-45	94,800 (including Isles of Scilly)
Total Fertility Rate (ONS 2013)	1.97 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	No overall strategy in place but active multi-agency Perinatal Mental Health Network
Care Pathways in place?	• Perinatal Mental Health Pathway • Multi-agency work underway to develop an Infant Mental Health Pathway
Pre-conception planning	• Provided by Specialist Perinatal Mental Health Team in addition to pre-existing mental health service support • Includes proactive support programmes and care planning
Midwifery Input	• Mandatory training introduced in Jan 2015 – developed with Specialist Midwife and Perinatal Mental Health Team Leader • Mental health assessed at booking, 28 weeks and 36 weeks, using Whooley questions, followed by PHQ9 and GAD7 if indicated • Skin to skin bonding promoted at birth and any concerns documented • A Standard Operating Procedure for identification, assessment and management of women with mental health issues is in place • Full time Specialist Midwife for Women with Complex Needs in post, however not all the time is available for perinatal mental health work • Individual Management Plans , incorporating escalation and crisis plans, are developed for identified women and placed in her hand-held record • Information shared with GP and HV. Formal postnatal handover to HV : Day 5 notification and day 10 handover • Support options and pathways into those options clear and well-understood by all staff
Health Visiting Input	• iHV perinatal mental health training, plus conferences provided by Angela Harrison Trust and training from SCPNMHT • Mental health assessed routinely at universal contacts, using Whooley questions, PHQ9 and GAD7 • Service consistency supported by HV protocols • No Specialist HV in post but Trust-wide HV Champion, supported by trained local Champions. Family Nurse Partnership for young vulnerable mothers • Information shared antenatally, at Day 5 notification and at formal Day 10 handover • Staff are clear about their local support options, but not all pathways are clear or fully understood
GP Input	NHS Kernow, with CAMHS and the Angela Harrison Trust, are currently planning training sessions for GPs emphasising the impact of infant mental health and antenatal neuro-development
Community Support	• Children's Centre support varies across county, but there is a strategic intention to target vulnerable families. Support includes: ○ Great Expectations multi-agency antenatal programme

	○ Here's Looking At You ○ Finding Yourself Again • Pentreath support Bluebird Groups on behalf of Angela Harrison Trust - delivered by trained volunteers to deliver non-therapeutic social networking • Angela Harrison Trust provide information leaflets for Health Visitors to give to expectant parents • Young Parent's Support Service, Young Mums Will Achieve peer support • Commissioned postnatal depression group, rolling programme based in Children's Centres in areas of highest need • Family Information Service website
Specialist Perinatal Mental Health Service	• Comprises 0.5 WTE Consultant, 1 WTE Band 7, 1 WTE Band 6 and 1 WTE Administrative Assistant • Service provides ○ Direct care ○ Telephone consultation and advice ○ Training to Midwives, HVs and CMHTs ○ Facilitation of local network ○ Development of multi-agency links and awareness raising
Access to IAPT	• Open access, including self-referral • Perinatal women prioritised • Usually contacted within 2 weeks
IAPT Offer	• Provided by BeMe and Outlook South West • Group or individual based on need and preference
CAMHS Input	• No identified infant mental health service • Joint working where CAMHS patients also require Specialist service
Mental Health Service Provision	• Psychiatric Liaison team in Royal Cornwall Hospitals • CMHTs, who are developing Champion roles • Home Treatment Team
Management of Crises/Prevention of admission	• Specialist Perinatal Mental Health Team works jointly with Home Treatment Team. Able to flex intensity of support up and down • Examples of women admitted to local non-specialist wards and flexible working to support infant links
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services
MMHA Ranking	Level 3
Current Gaps and areas of concern	• Pressure on Specialist Team – rising demands and expectations • No specific Infant Mental Health offer • Cross border inequity for women who deliver in Plymouth

Name of CCG	NEW Devon (Devon County)
Maternity Service Provider(s)	Royal Devon and Exeter NHS Foundation Trust Northern Devon Healthcare NHS Trust Plymouth Hospitals NHS Trust
Health Visiting Provider	Virgin Care
Mental Health Provider(s)	Devon Partnership NHS Trust Virgin Care (CAMHS)
Population: women 15-45	126,400
Total Fertility Rate (ONS 2013)	1.91 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	Strategy developed, needs updating. Work supported by Perinatal Network which meets quarterly
Care Pathways in place?	Perinatal Mental Health Pathway
Pre-conception planning	Women supported to make informed decisions about pregnancy. Any woman open to a CMHT, with a long-term diagnosis or significant previous illness is offered advice, support and early planning with postnatal follow up & review.
Midwifery Input	• Specialist Perinatal Mental Health Service provides training to NDDH and RD&E units • Mental health assessed at booking and throughout pregnancy, using Whooley questions, Prediction & Detection Tool • A Specialist Midwife for complex needs is based in the RD&E (1 WTE). • Information sharing robust in relation to women accessing Specialist Perinatal Mental Health Service. A range of methods is in place for the women who do not.
Health Visiting Input	• Training in Infant Mental Health & Maternal Mental Health provided to support implementation of the pathway • Mental health assessed at universal contacts, using Whooley questions, PHQ9, GAD7, EPDS • There is no specialist HV in post, but lead perinatal mental health HVs in Exeter, Mid and East Devon • Information sharing robust in relation to women accessing Specialist Perinatal Mental Health Service. A range of methods is in place for the women who do not.
GP Input	• Routine 6 week postnatal check • Work with Specialist Perinatal Mental Health Service to support women
Community Support	• Children's Centres offer range of groups and individual support • "Great Expectations" antenatal education • Activity pilots being planned jointly with Active Devon • Plans being developed to enhance joint working between Maternity Services and Children's Centres • Pilot of Specialist Perinatal Mental Health Team to outreach to community settings was successful and plans emerging to develop it further
Specialist Perinatal Mental Health Service	• Service provides to North Devon, Exeter and Torbay. Exeter and North Devon teams comprise 0.3 Psychiatrist sessions, 2.8 WTE Mental Health Nurses, 0.5 WTE Social Worker and 0.5 WTE Occupational Therapist • Based in Obstetric departments of local hospitals

