The Perinatal Mental Health Care Pathways

Full implementation guidance

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

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Foreword

Having a baby is a time of great excitement and joy for the expectant parents, but it is also a time of tremendous physical and emotional change. One in five women will experience a mental health problem during their pregnancy and in the first year after birth, with depression and anxiety disorders being the most common. Just like the physical health problems that can occur during and after pregnancy, emergent and existing mental health problems should be valued equally and treated promptly. This is especially important because suicide continues to be a leading cause of maternal death in the UK. Prompt and effective treatment not only minimises the risks for the mother, but also minimises the risks to her child's emotional, social and cognitive development.

This is why we are so committed to ensuring that every woman can access the right care at the right time, from the moment she starts planning her pregnancy right through to the end of the first postnatal year. The Five Year Forward View for Mental Health sets out clear objectives for improving perinatal mental health services across England. This includes expanding the provision of specialist perinatal mental health services, as well as strengthening the wider provision of care. Once implemented, these objectives will see 30,000 more women being able to access evidence-based care closer to home.

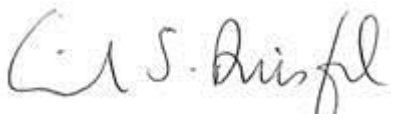
Our first task is to tackle existing gaps in access to specialist perinatal mental health services. National procurement of inpatient mother and baby units (MBUs) and specialist perinatal community mental health teams has started in the parts of the country where they are most needed. This will be funded through an investment of £365 million up to 2020/21. Funding will also be used to set the grassroots of sustainable change, including upskilling and expanding our workforce.

Every day across the NHS, excellent support is being offered to women by GPs, IAPT practitioners, midwives, health visitors and liaison mental health practitioners. We will continue to help these services to provide effective treatments that are tailored to each woman's needs. This will include supporting local delivery through the expansion of perinatal mental health networks.

With the experiences of the mother and child firmly at the centre of our plans, this implementation guidance is an important tool that helps us develop better perinatal mental health services consistently across England. It sets out five new pathways outlining timely access to evidence-based care. Each pathway captures a different aspect of care, depending on the mental health problem and the phase of pregnancy.

Working together, transparently and collaboratively, we will be able to deliver timely and consistent person-centred care for all women across the perinatal mental health care pathway. This will lead to better health and wellbeing for our current generation, as well as for those that follow.

Jo Black
Associate National Clinical
Director for Perinatal Mental Health



Giles Berrisford
Associate National Clinical
Director for Perinatal Mental Health

Key statements

The following statements are based on what the Expert Reference Group considered to be the most vital messages of this implementation guidance. They are written from the woman's perspective, to highlight the need to develop perinatal mental health services with the woman at the centre.

"I know that if I am planning a pregnancy and have a severe mental health problem, I will be able to be seen for preconception advice in my local community so that I have the information and advice I need to plan my pregnancy effectively."

"I know that during pregnancy and post-pregnancy check-ups, I will be routinely asked about my physical and mental health, as well as the health of my baby. If I am worried about my mental health, I will be able to discuss my concerns with someone in a supportive environment."

"I know that if I need a specialist assessment, I will be seen quickly and know the outcomes and next steps for treatment and care."

"I know that if I have a mental health problem during or after pregnancy, it will be treated with the same urgency as a physical health problem. This means that I will be able to receive the right care at the right time, based on my needs."

"I know that if I experience a mental health problem it will be treated with the same urgency, compassion and respect as a physical health problem. I know that if I experience a mental health crisis it will be treated as a medical emergency."

"I know that I will have a choice of a range of NICE[a]-recommended treatments, including psychological interventions, and, with the help of staff, will be able to make decisions that are right for both me and my baby."

"I know that if I need care in hospital for a mental health problem, I can stay with my baby in an MBU and will be able to go there as soon as possible."

[a] National Institute for Health and Care Excellence.

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1 Introduction

The pathway values statement

This guidance represents a commitment to ensuring that mental health care is delivered in a **person-centred**, **compassionate** and **supportive** way, promoting **safety** and **wellbeing** at the forefront. Mental health service provision should be **needs-led**, **responsive** and delivered in a way that **empowers** people to build on their strengths, promotes **recovery,** supports **families and carers**, and ensures **equality and fairness** for all.

1.1 Background

The Five Year Forward View for Mental Health set out the ambition that by 2020/21, 30,000 more women each year will be able to access specialist perinatal mental health care and treatment, in the community and inpatient settings. This ambition includes introducing mental health care pathways to help reduce unwarranted variation in quality in perinatal mental health care in England. NHS England has agreed to implement these, supported by additional investment of £365 million between 2015/16 and 2020/21.

Sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) are the vehicles for the transformation of all health and care services in a specific geographical footprint, and plans should be aligned with the overarching principles and ambitions set out in The Five Year Forward View for Mental Health and other documents listed in the box on the right.

1.2 Purpose and scope of this document

This guidance introduces a series of pathways that outline access to services for women with a mental health problem in the perinatal period (defined as pregnancy and the first 12 months after childbirth) or with a past or current mental health problem who are planning a pregnancy.

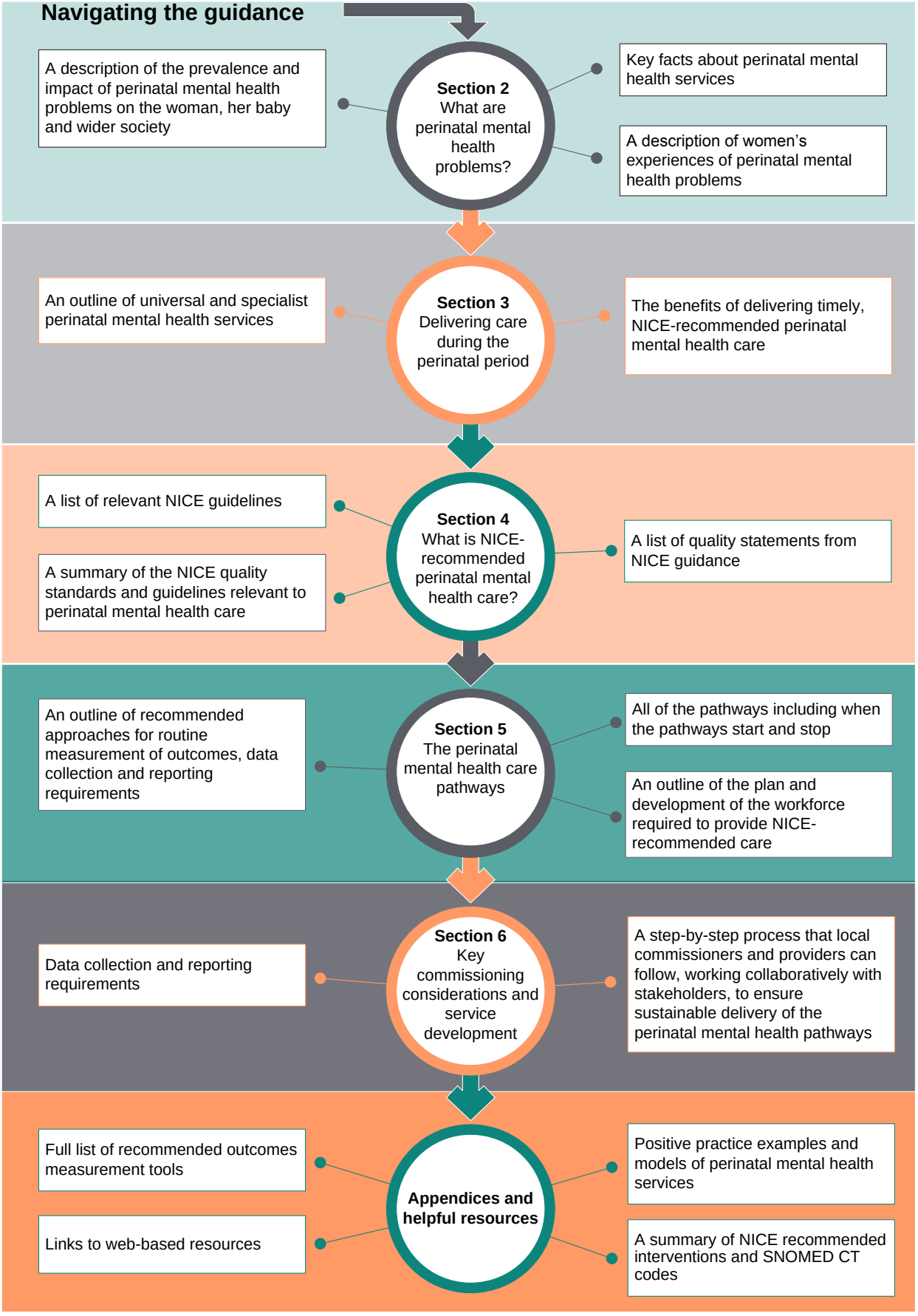
A key principle across the pathways is timely access to evidence-based perinatal mental health care for all women who need it. The evidence is clear that prompt access to effective treatment aids recovery and reduces NHS costs.

This guidance is primarily aimed at clinical commissioning group (CCG) mental health commissioners and providers of perinatal mental health services, statutory and non-statutory social care providers and local authorities, working collaboratively with women who use perinatal mental health services and their families and carers.

Key initiatives and policy drivers:

- The Five Year Forward View for Mental Health[1]
- Implementing the Five Year Forward View for Mental Health[2]
- Next Steps on the NHS Five Year Forward View[3]
- NHS Operational Planning and Contracting Guidance 2017–2019[4]
- Refreshing NHS Plans for 2017/18[5]
- Stepping Forward to 2020/21: The Mental Health Workforce Plan for England[6]

The following diagram shows how to navigate this guidance:


Navigating the guidance
A description of the prevalence and impact of perinatal mental health problems on the woman, her baby and wider society
Section 2 What are perinatal mental health problems?
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A description of women's experiences of perinatal mental health problems
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All of the pathways including when the pathways start and stop
An outline of the plan and development of the workforce required to provide NICE-recommended care
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A step-by-step process that local commissioners and providers can follow, working collaboratively with stakeholders, to ensure sustainable delivery of the perinatal mental health pathways
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Links to web-based resources
Appendices and helpful resources
Positive practice examples and models of perinatal mental health services
A summary of NICE recommended interventions and SNOMED CT codes

1.3 How was this guidance developed?

The perinatal mental health care pathways and this accompanying guidance and appendices and helpful resources have been developed by the National Collaborating Centre for Mental Health (NCCMH) following a process agreed with NICE, with involvement from an Expert Reference Group. This group included experts by experience, carers, practitioners, academics, commissioners, service managers and representatives from national NHS arm's length bodies.

1.4 Expectations of commissioners and providers

Commissioners and providers are already acting to ensure that services are being developed and improvement plans put in place in accordance with the NHS Operational Planning and Contracting Guidance 2017-2019, Refreshing NHS Plans for 2018/19 and Implementing the Five Year Forward View for Mental Health. New funding is available to support the development of specialist perinatal mental health services (£365 million between 2015/16 and 2020/21), and it is increasing over that period.

The availability and quality of these services may also be considered as NHS Improvement develops future iterations of its Single Oversight Framework.[7]

Commissioners should ensure that local service development plans for perinatal mental health services:

- are **co-produced** and implemented in collaboration with women using the services, their families and carers, as well as local mental health care providers, staff and partner organisations
- have **equity of access for all adults** – local commissioners should make explicit how they have taken into account their duties in relation to the Equality Act 2010,[8] and with regard to reducing health inequalities as set out in the Health and Social Care Act 2012.[9] Service design and communications should also be appropriate and accessible, to meet the needs of diverse communities – see Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties.[10]

A summary of the pathways for perinatal mental health care

Pathway 1: Preconception advice

Women with a complex or severe mental health problem (current or past) who are planning a pregnancy should receive timely preconception advice from a specialist community perinatal mental health service before they become pregnant.

Pathway 2: Specialist assessment

Women referred to a specialist community perinatal mental health team with a complex or severe perinatal mental health problem (known or suspected) should have timely access to a biopsychosocial assessment. Where a need for ongoing care or intervention is identified, the woman should also have an agreed care plan in place and have been allocated to a named professional.

Pathway 3: Emergency assessment

On receiving the referral for a perinatal mental health crisis, the mental health professional should contact the most appropriate person (the woman in crisis, family member/carer, or health or social care professional) without delay and agree the next steps to be provided in the woman's care and support. This should be done in line with national guidance such as the urgent and emergency liaison mental health care pathway guidance.

Failure to provide an emergency referral and adequate assessment or start treatment immediately poses significant risk to the mother and baby.

The woman should:

- have had a biopsychosocial assessment and an urgent and emergency mental health care plan in place, **and**
  - as a minimum, be en route to their next location if geographically different, **or**
  - have started the referral process for admission to an MBU, **or**
  - have been accepted and scheduled for intensive follow-up care at home or by the specialist community perinatal mental health team

or

- have immediate access to care and support if she is waiting for an admission to an MBU

or

- have started assessment under the Mental Health Act.

Pathway 4: Psychological interventions

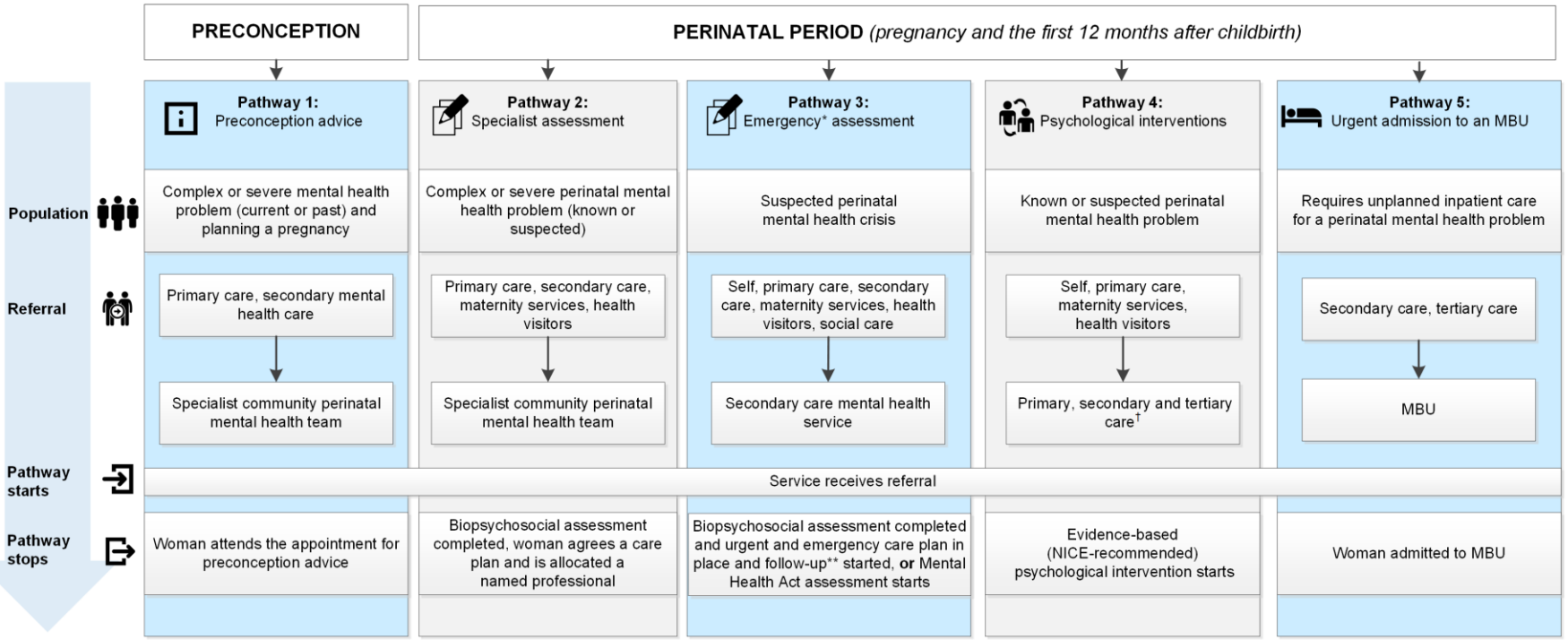
Women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period should receive timely access to evidence-based (NICE-recommended) psychological interventions.