Specialist Perinatal Mental Health Service (cont.)	• The service provides:
	  ○ Direct care
	  ○ Consultation and advice to all professionals
	  ○ Training to midwives, health visitors, mental health teams and Children's Centres
	  ○ Maintenance of robust local networks that co-ordinate support for women and enable a team around the family
	• Key features include:
	  ○ Pre-conception care
	  ○ Multi-disciplinary pregnancy planning for complex women usually in 1st trimester.
	  ○ Multi-disciplinary birth planning with midwives, mental health services and HVs, at 32-34 wks. Produces a single plan that includes relapse and escalation planning
	  ○ Care that bridges the gap between Maternity Services and Mental Health services, over and above CMHT input
	  ○ Clinical support to GPs
	  ○ Complex prescribing, risk assessment
	  ○ Strong safeguarding links within Devon Partnership Trust & DCC. Safeguarding supervision for complex cases.
	Service Development/initiatives
	  ○ Pilot Perinatal Team Clinic at Children's Centre in Exmouth (2014)
	  ○ Trauma informed pathway for women with a history of childhood trauma (in partnership with RD&E & Virgin)
	  ○ Under 18's referrals not accepted

Access to IAPT	• Referrals from GPs, HV's & Specialist Perinatal Mental Health Service and self-referrals • Pregnant women and those with a baby under 1 year are prioritised • Women are generally seen within 28 days
IAPT Offer	• Individual and group therapies offered • Work closely with Specialist Perinatal Mental Health Service and Children's Centres
CAMHS Input	• PIMH specialists in CAMHS teams , linked to SCPNMH Team • Liaise with Specialist Service through clinical meetings and weekly triage
Mental Health Service Provision	• Community Mental Health Teams (CMHT) • Assertive Outreach • Crisis Team • Liaison Psychiatry Teams
Management of Crises/Prevention of admission	• Care is offered as close to home as possible • The Specialist Perinatal Mental Health Service provides care alongside the Crisis Team • Where admission is required a Specialist Mother & Baby Unit admission is explored first. Some women choose admission to their local mental health unit without their baby in order to stay close to home. The Specialist Service, midwife and HV will then work closely with the woman during admission
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services
MMHA Ranking	Level 5
Current Gaps and areas of concern	• Access to MBU beds locally • There is no specific commissioning for Under 18's provision

Name of CCG	NEW Devon (Plymouth)
Maternity Service Provider(s)	Plymouth Hospitals NHS Trust
Health Visiting Provider	Plymouth Community Healthcare
Mental Health Provider(s)	Plymouth Community Healthcare
Population: women 15-45	54,600
Total Fertility Rate (ONS 2013)	1.76 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	In development, led by Working Group
Care Pathways in place?	Perinatal Mental Health Pathway – antenatal and postnatal
Pre-conception planning	Not systematically provided
Midwifery Input	• Mental health assessed at each antenatal contact, using Whooley questions • No Specialist Midwife in post, but a number of midwives are identified as having a lead role for vulnerable women and Family Nurse partnership in place for vulnerable young women • Information is shared via the booking form and verbal communication. Some localities have regular review meetings with HVs and work is underway to enhance effectiveness of joined-up working
Health Visiting Input	• Training has been provided by King's College, London plus an internal programme is being developed that will be rolled out across the service • Mental health assessed at each universal contact, using Whooley questions and EPDS • An operational pathway is in development • There is no specialist HV in post, but Family Nurse Partnership in place for vulnerable young women and the role of perinatal champions is in development across the city • Enhanced service MECSH provided by HVs to identified vulnerable women • Information is shared via the booking form and verbal communication. Some localities have regular review meetings with midwives and work is underway to enhance effectiveness of joined-up working • Support options and pathways into those options clear and well-understood by all staff, with a need to keep new staff updated
GP Input	• GPs refer to mental health services and can access clinical advice • Routine 6 week postnatal check
Community Support	• Children's Centres • Safety in Numbers group – crèche provided by Barnardo's • "Great Expectations" antenatal education • Chatterbox groups • Baby massage
Specialist Perinatal Mental Health Service	No formal specialist service Consultant Psychiatrist in post with protected time to support the current service

Access to IAPT	• Referrals accepted from healthcare professionals • Perinatal women are prioritised • Assessments take place within 2 weeks, with longer waits access to higher intensity therapies
IAPT Offer	• Tailored one to one support at step 2 and step 3 • CBT and counselling provided at step 3 • EMDR and Psychosexual counselling also at step 3
CAMHS Input	• Infant mental health team accessible for direct care and consultation
Mental Health Service Provision	• Same day CMHT assessment • Consultation, advice and support to primary care clinicians • Active review of women with long-term stable conditions • Crisis Team • Home Treatment Team • Complex Needs Team in place for women with dual diagnosis when presentation is complex and unstable
Management of Crises/Prevention of admission	• Use of full range of Adult Mental Health Services • Community support prevents admissions: Home Treatment Team co-ordinates and supports proactive work and prevention of escalation
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services
MMHA Ranking	Level 1
Current Gaps and areas of concern	• Designated and distinct Specialist Perinatal Mental Health Service – elements are in place but linkages are not fully effective • Support for dual diagnosis can be of concern, if a woman is presenting as stable, but pregnant • Referrals to Mental Health services are currently typically late and carry high risk • A need to upskill generic staff to have more confidence around identification, referral and wraparound support for the whole family • There is a challenge for Derriford because women from Plymouth, Devon and Cornwall receive care there and different support systems are in place for each.

Name of CCG	North Somerset
Maternity Services Provider(s)	Weston Area Health NHS Trust University Hospitals Bristol NHS Foundation Trust
Health Visiting Provider	North Somerset Community Partnership
Mental Health Provider(s)	Avon & Wiltshire Mental Health NHS Trust Weston Area Health Trust (CAMHS)
Population: women 15-45	35,900
Total Fertility Rate (ONS 2013)	2.01 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	In development, supported by designated lead Multi-agency Core Group in existence since 2006 and driving developments
Care Pathways in place?	• Perinatal/Parental and Attachment Pathway • Antenatal in pilot development
Pre-conception planning	No formal service in place but women with known issues are referred for support
Midwifery Input	• All midwives attend training for Mental Health First Aid, Solution Focussed Therapy, Solihull plus updates in the biannual Midwifery Professional Day • Mental health assessed routinely at booking, 36 weeks and postnatally, using Whooley questions, GAD7, PHQ9 and direct questions about previous mental health issues • Antenatal Mental Health Care pathway in pilot stage • Midwife Champion with substance misuse specialism, plus Midwife with responsibility for complex needs (0.2wte) • Midwife to HV communication takes place but work underway to formalise the processes and improve consistency • Extra midwife appointments offered to support women prior to medication being prescribed • If medication prescribed, women have obstetric consultant referral and plan, plus extra midwife appointments
Health Visiting Input	• All staff are Solihull trained and attend 2 day Perinatal Mental Health training via Institute of Health Visiting. Ongoing training provided by upskilled HVs • Mental health assessed routinely at universal contacts, using Whooley questions, GAD7, PHQ9, MORS and motivational interviewing skills • Standard Operating Procedure in place for identification, assessment and management of mental health issues • Adult mental health specialist works with HV service (0.81 WTE) • Midwife to HV communication takes place but work underway to formalise the processes and improve consistency • Support options and pathways into those options clear and understood by all staff • IAPT noted by HV service as being particularly helpful and flexible

GP Input	• Readily available and easy to access for women • Less engaged in multi-agency discussions • Routine 6 week postnatal check
Community Support	• Children's Centres • Mental Health First Aid groups • Think Family groups • Thrive
Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Self-referral plus option for direct HV referral • Perinatal women prioritised and can be seen within 7 days, subject to location of appointment
IAPT Offer	Individual therapy and group interventions
CAMHS Input	• Parent Child Relationship Clinic • Individual work • Facilitate Perinatal Attachment Core group for professional working
Mental Health Service Provision	• Primary Care Liaison Service • Adult Recovery Service, including Assertive Outreach Service • Intensive services • Some drop-ins available but not consistent across whole area
Management of Crises/Prevention of admission	Avoidance of admissions is managed via the Assertive Outreach service
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services
MMHA ranking	Level 0
Current Gaps and areas of concern	• Women in group categorised as in "moderate" need do not receive a commissioned service – need more low level support • Services look at postnatal depression, not anxiety, so work underway to develop that • Need to do more work with men • Lack of specialised perinatal mental health services

Name of CCG	Somerset
Maternity Service Provider(s)	Taunton & Somerset NHS Foundation Trust Yeovil District Hospital NHS Foundation Trust
Health Visiting Provider	Somerset Partnership NHS Foundation Trust
Mental Health Provider(s)	Somerset Partnership NHS Foundation Trust
Population: women 15-45	91,100
Total Fertility Rate (ONS 2013)	1.95 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	A Steering Group is in place to develop a county-wide multi-agency strategy that will be endorsed by all partners, and supported by training programme
Care Pathways in place?	Service-specific care pathways for Midwifery and Health Visiting
Pre-conception planning	No service offered
Midwifery Input	• Mental health assessed at booking and two further intervals antenatally, using Whooley questions. Additional support and more intensive Obstetric input provided to women identified as at risk • Specialist Midwife in post • Information is shared with HVs through communication forms, weekly HV liaison, phone calls, meetings with specialist teenage pregnancy HV and young parent HV Champions
Health Visiting Input	• Training includes iHV Champion Training, safeguarding, domestic abuse, in-house training on core contacts, maternal mental health & Listening Visits • Mental health assessed at each universal contact, using Whooley questions, Family Health Needs Assessment and EPDS • Standard Operating Procedure in place for identification, assessment and management of women with mental health issues • No Specialist HV in post, but a Clinical Area Manager has lead role • Listening Guidance developed, using Family Partnership (Crispin Day) methodology • Information is shared with midwives through communication forms, weekly midwifery liaison, phone calls, meetings with specialist teenage pregnancy HV and young parent HV Champions • Support options and pathways into those options not always clear or well-understood by all staff
GP Input	• CCG has developed Navigator apps, provides updates in Newsletters • Routine 6-8 week postnatal check
Community Support	• Not all Children's centres can offer groups or support • Toddler groups • Getset Somerset (Early Help) • Horizons group (joint HV and mental health team)
Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• GP, HV or self-referral • Perinatal women are prioritised

	• First triage and treatment session within 7 days at present, with short wait for interventions
IAPT Offer	Individual and group therapy sessions
CAMHS Input	• Following referral by GP

Mental Health Service Provision	• GPs form gateway to services and refer to CMHTs
	• Additional services include
	  ○ Treatment teams, including Assertive Outreach
	  ○ Crisis resolution
	  ○ Psychiatric Liaison
	  ○ Horizon Group in one locality, jointly delivered with HV

Management of Crises/Prevention of admission	• Crisis Resolution service will support women to stay at home wherever possible • Some women will opt to be admitted to adult mental health wards, without their baby
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	• Data received by the CCG is fragmented by service / specialty and does not easily allow for development and planning of services • Closer liaison with NHS England about usage of specialist services would be welcome
MMHA Ranking	Level 0
Current Gaps and areas of concern	• Lack of a joined up approach and communication between the services involved in supporting women who have been identified by health visitors as having perinatal mental health issues • Absence of training programme to support multi-agency delivery to women with very complex needs • Gap of support staff/services in mental health teams who could provide brief interventions whilst mothers await treatment/counselling and act as key workers to encourage engagement in appointments and further treatment • The development of a short-term “Recovery House” would enhance the experience and outcomes for women and their babies

Name of CCG	South Devon and Torbay
Maternity Services Providers(s)	South Devon Healthcare NHS Foundation Trust
Health Visiting Provider	Torbay and Southern Devon Health and Care NHS Trust
Mental Health Provider(s)	Devon Partnership NHS Trust Torbay and Southern Devon Health and Care NHS Trust (CAMHS)
Population: women 15-45	21,700
Total Fertility Rate (ONS 2013)	2.16 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	Strategy incorporated into overarching Mental Health and Maternity Strategies
Care Pathways in place?	Antenatal and Postnatal Map of Medicine Pathways in place
Pre-conception planning	Women supported to make informed decisions about pregnancy. Any woman open to a CMHT, with a long-term diagnosis or with significant previous illness is offered advice, support and early planning
Midwifery Input	• Annual refresher training delivered by Specialist team • Mental health assessed using Whooley questions and Prediction & Detection Tool, followed by more in-depth assessment if required, based on West Midlands Perinatal Institute records • Specialist Public Health Midwife in post (1.0 WTE). • Information sharing pathway between midwives and HVs currently under development. Interagency Communication Form in place for generic communication, and communication is robust in relation to women accessing Specialist PNMH Service
Health Visiting Input	• iHV training rolled out to all HVs by PNMH HV Champions • Mental health assessed at each universal contact, using Whooley questions and the Boots Foundation “My Pregnancy and Post Birth Wellbeing Plan”. Some HVs use EPNDS • A Standard Operating Procedure is in place for the 28wk antenatal assessment • No Specialist HV in post, but two PNMH Champions. Family Health Partnership in place for vulnerable young women • Information sharing pathway between midwives and HVs currently under development. Interagency Communication Form in place for generic communication, and communication is robust in relation to women accessing Specialist PNMH Service
GP Input	• Routine 6 week postnatal check • Supported by Specialist PNMH Service
Community Support	• Antenatal classes in Children’s Centres, co-delivered by Action for Children, midwives and HVs • Range of groups and individual support offered through Children’s centres
Specialist Perinatal Mental Health Service	• Service provided to Torbay, North Devon and Exeter. Torbay team comprises 0.2wte Perinatal Psychiatrist, 3.0 WTE Mental Health Nurses and 1.0 WTE Social Worker • Based in Maternity Unit of Torbay Hospital