Pathway 5: Inpatient care (MBUs)

Women who need unplanned inpatient care should have urgent access to an MBU.

A full description of the pathways can be found in Section 5.

The perinatal mental health care pathways summary diagram



IAPT = Improving Access to Psychological Therapies; MBU = mother and baby unit.

* *In line with the urgent and emergency liaison mental health care pathway guidance.*

** *Follow-up is defined as one of the following: being en route to the next location (if geographically different); having started the referral process for admission to an MBU; having been accepted and scheduled for intensive follow-up care at home or with the specialist community perinatal mental health team.*

† *Where a psychological intervention is provided by an IAPT service, the IAPT access and waiting time standard applies.*

2 What are perinatal mental health problems?

I felt I needed [to] keep up the facade of a 'perfect mum & wife' and keep a spotless home, the pressure I felt was so overwhelming. (Pressure which was mostly put on me by myself) I constantly compared myself to others ... But this all made me feel worse, it fed my negative thoughts, increased my depression and it was exhausting. When my [postnatal depression] was diagnosed my first reactions were a mix of relief at realising what it was and great shame/embarrassment. I felt I couldn't dare tell people – after all what do I have to feel depressed about? I have everything I wished for and I knew I was lucky, a lovely home, beautiful healthy children and a loving husband. I feared people would think I was being ungrateful, and I didn't have a right to feel depressed when others have such awful things going on in their lives.

A woman with postnatal depression, taken from The Pressure of Perfection blog

In this guidance, a perinatal mental health problem is defined as any mental health problem that occurs during pregnancy and the first 12 months following childbirth. The experience of mental health problems in that time is likely to be similar in nature, course and risk of relapse to those at other times in a woman's life,[11] but postpartum psychosis (the sudden onset of psychotic symptoms after childbirth) is unique to the postnatal period. The key difference in the provision of care for perinatal mental health problems is a more pressing need for prompt and effective care because of the impact they can have on both the woman and her baby (see Section 2.2).

2.1 How common are perinatal mental health problems?

About one in five women will experience a perinatal mental health problem.[12] Depression and anxiety disorders (such as generalised anxiety, social anxiety, obsessive-compulsive and post-traumatic stress disorders) are the most frequent, occurring in around 15% of women in the perinatal period.[11]

Serious mental illness requiring admission is much less common, with around two to three women per 1,000 deliveries being admitted to an MBU.[13 14]

Postpartum psychosis is even less common, affecting one to two out of every 1,000 women who give birth.[15]

Risk factors for the development of mental health problems during the perinatal period are comparable to those at any other stage. These factors include a history of mental health problems, childhood abuse and neglect, domestic violence, interpersonal conflict, inadequate social support, unplanned or unwanted pregnancy, and migration status.[12 16] As well as increasing the odds of a maternal mental health problem, these factors can also directly impact on the developing child. A history of bipolar disorder (or postpartum psychosis) can markedly increase the risk of postpartum psychosis and is an important indicator for further assessment and monitoring, even if the woman is well and has had no recent episodes of illness.[11 12] Monitoring is particularly important in the first 3 months after birth where there is an increased risk of psychosis (with highest risk in the first 2 to 4 weeks after birth).[13 14]

2.2 The impact of perinatal mental health problems

Mental health problems during pregnancy can have a harmful impact not only on the woman but also on the unborn or developing baby, and wider society.

2.2.1 Impact on the woman

Without treatment, perinatal mental health problems can lead to a range of adverse psychological, social, parenting and employment outcomes in the woman,[12] including an increased risk of relapse.[17] These impacts can be intensified for some severely unwell women, for whom the speed and progression of a severe mental illness may be more rapid during the perinatal period.[12]

If the problem is particularly severe (such as the onset of an acute psychotic episode), lack of prompt and effective treatment can have very serious consequences, including suicide.[18] Although maternal deaths are low in the UK, deaths related to psychiatric disorders contribute to a significant proportion of such deaths.[19] Maternal death by suicide in the UK is the leading cause of direct deaths for women during the perinatal period.[20 21]

2.2.2 Impact on the developing child and family relationships

Mental health problems during the perinatal period can also result in a broad range of negative outcomes in the unborn or developing baby. The risks, described above, are not inevitable, but are instead moderated by a range of factors. These include socioeconomic status, level of social support (including support for partners), parenting stress and the persistence and severity of the mental health problem.[22 23]

Exposure to a maternal mental health problem, and associated lifestyle factors, is associated with:

- during pregnancy, an increased risk of premature births and stillbirths,[24] obstetric complications,[25] congenital malformations[26] and delayed physical growth[23]
- an increased risk of behavioural and emotional problems for the baby later in life[23 27 28] and the possibility of lower IQ and poorer educational attainment[23]
- an increased risk of impaired mother–baby interactions and parenting difficulties, particularly in women with a chronic mental illness,[23 29 26] which in turn may have a negative impact on the baby.

When a mental health problem occurs in the absence of social adversity and the duration of the mental health problem is shorter, the risks to the baby are generally lower. This emphasises the need for prompt and effective care during this period, particularly for those parents at high risk (see Section 3.1).

2.2.3 Impact on society

Perinatal mental health problems are extremely costly to society. A report by the London School of Economics and the Centre for Mental Health estimates that for each 1-year cohort of births in England, lack of timely access to high-quality perinatal mental health care costs the NHS and social services £1.2 billion and society approximately £8.1 billion.[30] This is equivalent to almost £10,000 per birth in England. Of the societal cost, 72% relates to lost productivity resulting from the adverse impact on the child over their lifetime. Calculations were based on available evidence for certain disorders (depression, anxiety disorders and psychosis) and therefore may be an underestimate.

3 Delivering care during the perinatal period

3.1 What are the benefits of perinatal mental health services?

After what had happened with [my daughter], I was determined to be better prepared second time round. I discussed the issues thoroughly with my psychiatrist, who was positive that things would be better if we took the necessary steps. I felt it was better to try to stay well. It worked! Perhaps I was lucky, but I also think I helped to make my own luck second-time round. This is why it is so important to plan your pregnancy.

'Postpartum psychosis – and how I avoided it second-time round', *Pendulum*, September 2009

With timely access to a wide range of effective NICE-recommended psychosocial and pharmacological interventions,[31] many women will fully recover.[20 32 4] Many of these interventions also provide substantial long-term gains for the baby and wider family.[20]

The benefits of high-quality, perinatal mental health care include:

- **earlier identification:** advice and psychoeducation for the woman and immediate family can improve mental health awareness and encourage earlier identification – this is particularly important if there is a risk of rapid deterioration[15 33]
- **improved mother–baby interactions**, including strengthened attachment processes and improved parenting styles;[34] this in turn can help the mother to better adapt to and meet the child's needs
- **a positive experience of pregnancy:** for women with long-term mental health problems, early intervention, psychoeducation and preconception advice can be key to minimising risks and promoting a more positive experience of pregnancy
- **optimal management** of new and existing[35] perinatal mental health problems; this may improve quality of life and reduce adverse long-term outcomes for the mother and wider family[12 23]
- **early intervention:** this can minimise the risk of escalation and in turn lead to reduction in the number of avoidable inpatient admissions[36] and number of maternal deaths.[20]

A recent review has suggested that a range of universal and specialist interventions during the perinatal period can also deliver significant savings to society, as well as to the health and social care system.[35]

I was hugely blessed that the GP that I'd never seen before at my surgery was absolutely flipping wonderful... . She also said, 'Don't worry about crying, just be honest'. She listened to what I said and asked me to fill out the questionnaire for her about how I was feeling. It was a huge relief that day to have voiced my concerns and feel heard, but it was probably one of my scariest moments, too, as after recognising it for what it was, I realised just how much I was struggling and finally admitted that unless I got help I couldn't go on living the way I was. It was just too hard.

Spring Will Appear, 'My first trip to the GP', personal blog, 11 March 2015

3.2 A whole system approach to providing care and support during the perinatal period

A range of partners are involved in the delivery of care during the perinatal period. Care can be commissioned via NHS England, CCGs and local authorities, and should engage both the woman, as well as her partner, family or carer (where applicable).

The role of families and carers

Families and carers play an invaluable role in helping people to recover from perinatal mental health problems. It is vital their contribution as expert partners in care is recognised and valued. This includes being able to access support as individuals and in their caring role (see the Care Act 2014 or Children and Families Act 2014 as applicable).

Key partners and providers include:

- **Universal services**, including primary care, maternity services and health visiting
- **Mental health services**, including Improving Access to Psychological Therapies (IAPT) and secondary care mental health services
- **Specialist perinatal mental health services**, including community teams and MBUs
- **Perinatal mental health networks**
- **Adult and children's social care**, which can support the woman and her family during recovery and the discharge process
- **Wider local authorities and social care**, which can address any key social needs and ensure access to support for example housing, employment, debt and benefits.

The delivery of care should be collaborative, take the whole pathway into account, and be underpinned by local awareness and high-quality training and development.

3.2.1 Universal services

Primary care services

Primary care is typically the first point of contact for a woman when she is pregnant or planning a pregnancy. Together with maternity services, primary care services are responsible for the woman's overall care in the perinatal period.

This care includes:

- providing advice on preconception care, including liaising with secondary mental health and specialist perinatal mental health services when necessary
- helping maternity services and health visitors conduct antenatal and postnatal health checks for the woman and the unborn and developing baby/child
- identifying, monitoring and assessing mental health problems
- providing and reviewing mental health interventions in primary care or in collaboration with IAPT, secondary mental health and specialist perinatal mental health services
- making referrals to IAPT, secondary mental health and specialist perinatal mental health services.

Maternity services and health visiting

Maternity services are responsible for the wellbeing of the woman and the safe delivery of the baby. Typically, there will be scheduled appointments during pregnancy, including a booking appointment in which the woman will be asked about her physical health and a series of standard questions about her mental health.[12] As part of this, they are also responsible for identifying additional physical and mental health needs and can play an important role in the recognition of perinatal mental health problems (see NICE quality statement 3).

In the week after childbirth, and for longer if necessary, midwives visit new mothers at home. Care is then handed over to health visitors who monitor the baby and support the parents, either at home or in community clinics. Throughout the perinatal period, maternity services and health visitors can help to identify emerging mental health problems and refer to appropriate mental health interventions (see Appendix A in the appendices and helpful resources).

3.2.2 Mental health services

Improving Access to Psychological Therapies

IAPT services provide NICE-recommended psychological interventions for adults with depression and anxiety disorders; this includes women during the perinatal period. NICE-recommended psychological interventions have been shown to be as effective as pharmacological treatments in many cases of depression and anxiety disorders, and many women also prefer them. Self-referrals, as well as referrals from primary or secondary care, are accepted by IAPT services.

It is important that local IAPT services take a flexible approach during the perinatal period to provide timely and effective support for women. See Section 1.5 of the positive practice examples, in the appendices and helpful resources, and the IAPT Manual for further information.

Secondary care mental health services

Initial presentation

A woman presenting to secondary care for the first time with a complex or severe mental health problem (or who is currently not in contact with services) may require a planned or urgent assessment. She might initially present or be referred to:

- a community mental health team (or a children and young people's mental health team if she is under 18 years old), or a crisis resolution and home treatment team (when the need for urgent assessment arises in a community setting)
- drug and alcohol services
- a mental health liaison team (in an emergency department, a general hospital or a maternity clinic or ward).

Following assessment, these services should agree an initial care plan with the woman that determines what care and support may be required from secondary mental health services (such as community mental health, drug and alcohol, eating disorders or personality disorder services) or specialist perinatal mental health services.

Longer-term care

Many women with complex or severe problems will already be in contact with secondary care services (or children and young people's mental health services if they are under 18 years old), and they may be pregnant or be considering getting pregnant. Secondary care mental health staff will discuss with the woman and determine what care and support may be required. This could involve:

- being given advice from a specialist perinatal mental health service on care and treatment (including annual reviews) in the perinatal period, with continuing care and case management (and home-based outreach services where needed) from generic secondary care services
- referral to a specialist perinatal mental health service, which might lead to a shared care role with the secondary mental health service or taking on responsibility for the coordination and delivery of care throughout the perinatal period.

Children and young people's mental health services

When women under the age of 18 experience perinatal mental health problems, it is important that they are provided with timely, age-appropriate care, advice and support. These are usually provided by children and young people's mental health services.

It is also important to consider infant mental health care to complement and support the wider ambitions of improving perinatal mental health care.

3.2.3 Specialist perinatal mental health services

Specialist community perinatal mental health teams

Specialist community perinatal mental health teams provide care and treatment for women during pregnancy and the postnatal period who have complex or severe mental health problems. They also offer specialist psychiatric and psychological assessment and treatment and liaise closely with other mental health services, maternity services and MBUs.

Key functions include:

- assessing women with complex and severe mental health problems in the perinatal period
- providing preconception advice to women with a history of severe mental illness who are considering pregnancy
- providing care for women with complex or severe mental health problems
- working closely with primary care, maternity, obstetric and secondary care mental health services (including children and young people's mental health services) and local authorities as appropriate, and advising on detecting, preventing and managing perinatal mental health problems
- referring and supporting admission to specialist inpatient services, and providing care and support for the woman when she is discharged.

Specialist community perinatal mental health teams should be multidisciplinary and include consultant perinatal psychiatrists, nurses, psychologists and psychological therapists, allied health professionals (such as occupational therapists) and nursery nurses. They also should have clear links with midwifery and health visiting, and should have appropriate links to social workers.

The Royal College of Psychiatrists' Perinatal Faculty has produced a prototype service specification for specialist community perinatal mental health teams, which can be found here.

Mother and baby units

MBUs are specialist inpatient services commissioned by NHS England. They provide inpatient care for women with a complex or severe mental health problem.

> ***They actually showed me different ways I can like cope with looking after [my baby] … It's kind of like a family. You don't really notice the transition from day to night staff and they're really warm and friendly and they're always willing to talk to you and always have time … Just knowing that there were other mums, it was just like the biggest comfort ever.***
>
> A mother, in Johnson S, Taylor LB, et al. Unpublished data, 2016

Their primary function is to enable women to receive care in an inpatient setting while remaining with their babies. Emergency admissions, including women detained under the Mental Health Act 1983[37] (amended 2007[38] and by the Policing and Crime Act 2017[39]), or planned admissions (for less urgent but complex cases), may be accepted. It is generally neither appropriate nor advisable for a woman and her baby to be admitted to an acute psychiatric ward. Further information can be found in the MBU service specifications.[40]

Key functions of MBUs include:

- providing effective treatment for the mother while at the same time admitting her baby, avoiding unnecessary separation of the two
- supporting the developing mother–baby relationship

- providing support and assistance in the care of the baby
- working closely with specialist community perinatal mental health teams and other providers in primary, secondary and social care to encourage timely discharge.

An MBU should be staffed by a multidisciplinary team that includes consultant perinatal psychiatrists, nurses and support workers, psychologists and psychological therapists, allied health professionals (such as occupational therapists) and nursery nurses. There should also be strong links with maternity, health visiting and social care.

3.2.4 Perinatal mental health networks

Perinatal mental health networks play an important role in supporting strategic planning and local delivery –see the Antenatal and Postnatal Mental Health NICE guideline.[12]

Networks perform a range of key functions, including:

- providing specialist advice to:
  - commissioners to support local decision-making on what a good service should look like
  - services, including maternity and mental health services (community and inpatient), for example on the development of materials to support preconception advice, including the use of medication
- facilitating training, including general awareness, core professional training and specialist training
- encouraging research and supporting routine outcome monitoring, audit and evaluation of local services.

4 What is NICE-recommended perinatal mental health care?

A key element of the pathways is the delivery of high-quality, evidence-based (NICE-recommended) care. High-quality perinatal mental health care is set out in the Antenatal and Postnatal Mental Health NICE guideline and quality standard.[42]

Further information on how commissioners can monitor the delivery of NICE-recommended care can be found in Section 5.7.

Antenatal and Postnatal Mental Health NICE guideline (NICE guideline 192)

A summary of the evidence-based recommendations can be found in Appendix A of the appendices and helpful resources.