	• The service provides:
	  ○ Direct care
	  ○ Consultation and advice to all professionals
	  ○ Training to midwives, mental health teams and Children's Centres
	  ○ Maintenance of robust local networks that co-ordinate support for women and enable a team around the family
	• Key features include:
	  ○ Pre-conception care
	  ○ Multi-disciplinary pregnancy planning for complex women usually in 1st trimester.
	  ○ Multi-disciplinary birth planning with midwives, mental health services and HVs, at 32-34 wks. Produces a single plan that includes relapse and escalation planning
	  ○ Care that bridges the gap between Maternity Services and Mental Health services, over and above CMHT input
	  ○ Clinical support to GPs
	  ○ Complex prescribing, risk assessment
	  ○ Strong safeguarding links within Devon Partnership Trust & DCC. Safeguarding supervision for complex cases.
	  ○ Under 18's referrals accepted

Access to IAPT	• Referrals from GPs, Specialist Perinatal Mental Health Service and self-referrals • Pregnant women and those with a baby under 1 year are prioritised • Women are generally seen within 28 days
IAPT Offer	• Individual and group therapies offered • Work closely with Specialist Perinatal Mental Health Service and Children's Centres
CAMHS Input	• Named Perinatal Mental Health practitioner in CAMHS • Liaise with Specialist Perinatal Mental Health Service through clinical meetings and weekly triage
Mental Health Service Provision	• Community Mental Health Teams • Depression and Anxiety Service • Assertive Outreach • Crisis Team • Liaison Psychiatry Teams
Management of Crises/Prevention of admission	• Care is offered as close to home as possible • Where admission is required a Specialist Mother & Baby Unit admission is explored first. Some women choose admission to their local mental health unit without their baby in order to stay close to home. The Specialist Service, midwife and HV will then work closely with the woman during admission
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services
MMHA Ranking	Level 5
Current Gaps & Areas of Concern	• Access to local beds

Name of CCG	South Gloucestershire
Maternity Services Provider(s)	North Bristol NHS Trust Royal United Hospitals Bath NHS Foundation Trust University Hospitals Bristol NHS Foundation Trust
Health Visiting Provider	North Bristol NHS Trust
Mental Health Provider(s)	Avon and Wiltshire Mental Health NHS Trust North Bristol NHS Trust (CAMHS)
Population: women 15-45	52,300
Total Fertility Rate (ONS 2013)	1.84 (SW Mean = 1.91, Range = 1.74 – 2.16,)
Multi-Agency Strategy in place?	Not a current version There is a Multi-Agency Training Steering Group that co-ordinates training delivery
Care Pathways in place?	Antenatal pathway in development
Pre-conception planning	Women with known issues offered early Obstetric appointment when planning subsequent pregnancies
Midwifery Input	• Mental health assessed routinely at booking, 36 weeks and postnatally, using Whooley questions • Section in hand held maternity notes to review mental health • UHB Midwives use at risk notification form and refer to weekly Consultant Obstetrician / Midwifery matron clinic for triage and onward referral. This is pilot work. • NBT midwives refer directly, or advise women to self-refer, to IAPT • No Specialist Midwife in post • Information is shared via the Handover Tool
Health Visiting Input	• Solihull training provided by Perinatal Me Team • Some ad hoc training provided by New Horizons • Mental health assessed at Family Health Needs Assessment and each contact, using Whooley questions • No Specialist HV in post, but Perinatal Champions in place • Information shared via the handover Tool and at monthly GP / HV meetings
GP Input	• Mental health referral letters copied to GP • Midwives and HVs can recommend a woman to see her GP but there is no mechanism in place to check compliance • Routine 6 week postnatal check
Community Support	• Children's Centres offer range of individual and group support • Bluebell • Off the Record for 11-25 year olds • Southern Brooks Community Partnership • Pockets of good voluntary sector practice
Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Open referral • Perinatal women prioritised • Assessed within a week, with a wait for therapy

IAPT Offer	• Delivered by a range of providers - individual and group interventions • Includes CBT, counselling, psycho educational interventions, mood management, managing anxiety and stress, managing long term health conditions, anger management, self-esteem and relaxation • Also offer a postnatal depression group, part funded by South Gloucestershire Council
CAMHS Input	• Primary Infant Mental Health Service in place, provides training, advice & consultation, and direct care • Also provides consultation to staff on New Horizons • 5 day training in Social and Emotional Development offered to staff in universal services • Referrals from HVs, Community Nursery Nurses, GPs and occasionally Paediatricians
Mental Health Service Provision	• Primary Care Liaison Service offers rapid assessment and short-term interventions • Recovery service, incorporating Assertive Outreach • Intensive services
Management of Crises/Prevention of admission	Intensive services work with other services to monitor mother and support family, with on-call out of hours
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Providers are able to provide commissioners with data that supports development and planning of services No feedback from NHS England about usage or case mix of New Horizons
MMHA Ranking	Level 0
Current Gaps and areas of concern	• Lack of specialist Perinatal Mental Health Consultant support for maternity and adult mental health services • Links and co-ordination across services could be improved • There is evidence that universal services identify issues but do not refer early enough or often enough • Inconsistency in practice – one Trust has a (pilot) triage system in place, the other relies on midwives making onward referral • IAPT Postnatal groups have not been well-attended – women appear to prefer 1-1 support • There are some issues with the range of culturally sensitive services • Lack of services for mild-moderate anxiety and depression • No option for intensive community support to prevent admission