Other NICE guidelines applicable to the perinatal period

- Antenatal Care for Uncomplicated Pregnancies NICE guideline
- Caesarean Section NICE guideline
- Intrapartum Care for Healthy Women and Babies NICE guideline
- Multiple Pregnancy: Antenatal Care for Twin and Triplet Pregnancies NICE guideline
- Postnatal Care Up to 8 weeks After Birth NICE guideline
- Pregnancies and Complex Social Factors NICE guideline
- Service User Experience in Adult Mental Health NICE guideline.

It should be noted that many of the other mental health guidelines are relevant to women in the perinatal period.

Antenatal and Postnatal Mental Health NICE quality standard – quality statements (NICE quality standard 115).

QS1. Women of childbearing potential are not prescribed valproate to treat a mental health problem.

QS2. Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

QS3. Pregnant women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.

QS4. Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.

QS5. Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.

QS6. Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.

QS7. [Developmental] Specialist multidisciplinary perinatal community services and inpatient psychiatric MBUs are available to support women with a mental health problem in pregnancy or the postnatal period.

Note. QS = quality statement.

5 The perinatal mental health care pathways

5.1 Timely access to evidence-based care

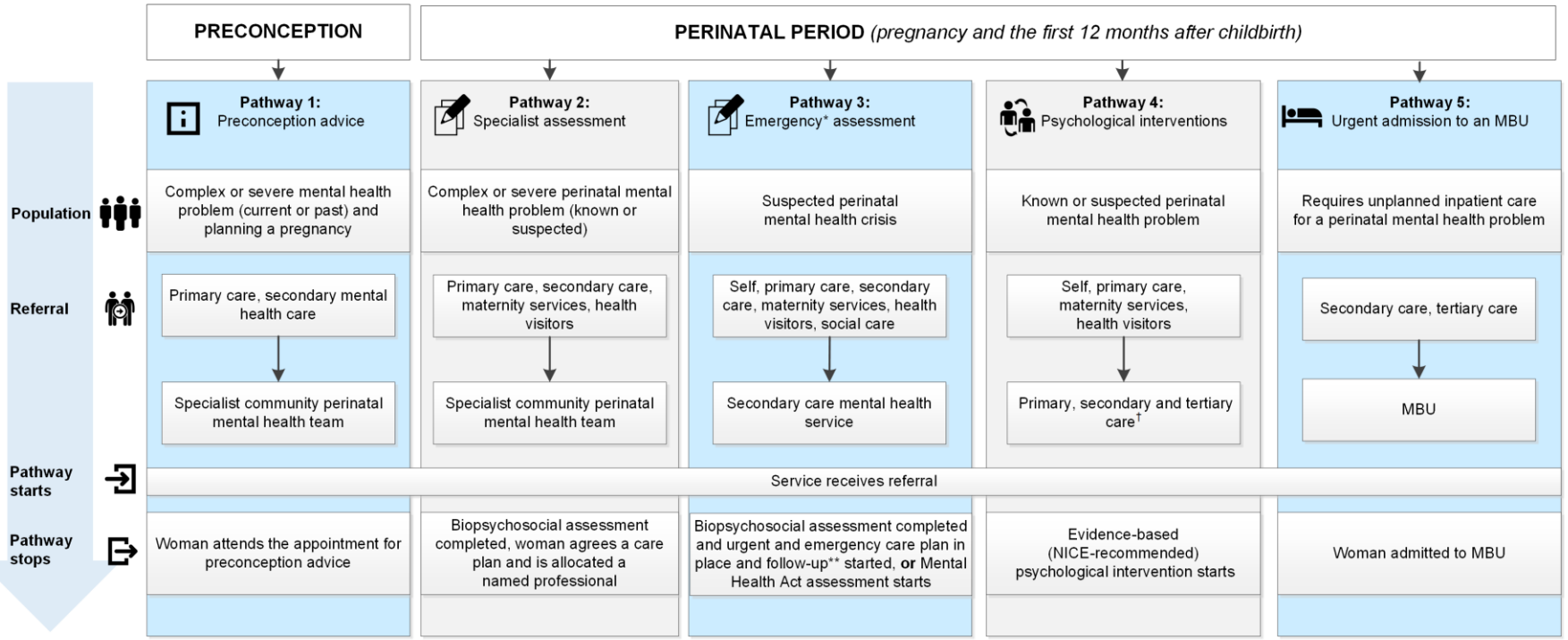
Most mental health problems are just as common in the perinatal period as at any other stage of a woman's life. However, when they occur there is a more pressing need for prompt access to care. This can improve outcomes for the woman and minimise the negative impacts on the unborn or developing baby/child (see Section 2.2).[12]

Work is underway to improve the provision of mental health services for women during the perinatal period (see Five Year Forward View for Mental Health: One Year On[41]). There are five pathways for perinatal mental health care (see Figure 1), which outline the delivery of timely access to evidence-based care (that is, treatment is to be delivered in accordance with NICE guidance; see Section 4). As investment in the system increases towards 2020/21, local areas should look at how the services and care they offer align with this guidance. This will help areas to reduce inappropriate variation and drive local improvement from a range of different baselines.

Timely access should remain a priority even when a woman moves between different pathways as her needs change.

Figure 1

The perinatal mental health care pathways summary diagram



IAPT = Improving Access to Psychological Therapies; MBU = mother and baby unit.

* *In line with the urgent and emergency liaison mental health care pathway guidance.*

** *Follow-up is defined as one of the following: being en route to the next location (if geographically different); having started the referral process for admission to an MBU; having been accepted and scheduled for intensive follow-up care at home or with the specialist community perinatal mental health team.*

† *Where a psychological intervention is provided by an IAPT service, the IAPT access and waiting time standard applies.*

5.2 Pathway 1: Preconception advice

Advice and monitoring can help prevent many avoidable mental health problems and minimise the risks associated with pregnancy, particularly in women at high risk of mental illness.[12 42] Up to 90% of women will stop taking medication for an existing mental health problem when they discover that they are pregnant, often without consulting a practitioner.[31 43] This can have major adverse consequences, including relapse (see Section 2.2). Access to good quality advice, information and support will help women make informed decisions during their pregnancy. These decisions should be jointly planned, in advance, by the woman with the practitioner.[12] Preconception advice may include:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem (including the risk of relapse)
- how a mental health problem and its treatment might affect the woman and her parenting style, and the unborn baby or baby, including the implications of medication and for breastfeeding.

Women with a complex or severe mental health problem (current or past), who are planning a pregnancy, should be referred to a specialist community perinatal mental health service for preconception advice. Referrals will typically be made from primary care, or from secondary mental health care.

Pathway 1:
Women with a complex or severe mental health problem (current or past) who are planning a pregnancy should receive timely preconception advice from a specialist community perinatal mental health service before they become pregnant.

5.2.1 Pathway starts

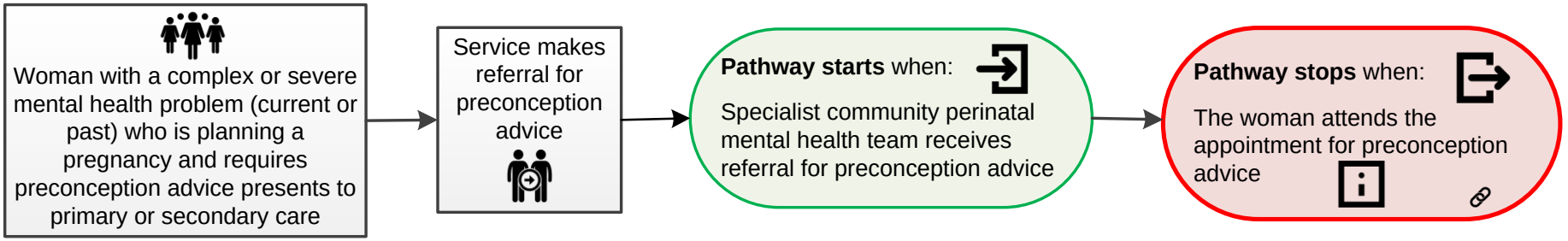
The pathway starts when the specialist community perinatal mental health team receives the referral (see Figure 2).

5.2.2 Pathway stops

The pathway stops when the woman attends the appointment for preconception advice. Preconception advice should include a review of current medication, as well as any benefits or risks associated with stopping or changing treatment. If a woman has a long-term mental health problem, it may be preferable for specialist advice to be provided for both the woman and the primary or secondary care team.