Name of CCG	Swindon
Maternity Services Provider(s)	Great Western Hospitals NHS Foundation Trust Oxford University Hospitals NHS Trust
Health Visiting Service Provider	Children, Families and Community Health Service, Swindon Borough Council
Mental Health Provider(s)	Avon and Wiltshire Mental Health NHS Trust Oxford Health NHS Foundation Trust (CAMHS) LIFT Psychology services provided by SEQOL (April 2015)
Population: women 15-45	45,300
Total Fertility Rate (ONS 2013)	1.99 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	In development, will be informed by Care Pathway. Work overseen by a Steering Group, led by Public Health
Care Pathways in place?	• Integrated Pathway in development – based on what is currently in place and strengthening consistency • Separate pathway for Teenage Mothers to be developed
Pre-conception planning	Not systematically provided
Midwifery Input	• New Horizons has provided ad hoc training. Midwives required to complete Cardiff e-learning and "Vulnerable Women" update as part of mandatory training • Mental health routinely assessed at booking, 36 weeks and postnatally using Whooley questions • No Specialist Midwife in post, but there is a lead for vulnerable women, including perinatal mental health (0.8 WTE) • Information is shared via Vulnerable Pregnant Women pathway mechanisms and monthly HV / midwife team meetings
Health Visiting Input	• LIFT Psychology has provided training. Also exploring commissioning of training to support implementation of integrated pathway • Mental health assessed at universal contacts, using Whooley questions and clinical enquiry. Introducing HADS from April 2015 • Standard Operating Procedure in place for identification, assessment and management of women with mental health issues but under review to align with new Integrated Pathway • No Specialist HV, but training HVs to develop expertise. Also, Family Nurse Partnership available for vulnerable young women and Baby Steps programme delivered • Information is shared via Vulnerable Pregnant Women pathway mechanisms and monthly HV / midwife team meetings • Support options clear to all staff, but pathways into those options not always clear or well-understood. Work underway to review
GP Input	• GP lead identified. Primary Care to be involved further in next phase of Pathway development • Routine 6 week postnatal check

Community Support	• Children's Centres increasingly focusing on targeted families • IAPT generic wellbeing courses run in Children's Centres • Community provision variable across area • Women have opportunity to remain involved with services through interview panels / CQC inspections
Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Service is open to anyone who opts in • Parents where the wellbeing issue is likely to have an impact on the children are prioritised • All clients seen within 2-4 weeks
IAPT Offer	• Individual and group sessions • Specialised wellbeing after baby course that is run in association with midwives • Also run a range of generic wellbeing courses (e.g. low mood, self-esteem and anxiety) course from children centres with crèches where workers can refer directly into the groups
CAMHS Input	• Tier 2 service (TaMHS) available • No Tier 3 service for under 5's • CAMHS available to young mothers under 18 years
Mental Health Service Provision	• Women known to mental health services can access obstetrician-led Sycamore Clinic at Great Western Hospital by referral. This facilitates risk assessment and advice, followed by ongoing management by midwives • Primary Care Liaison Service • Recovery service, incorporating Assertive Outreach • Intensive service
Management of Crises/Prevention of admission	Held in the community by secondary care, with support from New Horizons Mother and Baby Unit
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	Data pilot underway (to March 2015) which will be collated and inform local commissioning and planning of services
MMHA Ranking	Level 0
Current Gaps and areas of concern	• No Specialist Perinatal Mental Health Service • Need a Pathway Lead to drive progress and develop a training programme to support Pathway implementation • No generic mental health clinicians have perinatal mental health expertise • Pattern of provision for women with more severe needs than can be managed within IAPT is unclear

Name of CCG	Wiltshire
Maternity Services Provider(s)	Great Western Hospitals NHS Foundation Trust Royal United Hospitals Bath NHS Foundation Trust Salisbury NHS Foundation Trust
Health Visiting Service Provider	Great Western Hospitals NHS Foundation Trust
Mental Health Provider(s)	Avon & Wiltshire Partnership NHS Trust Oxford Health NHS Foundation Trust (CAMHS)
Population: women 15-45	84,700
Total Fertility Rate (ONS 2013)	1.99 (SW Mean = 1.91, Range = 1.74 – 2.16)
Multi-Agency Strategy in place?	Perinatal Mental Health incorporated into MSLC priorities Mental Health strategy
Care Pathways in place?	Integrated PNMH Pathway being finalised, due for launch May 2015 • Antenatal and referral • Postnatal • Infant Emotional Health
Pre-conception planning	Offered by GPs and via LIFT Psychology. To be included in pre-conceptual care campaign planned for later in 2015
Midwifery Input	• Some ad hoc training from Salisbury Psychology Service, Swindon IAPT. Comprehensive training programme being developed as part of Pathway • Assessed at booking and each antenatal contact, using Whooley questions. Salisbury midwives also use HADS • Perinatal Mental Health Screening Tool in development that combines Whooley, GAD2, pre-history and current mental health. Will be used by midwives & HVs • Midwives will function as lead person and support access to LIFT where appropriate as part of new pathway • 1.0 WTE Specialist Midwife for vulnerable women at Salisbury and RUH • GWH has Perinatal Mental Health Clinic run by Obstetrician and Midwife, RUH has joint Midwife / Hospital Mental Health Liaison Nurse clinic, and Salisbury has links with Psychology service • Information shared with HV via Liaison Pathway
Health Visiting Input	• Training programme in development as part of Perinatal Mental Health Pathway review • Mental health assessed at each universal contact, following NICE guidelines and using EPDS • HVs can deliver up to 6 sessions of Solution-Focused Therapy • Perinatal Mental Health Screening Tool in development that combines Whooley, GAD2, pre-history and current mental health. Will be used by midwives & HVs • No Specialist HV in post, but 2 HVs have accessed additional training and will cascade learning across service • Information is shared from midwife using Liaison Pathway • Support options not clear to all staff and some pathways into those options are currently under review
GP Input	• Pre-conception care • Mental health assessment as part of 6-8 week postnatal check