Reasons for non-attendance or cancellation should be recorded and monitored. In instances when preconception advice is no longer clinically appropriate (for example, the woman changes her mind about wanting to conceive), the woman should leave the pathway and this should be coded appropriately. If the woman becomes pregnant while waiting for an appointment, she should still be encouraged to attend the appointment for preconception advice.

Figure 2: Pathway 1: Preconception advice



*If a woman goes on to become pregnant, she may need a **specialist** or **emergency assessment** (**Pathway 2** or **3**), **psychological interventions** (**Pathway 4**) or **admission to an MBU** (**Pathway 5**).*

5.3 Pathway 2: Specialist assessment

To improve identification rates and reduce the long-term adverse outcomes of undiagnosed and untreated mental health problems, it is crucial that all women are asked about their mental health at each routine antenatal and postnatal contact.[12 42]

If a mental health problem is suspected, a face-to-face assessment should be conducted to identify any potential mental health problems during the pregnancy or the postnatal period. This helps ensure that at the earliest possible opportunity women are offered, and able to access, timely and appropriate treatment that emphasises recovery.

Pathway 2:
Women referred to a specialist community perinatal mental health team with a complex or severe perinatal mental health problem (known or suspected) should have timely access to a biopsychosocial assessment. Where a need for ongoing care or intervention is identified, the woman should also have an agreed care plan in place and have been allocated to a named professional.

When a complex or severe mental health problem is known or suspected, a referral should be made from primary or secondary care, maternity services or a health visitor to a specialist community perinatal mental health team for a biopsychosocial assessment.[12]

5.3.1 Pathway starts

The pathway starts when the service receives the referral (see Figure 3):

- if there is more than one referral, the woman enters the pathway when the first referral is received by the service
- when an onward referral is made, the woman enters the pathway when the service receives it.

5.3.2 Assessment

The Antenatal and Postnatal Mental Health NICE guideline recommends that a comprehensive and face-to-face perinatal mental health assessment is conducted (see Table 2 in Appendix A in the appendices and helpful resources for further details).

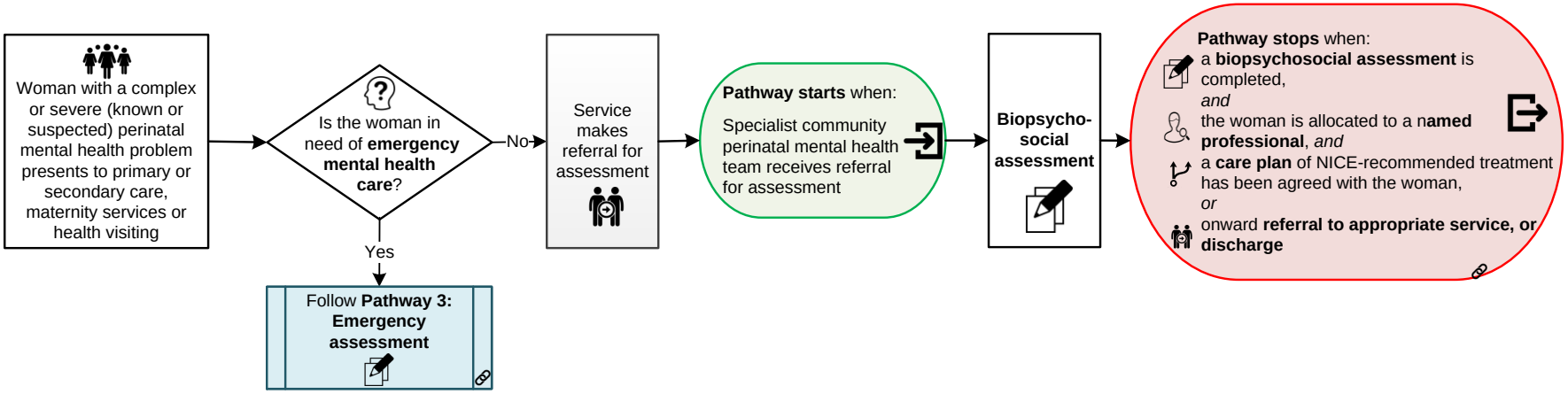
5.3.3 Pathway stops

If the assessment confirms a perinatal mental health problem that requires intervention from a specialist community perinatal mental health team, the pathway stops when:

- the woman has had a biopsychosocial assessment
- a care plan of NICE-recommended treatment has been agreed with the woman and is in place
- the woman has been allocated to a named professional.

If the woman does not require further intervention from a specialist community perinatal mental health team, she leaves the pathway once she has been told the outcome of the assessment and been discharged. The service should then still ensure that the woman receives any help that she needs. This may include an onward referral to an appropriate service, such as IAPT or primary or secondary care.

Figure 3: Pathway 2 – Specialist assessment



*The woman may go on to need an **emergency assessment** (**Pathway 3**), **psychological interventions** (**Pathway 4**) or **admission to an MBU** (**Pathway 5**).*

Principles for developing a care plan

- It is important that **a coordinated, agreed care plan is jointly developed with the woman and clinician**. The care plan should emphasise a recovery-based approach, with the woman at the centre. This may include the use of psychological interventions or referral to an MBU, as described in Pathways 4 and 5, respectively. A care plan might also include elective admission for those women known to be at high risk of relapse in the perinatal period, or for a parenting assessment.
- Once a care plan has been agreed, **treatment should start as soon as possible**, **at a time that is most appropriate to the woman's needs**.
- When a woman has more complex needs (for example, learning disabilities or acquired cognitive impairment), consideration should be given to **whether a specialist should be consulted** during the assessment and when developing the care plan. As part of this, if harmful or dependent drug or alcohol use is identified in pregnancy or the postnatal period, the woman should be **referred to a specialist drug/alcohol service** for advice and treatment.

  The **GP and referrer should also be informed of the outcome** of the assessment.

5.4 Pathway 3: Emergency assessment

A woman may experience a mental health crisis during the perinatal period for a variety of reasons, for example, onset of postpartum psychosis (which can lead to rapid deterioration), or a severe depression that places the mother and baby at risk of harm. When the woman (or anyone else) suspects a crisis, a referral should be made immediately for an emergency assessment. This may be carried out by a secondary care mental health service, such as a crisis resolution and home treatment team or a liaison mental health team. A specialist community perinatal mental health team should lead or support this assessment where possible. For further information on urgent and emergency mental health care, see the urgent and emergency liaison mental health care pathway guidance.

5.4.1 Pathway starts

The pathway starts when the service receives the referral (see Figure 4). If there is more than one referral, the woman enters the pathway when the first referral is received by the service. When an onward referral is made, the woman enters the pathway when the service receives it.

5.4.2 Response and assessment

On receiving the referral for a perinatal mental health crisis, the mental health professional should contact the most appropriate person (whether this is the woman in crisis, family member/carer, or a health or social care professional) without delay and agree the next steps to be provided in the woman's care and support. Contact may be face-to-face or by telephone, and should include support, advice and triage.

As part of this, the service should check whether any existing care plans are in place. A decision should then be made as to whether a biopsychosocial assessment or assessment under the Mental Health Act is appropriate.

Pathway 3:

On receiving the referral for a perinatal mental health crisis, the mental health professional should contact the most appropriate person (the woman in crisis, family member/carer, or health or social care professional) without delay and agree the next steps to be provided in the woman's care and support. This should be done in line with national guidance such as the urgent and emergency liaison mental health care pathway guidance.

Failure to provide an emergency referral and adequate assessment or start treatment immediately poses significant risk to the mother and baby.

The woman should:

- have had a biopsychosocial assessment and an urgent and emergency mental health care plan in place, **and**
  - as a minimum, be en route to their next location if geographically different, **or**
  - have started the referral process for admission to an MBU, **or**
  - have been accepted and scheduled for intensive follow-up care at home or by the specialist community perinatal mental health team

or

- have immediate access to care and support if she is waiting for an admission to an MBU

or

- have started assessment under the Mental Health Act.

5.4.3 Pathway stops

The pathway stops under the conditions listed in Pathway 3.