	• Representative GP has been on pathway planning group
Community Support	• Children's Centres represented on pathway planning group • Community groups • Access to Early Help • Baby Steps groups run through Children's centres at 6 sites
Specialist Perinatal Mental Health Service	No specialist service
Access to IAPT	• Open access and self-referral • Perinatal women prioritised and bypass Tier 1 • Assessments within 28 days, aiming to reduce to 14 days • Good links between IAPT and PCLS to ensure appointments available for women with moderate mental health concerns
IAPT Offer	• Working with services across Wiltshire to develop Perinatal Mental Health Pathway • LIFT Psychology Service – individual and group interventions • Wellbeing and baby courses delivered at local children's centres • Stepped care model
CAMHS Input	• Primary Infant Mental Health Service agreed as part of new integrated Perinatal Mental Health pathway • Currently not able to work preventatively where maternal: fetal attachment issues identified, but staff have the skills
Mental Health Service Provision	• Strong commitment from provider to take forward developments • Primary Care Liaison Service acts as gateway to secondary care • PCLS workers in each of the three areas developing specialism in Perinatal Mental Health – providing advice to Midwives, HVs and GPs as well as assessment for those women with greater need • Accelerated access for perinatal women • Recovery service, incorporating Assertive Outreach • Intensive services • Exploring idea of e-learning Training for generic mental health staff
Management of Crises/Prevention of admission	Supported by Intensive Team working alongside ongoing support
Access to beds	Mother and Baby Unit in Bristol, or via Out of Area processes
Data to inform commissioning	As part of Pathway development, providers are working to improve data quality in order to support the ongoing development and planning of services
MMHA Ranking	Level 0
Current Gaps and areas of concern	• Lack of clear clinical governance processes • Lack of specialist perinatal mental health psychiatrist to provide clinical leadership • Lack of perinatal mental health specialism locally for those at greatest risk • Concern about access to LIFT as a signposting service for women with PMH concerns. Working to enhance understanding and support for access • Would like to enhance links between LIFT and all parts of the system e.g. Early Years • Would like to expand reach and scope of training programmes

New Horizon Mother and Baby Unit	
Provided by	Avon & Wiltshire Mental Health Partnership NHS Trust
Commissioned by	NHS England
Geographical Coverage	South West England, but functions as national resource when necessary
Population: women 15-45	South West: 992,400
Total Fertility Rate (ONS 2013)	South West Mean = 1.91, Range = 1.74 – 2.16
Core Service Offer	• Inpatient care for the most severely unwell – including during pregnancy • Provision of advice to Recovery and Obstetric Services, and Primary Care • A range of evidence-based interventions is offered, including drama therapies, occupational therapy interventions and Mellow Parenting group • Planning for discharge starts on admission and includes the family and social support. Readmission is rare. • The presence of an Occupational Therapist in the team allows for confidence building activities away from the unit, as well as trial periods at home. • Within Bristol, the role of Recovery Navigators within the CMHT Recovery teams is valued in supporting women post-discharge • Clinical interventions are positively audited through Royal College of Psychiatrists Perinatal Quality Network Peer Review processes • The team is coherent, staff turnover is low and patient and family feedback is positive. Friends and Family test is completed
Pre-conception planning	Staff have skills and expertise to provide advice and support but capacity is limited
Support for Babies	• Midwives from Southmead Maternity Unit provide direct support • Some individual HVs visit to provide universal care but there is no agreed arrangement for a named HV to be attached to the unit • Local GP surgery very responsive in meeting the universal health needs of babies whose mothers are on the Unit • Access to Brisdoc and the Children's Hospital A&E when needed
Support for Fathers and Families	• Included in care planning, delivery and discharge planning Physical layout of Unit inhibits fathers and families staying, although staff are flexible where possible
Midwifery Links	• Maternity Services on site are very responsive and working relationships are good • Unit offers advice to local maternity units but this can pressurise resources • Some ad hoc training of midwives is offered
Health Visiting Links	• No Liaison HV in place, although individual HVs do visit • Unit Nursery Nurses liaise with individual HVs Would like to see a baby clinic on unit, to normalise universal care
GP Links	• Close and responsive links with local surgery for primary care needs of babies • Surgery provides immunisations and checks for babies on a Temporary Resident basis • Unit provides advice and support to GPs, with prescribing
Community Links	Voluntary Sector groups support dance and drama therapy

Links to generic Mental Health Services	• The post-discharge pathway is via the Recovery Services across the region • Access to generic services is on the basis of negotiation, case by case • There is no consistency of response from generic services across the south west. As well as impacting on the quality of care for women post-discharge, this is a concern for Unit staff who feel they hold significant clinical risk • A protocol for joint working between is being developed between New Horizon and Recovery Services in order to plan for women who are currently well but at high risk of relapse postnatally • There is an identified need for further training within generic services • A Specialist community perinatal mental health service would enable the interface to be more positively experienced by women and their families
Support for Prevention of Admission/Early Discharge	• Advice and support offered to Maternity Services, HVs, GPs and Mental Health community teams • Discharge planning starts at the point of admission, in order to facilitate the earliest possible return home • The role of OT facilitates confidence building, trial periods at home and skills development for women as they recover
Data to inform commissioning	Data is supplied to NHS England. CCGs and the Unit have all expressed a wish to see wider discussions about population needs, trends and usage
Current Gaps and areas of concern	• Need to clarify what is to be delivered by New Horizons and what needs to be commissioned elsewhere • Would like clarity about role, scope and extent of outreach – it is currently difficult to look more widely than Bristol / Avon area • Would like to be able to develop a clear support and advice offer that shares expertise, including to Primary Care. This function is currently offered as an add-on to core delivery and cannot therefore be consistent • Would like to see more CCG involvement in order to integrate pathways and enhance local communication • Worry about bed capacity – have to turn away admissions. A centralised bed management function would release staff from “chasing” beds • Not resourced to see the vulnerable but well • The decommissioning of the Mother and Baby Unit in Wales provides additional pressure on the beds in Bristol.