If the woman is not experiencing a mental health crisis or the crisis has resolved, she can leave the pathway. The service should ensure that the woman receives appropriate follow-up support. This should be provided by a specialist perinatal community mental health team (see Pathway 2, Section 5.3) or a community mental health team.

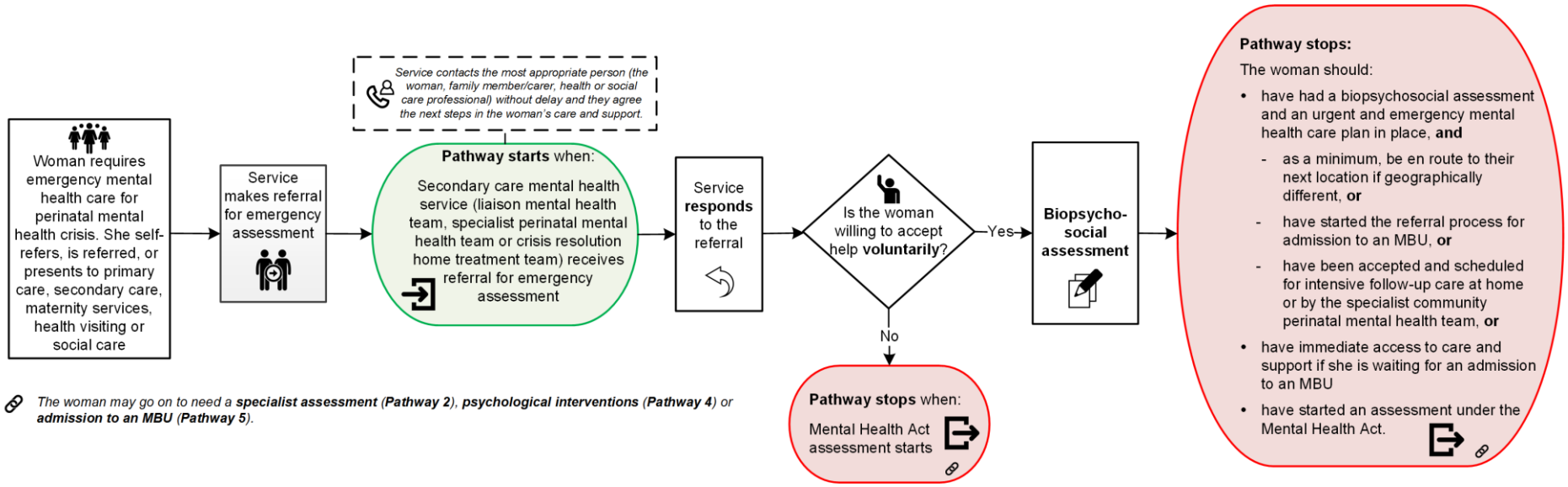
Mental Health Act assessment

If it is decided an assessment under the Mental Health Act is required, the pathway stops when the Mental Health Act assessment starts.

Principles for Pathway 3

- When it is not possible to conduct a biopsychosocial assessment, the service should have arrived to meet the person face-to-face and have had an initial crisis assessment as a minimum. A full assessment should be completed within a clinically appropriate timeframe.
- Where the assessment is conducted by a secondary mental health service, more advice should be sought as required from a perinatal specialist. This may be provided by a specialist community perinatal mental health team or MBU.
- Care should ensure the safety of the woman and the baby. This may include arranging an admission to an MBU unless there is specific reason not to do so (see Pathway 5, Section 5.6) or follow-up care with an intensive home treatment team or, where available, a specialist community perinatal mental health team.
- Immediate care should be made available if a woman is waiting for an admission to an MBU; this may be provided by an intensive home treatment team or where available, a specialist community perinatal mental health team.
- If the woman is on a maternity ward and is medically unfit for discharge, all provisions required to support her and closely monitor her mental state should be made.
- If the woman decides to discharge herself, and there are concerns regarding immediate harm, all efforts should be made to support her. This may include an assessment under the Mental Health Act.

Figure 4: Pathway 3 – Emergency assessment



5.5 Pathway 4: Psychological interventions

Many women who develop a perinatal mental health problem will have depression or an anxiety disorder. Psychological interventions (either alone or in conjunction with pharmacological treatment) are extremely effective for treating depression and anxiety disorders, and many women prefer them to taking medication.[12] They are also recommended for the treatment of a range of other perinatal mental health problems including severe mental illness and eating disorders.[12] See Appendix A (Table 3) in the appendices and helpful resources for a summary of NICE-recommended psychological interventions for women in the perinatal period.

Psychological interventions may be provided via primary, secondary or tertiary care. Where a psychological intervention is provided by an IAPT service, the IAPT access and waiting time standard applies.

Pathway 4:
Women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period should receive timely access to evidence-based (NICE-recommended) psychological interventions.

5.5.1 Pathway starts

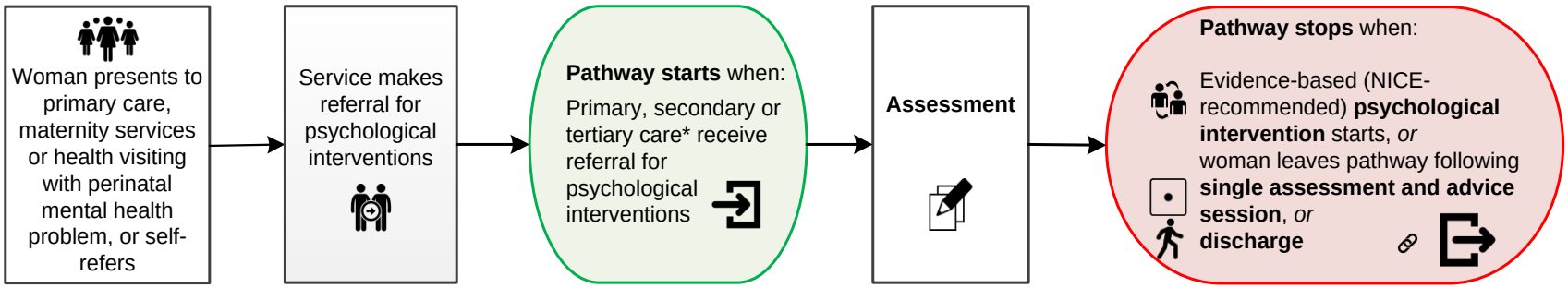
The pathway starts when the service receives the referral (see Figure 5). If there is more than one referral, the pathway starts when the first referral is received by the service. If a woman self-refers to a service, the pathway starts when the request is received by that service.

5.5.2 Pathway stops

Following assessment, if it is decided that the woman requires psychological therapy, the pathway stops when she has started an evidence-based (NICE-recommended) psychological intervention.

Some women may benefit from a single assessment and advice session and need no further treatment or are signposted to another appropriate service. If it is judged that the woman does not require treatment, she will leave the pathway.

Figure 5: Pathway 4 – Psychological interventions



** Where a psychological intervention is provided by IAPT service, the IAPT access and waiting time standard applies.*

*The woman may go on to need a **specialist or emergency assessment** (**Pathway 2 or 3**).*

5.6 Pathway 5: Inpatient care – urgent admission to an MBU

A small number of women with a complex or severe mental health problem will need unplanned inpatient care during the perinatal period. In these situations, both mother and baby should have urgent access to an MBU.[b]

MBUs provide support and care for the mother in her parenting role, and have staff with specialist expertise to manage complex or severe perinatal mental health problems (see Section 3.2.3).[12]

Pathway 5:
Women who need unplanned inpatient care should have urgent access to an MBU.

5.6.1 Pathway starts

The pathway starts when the MBU receives the referral (see Figure 6).