Appendix 2 - Information Collected through the Stakeholder Meetings

The woman:	Support Prior to Conception
Is well, with no known mental health issues	• General public awareness raising: TV adverts, soaps etc. • Education in schools: part of Personal, Social, Health and Economic Education (PSHE) delivery • Posters in public places: supermarkets, Children's Centres • Health promotion across universal services about pregnancy and mental wellbeing • Opportunistic discussions at Family Planning Clinics • New patient screening questions at GP practices • Pre-conception discussions with Practice Nurse/GP/Health Visitor/Midwife • Messages on prescriptions e.g. "Thinking of becoming pregnant? Speak to your GP or Pharmacist about your prescription" • Flag system to trigger pre-conception conversation for subsequent pregnancies • Written information to support verbal information
Has an active mental health plan in place **Has a known condition that may deteriorate in pregnancy or post-partum**	• Mental health services to be proactive about pre-conception counselling. Consider having a general conversation about pregnancy with all women of childbearing age. If clinical decision to not have this conversation, document the reasons and re-visit as appropriate • Ensure possibility of pregnancy is considered in all care plans • Key messages to include general awareness, preparation for pregnancy, prescribing • Include the family in conversations • Regular review of women on medication, being clear about who is responsible for this
Is currently well and not accessing mental health services. **She has had previous mental health problems and is at high risk of relapse**	• Use of Quality and Outcomes Framework (QOF) register to give GPs a proactive opportunity to screen for all patients with mental health issues • Messages on prescriptions e.g. "Thinking of becoming pregnant? Speak to your GP/Pharmacist about your prescription" • Opportunity for in-depth conversations with someone knowledgeable and confident about medication during pregnancy and breastfeeding • "Tell me what might happen and importantly what I can do about it. Allow me to feel supported and hopeful but not stigmatised." • Access to specialist advice for women and agencies • Advice via telephone help lines, apps or websites

The woman:	Support at Booking and in Early Pregnancy
Is well, with no known mental health issues	• Allow midwives time at booking appointment to have a meaningful, but normalised, conversation • Consider separating the wellbeing conversation from the booking appointment • Ensure a consistent approach by midwives to screening • Staff to understand that the anxiety may be a non-pathological response to being pregnant • Use wellbeing plans for every pregnant woman and her unborn infant e.g. “Tommy’s” wellbeing plan • Maternity care planning should include all those who are part of the mother’s support network • Ensure universal antenatal education is offered that includes mental health and wellbeing • Signpost to validated quality resources: apps, online information, e-tools • Encourage engagement with Children’s Centres and other sources of social support
Has no history of mental health problems but mild / moderate issues are identified in pregnancy	• Ensure a consistent response to identified issues through screening • Ensure that midwives and HVs know where, and to whom, to refer women with identified needs • Ensure all professionals are aware of available local services • Ensure all women are signposted to appropriate services • Develop a locally agreed suite of resources that are recognised as best practice • Identify indicators of parent / infant relationship issues as early as possible • Consider the mental health of the baby’s father • Ensure access to support for women who have experienced previous trauma or sexual abuse
Has an active mental health plan in place **Has a known condition that may deteriorate in pregnancy or post-partum**	• Joint assessment and care planning between, as a minimum, MH and Maternity services. Include other services, including community support, as relevant • Care plans to include relapse indicators • Co-ordinated / joint care delivery, underpinned by good information-sharing • Rapid access to the correct medication and information • Encourage engagement with Children’s Centres and other sources of social support • Identify any potential parent / infant relationship issues as early as possible • Focus on keeping women safe, and at home if possible • Support for Community Mental Health Teams to manage acutely ill women at home
Is currently well and not accessing mental health services. **She has had previous mental health problems and is at high risk of relapse**	• Ensure midwives understand referral options following a concern at booking • Provide opportunity for in-depth conversation with someone knowledgeable and confident about medication during pregnancy and breastfeeding • “Tell me what might happen and importantly what I can

The woman:	Support at Booking and in Early Pregnancy
	do about it. Allow me to feel supported and hopeful but not stigmatised" • Ensure woman is offered access to wider community support • Advice via telephone help lines, apps or websites • Access to specialist advice for women and agencies • Joint care plans in place for maternity / MH care that include relapse indicators • Develop an escalation plan for women who aren't eligible for active MH support whilst well e.g. bipolar • Provide good information for families about how to recognise and support worsening symptoms • Ensure information is fully shared between all involved services • Offer proactive access to Improving Access to Psychological Therapies (IAPT), supporting self-referral and attendance • Ensure waiting times for IAPT are <14 days and prioritise pregnant women • All services to identify service-specific risk and collate into total risk for the woman and her baby
Has no history of mental health problems but suddenly becomes severely unwell	• Urgent referral by clinician at point of contact for specialist assessment: to Specialist Community Perinatal Mental Health Team (SCPNMHT) if one is in place, otherwise mental health services • Provide community based social support as well as medicalised interventions • May need Crisis Team support

The woman:	Support in Later Pregnancy
Is well, with no known mental health issues	• Ongoing assessment by midwives • HV antenatal home visit at 28-32wks • Development of proactive Birth Plan, as part of an integrated Wellbeing Plan • Staff to understand that anxiety may be a non-pathological response to being pregnant • Care planning should continue to include all those who are part of the mother's support network • Ensure universal antenatal education is offered that includes mental health and wellbeing • Signpost to validated quality resources: apps, online information, e-tools • Encourage engagement with Children's Centres and other sources of social support
Has no history of mental health problems but mild / moderate issues are identified in pregnancy	• Ensure a consistent response to identified issues through screening • Ensure that midwives and HVs know where to refer women with identified needs

The woman:	Support in Later Pregnancy
	• Ensure all professionals are aware of available local services • Ensure all women are signposted to appropriate services • Develop a proactive Birth Plan, as part of an integrated Wellbeing Plan • Develop a locally agreed suite of resources that are recognised as best practice • Identify indicators of parent / infant relationship issues as early as possible • Consider the mental health of the baby's father • Ensure access to support for women who have experienced previous trauma or sexual abuse
Has an active mental health plan in place **Has a known condition that may deteriorate in pregnancy or post-partum**	• Ongoing joint assessment and care planning between, as a minimum, MH and Maternity services. Include other services, including community support, as relevant • Develop a multi-disciplinary care plan for birth with the mother. To incorporate Birth Plan, medication management in labour and relapse indicators • Ongoing co-ordinated / joint care delivery, underpinned by good information-sharing • Support woman to remain engaged in services throughout pregnancy • Encourage engagement with Children's Centres and other sources of social support • Ongoing rapid access to medication advice. Include Neonatologist to identify risks to baby during labour • Identify any potential parent / infant relationship issues as early as possible • Focus on keeping women safe and at home if possible. If admission required, it should be to MBU • Support for CMHTs to manage acutely ill women at home
Is currently well and not accessing mental health services. **She has had previous mental health problems and is at high risk of relapse**	• Ensure midwives understand referral options following a concern at any time during pregnancy • Provide Obstetrician-led care for careful monitoring of mother and baby • Services to understand the speed at which changes can happen in pregnancy, and ensure priority access • Provide ongoing opportunities for in-depth conversation with someone knowledgeable and confident about medication during pregnancy, labour and breastfeeding • Encourage access to wider community support • Ongoing advice via telephone help lines, apps or websites • Ongoing access to specialist advice for women and agencies • Joint care plans in place for maternity / MH care that include Birth Plan and relapse indicators • Develop an escalation plan that can be quickly triggered and implemented • Ensure a specific discussion about management of medication during labour

The woman:	Support in Later Pregnancy
	• Provide good information for families about how to recognise and support worsening symptoms • Ensure information is fully shared between all involved services • Offer proactive access to IAPT, supporting self-referral and attendance • Ensure waiting times for IAPT are <14 days and prioritise pregnant women • All services to identify service-specific risk and collate into total risk for the woman and her baby
Has no history of mental health problems but suddenly becomes severely unwell	• Urgent referral for specialist assessment: to SCPNMHT if one is in place, otherwise mental health services • Provide community based social support as well as medicalised interventions • May need Crisis Team support

The woman:	Support during Birth
Is well, with no known mental health issues	• Use the proactive Birth Plan to safely manage labour • Ensure support with relaxation techniques and pain management • Ensure awareness of mental capacity and ability to consent
Has no history of mental health problems but mild / moderate issues are identified in pregnancy	• Use proactive Birth Plan to safely manage labour • Ensure support with relaxation techniques and pain management • Identify indicators of parent / infant relationship issues as early as possible • Ensure access to support for women who have experienced previous trauma or sexual abuse
Has an active mental health plan in place **Has a known condition that may deteriorate in pregnancy or post-partum**	• Use proactive Birth Plan to safely manage labour • Ensure support with relaxation techniques and pain management • Implement the management plan for medication during labour • Paediatrician to be informed when there is a known intrapartum issue e.g. prescribed lithium • Ongoing assessment that labour is progressing as the woman expected • Ensure a process for managing the after-effects of any birth trauma • Escalate changes in condition to Obstetrician and MH specialist
Is currently well and not accessing mental health services. **She has had previous mental health problems and is at high risk of relapse**	• Use proactive Birth Plan to safely manage labour • Ensure support with relaxation techniques and pain management • Identify indicators of parent / infant relationship issues as early as possible

	• Ensure access to support for women who have experienced previous trauma or sexual abuse • If planning for home birth, develop a contingency plan for transfer to Maternity Unit
Has no history of mental health problems but suddenly becomes severely unwell	• All staff to be aware that any woman can develop an intrapartum psychosis that was not anticipated or identified • Ensure support with relaxation techniques and pain management and ensure others in room are not adding to the anxiety surrounding the event • De-brief everyone involved at end of labour • Support the woman to process the event • Piece together the story of the delivery event and inform all those who need to know • Reassess mother's mental state after event and develop plan of support and interventions

The woman:	**Postnatal Support**
Is well, with no known mental health issues	• Universal assessment of maternal mental health by midwife • Routine assessment of parent / infant relationship by midwife, underpinned by understanding of secure attachment • Universal assessment of maternal mental health by HV at 10-14 days, 6-8wks • Routine assessment of parent / infant relationship by HV at each contact, underpinned by understanding of secure attachment • Full access to all elements of the HV Healthy Child Programme 0-5, including specified core visits • Encourage access to Children's Centres, social support groups • Ensure women, their partners and professionals know who to talk to if concerns arise • All professionals to be aware of local services and how to refer, including specialist infant mental health services where they are in place • Provide enhanced support for all teenage parents and parents with learning disabilities • Ensure support for fathers and other family members • Ensure support for vulnerable families and those who find it hard to access services
Has no history of mental health problems but mild / moderate issues are identified in pregnancy	• Ongoing routine assessment of mother's mental wellbeing • Ongoing routine assessment of parent / infant relationship • Actively encourage access to local community support, including Children's centres • HV to escalate care to Universal Plus, including ○ Listening Visits if indicated

	○ Enhanced support for partner and family members ○ Enhanced breastfeeding support ○ Physical screening for mother if indicated • Ensure HVs are clear where to refer, if concerns about mother or baby escalate, including: ○ Specific local support groups ○ Infant Mental Health Service (if in place) ○ IAPT, supporting self-referral and attendance
Has an active mental health plan in place **Has a known condition that may deteriorate in pregnancy or post-partum**	• Continue to deliver agreed care plan, being alert for sudden escalation of symptoms • Continue to provide integrated support for young parents who are accessing CAMHS • Pick up issues from any birth trauma events and provide ongoing support and risk management • Focus on keeping the woman safe, and at home if possible • Support for CMHTs to manage acutely ill women at home • Access to Mother and Baby Unit beds, if admission becomes necessary • Provide post-pregnancy planning for future pregnancies
Is currently well and not accessing mental health services. **She has had previous mental health problems and is at high risk of relapse**	• Continue to deliver agreed care plan, being alert for sudden escalation of symptoms • Facilitate access to community support groups • Ensure access to information about medication and immediate feeding choices • Telephone advice for GPs and others relating to medication • Access to specialist advice, support and treatment, if woman's condition deteriorates • Access to Mother and Baby Unit beds, if admission becomes necessary • Provide post-pregnancy planning for future pregnancies
Has no history of mental health problems but suddenly becomes severely unwell	• Pick up issues from birth trauma event and provide ongoing support and risk management • Urgent referral for specialist assessment: to SCPNMHT if one is in place, otherwise mental health services • May need Crisis Team support • Provide community based social support as well as medicalised intervention

Glossary

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CQC	Care Quality Commission
EMDR	Eye Movement Desensitization and Reprocessing
EPDS	Edinburgh Postnatal Depression Scale
GAD -2/-7	Generalised Anxiety Disorder Scale
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HESW	Health Education South West
HV	Health Visitor
iHV	Institute of Health Visiting
IAPT	Improving Access to Psychological Therapies
MBU	Mother and Baby Unit
MECSH	Miller Early Childhood Sustained Home-visiting
MORS	Milestones of Recovery Scale
NBAS	Neonatal Behavioural Assessment Scale
NCT	National Childbirth Trust
NHS	National Health Service
PCLS	Primary Care Liaison Service
PCOMs	Patient Centred Outcome Measures
PHQ9	Patient Health Questionnaire
PIMH	Perinatal and Infant Mental Health
PSHE	Personal, Social, Health and Economic Education
PTSD	Post Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
SCN	Strategic Clinical Network
SCPNMHT	Specialist Community Perinatal Mental Health Team
WTE	Whole Time Equivalent