5.6.2 Pathway stops

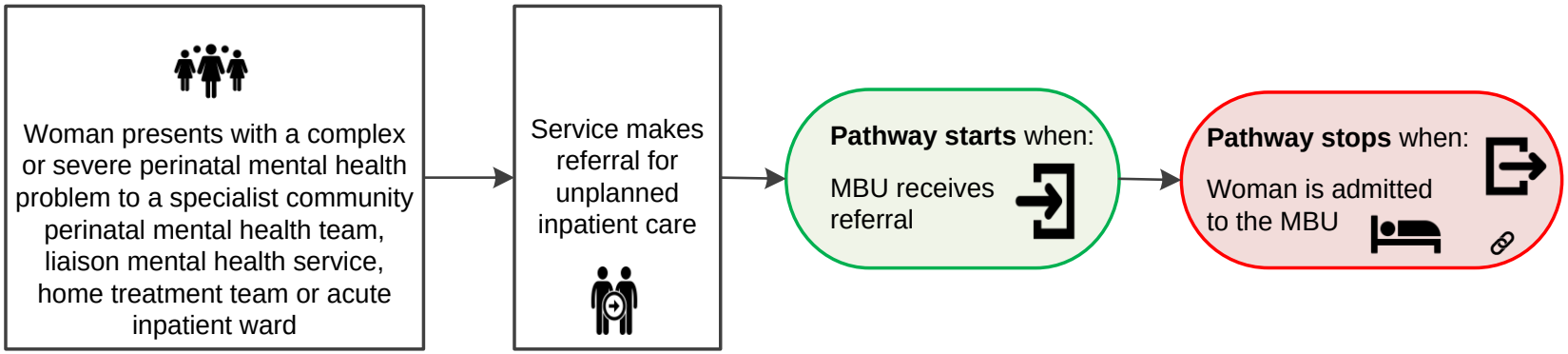
The pathway stops once the woman is admitted to an appropriate MBU.

Principles for admissions to MBUs

- Once the referral has been accepted, the referrer and GP should be informed of the admission by the next working day.
- It is the responsibility of the referrer to locate an MBU. In some circumstances (for example, if the MBU is too far away or the woman is unable to travel), the woman and/or her family may refuse the admission. In such instances the woman does not leave the pathway until the woman has been allocated to an appropriate MBU.
- In a small number of instances, an admission to an MBU is not appropriate; for example, a woman (or her family) expresses a strong wish not to be admitted, the woman is not the baby's primary caregiver, or there are safeguarding concerns.
- Where admission to an MBU is inappropriate, the woman may leave the pathway; the reasons should be recorded and monitored. Appropriate follow-up steps should be taken, including an agreed NICE-recommended care (community or inpatient) package.

[b] The criteria for admission to an MBU can be found in the Service Specification Document for MBUs.

Figure 6: Pathway 5 – Inpatient care: urgent admission to an MBU



*The woman may go on to need **psychological interventions** (**Pathway 4**).*

5.7 Measuring and reporting performance against the pathways

Complete, timely and accurate data collection, and subsequent submission to any national datasets, should be viewed as an integral part of any pathway and the responsibility of all service providers. Appropriate data collection helps improve service quality overall and is essential for services involved in follow-up care.

5.7.1 Submission of data items

The ambition is that changes will be made to the Mental Health Services Dataset (MHSDS) to incorporate key measurements of time and interventions related to the perinatal mental health care pathways to support implementation. It is anticipated that these changes should take effect from 2018/19.

Further guidance will be developed in due course about specific data items to support consistent and accurate data submissions, including how to use Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT) codes to report on delivery of interventions and care. SNOMED CT codes can be found in Appendix B in the appendices and helpful resources.

5.7.2 Outcome measurement

Clearly defined outcomes that are collected routinely (preferably on a session-by-session basis) are an essential part of measuring and monitoring the effectiveness of a service. The Expert Reference Group has recommended a range of outcome measures that are relevant to one or more pathway(s) (see Table 5 in the appendices and helpful resources). The group recognises that the needs of women with perinatal mental health problems and how they will be assessed could vary in frequency and duration, depending on the areas being assessed and the purpose of the assessment. In addition to their recommendations, the decision about which outcome measure to use should be informed by the specific disorder and established sources, such as existing NICE guidance (see Section 4), the IAPT dataset[c] and the International Consortium for Health Outcome Measurements.

5.7.3 Quality assessment and improvement programme

All specialist community perinatal mental health teams and inpatient MBUs will be expected to participate in a quality assessment and improvement exercise. This will be organised and administered by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) supported by the existing Quality Network for Perinatal Mental Health Services.

The CCQI worked with a subset of the Expert Reference Group that oversaw the development of this guidance to produce:

- an assessment framework, setting out expectations for care in accordance with the implementation guidance. It is expected that the assessment framework will focus on the quality of interventions, whether care is NICE-recommended, whether services are routinely using outcome measures and whether they are addressing inequalities
- web-based self-assessment tools (one for specialist community perinatal mental health teams and one for inpatient MBUs), which allow services to gauge their performance. Self-assessment returns will be validated and scored, and results from the self-assessment will be published. Services will be provided with benchmarking data to see how they compare with others nationally. Commissioners and providers will be able to use self-assessment

[c] Where care is provided by an IAPT service it should adhere to the IAPT minimum dataset.

information to target areas for service development and quality improvement.

Throughout the process, the CCQI will facilitate shared learning between clinical teams. The CCQI will also provide quality improvement advice and support to services.

5.8 Planning and developing the workforce required to provide NICE-recommended care

The right workforce, with the right capacity and skill mix, is essential for ensuring the delivery of NICE-recommended care.

Health Education England (HEE) has developed and published a tiered, multidisciplinary competency framework for perinatal mental health. The framework sets out the essential skills and knowledge necessary for all staff involved in the care of women with perinatal mental health problems. It sets out standards needed in education and training including raising awareness of perinatal mental health problems, knowledge and skills for those that have regular contact with women with perinatal mental health problems and knowledge and skills for those in leadership. HEE will also develop the framework digitally to improve ease of access and use.

6 Key commissioning considerations and service development

6.1 Introduction

With a national programme underway, a number of local areas have started to introduce effective and sustainable change, the pace and impact of which continues to accelerate in line with increasing investment until 2020/21. To ensure that 30,000 more women each year will be able to access perinatal mental health services by 2020/21, similar leadership, insight and determination is required across all local health and social care partners.

When designing and commissioning services, commissioners and providers should ensure that the primary ethos is safe, empathetic and compassionate care, which focuses on recovery.

Commissioners should ensure that women who use services, and their families and carers, are placed at the centre of the commissioning process. Taking a values-based approach to commissioning can help commissioners get a clear picture of what is happening in their local areas and provide good care that both meets the needs of the population and is economically viable.[44]

The following section is a practical guide outlining what is expected from commissioners, to support their preparations for implementing the pathway, including developing the capacity and capability of perinatal mental health services.

6.2 Joint strategic planning

Key to delivering these new ambitions will be the joint development of integrated care pathways that encourage multi-agency working between primary and secondary care, mental and physical health services, children's and adult services and health and social care.

Plans and decisions for change should be grounded in evidence and co-produced with key partners, service users and the wider public. Clinically-led specialist perinatal mental health implementation teams and networks have already started supporting the development of pathways in localities and can continue to provide helpful input and advice to support integrated working beyond local boundaries, including considering arrangements as part of local STPs and ICSs.

6.3 Understanding local demand

Effective approaches to reducing differences in access, experience of care and clinical outcomes are built from the best available evidence on why and how such variations occur. Commissioners should develop a rich picture of the current and future needs of the local population. This should be outlined in a Joint Strategic Needs Assessment. As part of this, commissioners should:

- **Estimate local incidence rates of perinatal mental health problems**: this includes using sources such as NHS Digital, the Office for National Statistics, National Child and Maternal Health Intelligence Network and Public Health England's Perinatal Mental Health Profile to get an accurate picture of conception and birth rates in the area
- **Understand local referral rates**: this includes collaborating with providers, women with perinatal mental health problems and their families and carers, clinicians and the public to build a realistic understanding of how many people are referred, as well as when and how they are referred
- **Understand the local demographic profile and variance in incidence and referral rates**: incidence and referral rates will vary across a range of

demographics, such as age and ethnicity. Perinatal mental health services should be designed to meet the needs of diverse communities, be accessible to them and be able to communicate with them effectively. An Equality Impact Assessment should be conducted to highlight the needs and solutions for specific groups at risk of inequality

- **Arrive at a local estimate** by combining the factors above.

6.4 Building a case for change

Commissioners should work with providers and wider stakeholders to agree on an objective or future service model. Proposed models should be driven by evidential data and best practice, as detailed in NICE guidance, NICE quality standards and other principles (including the Quality Network for Perinatal Mental Health Services and Community Teams).

Following the development of an outline service model, a plan should be produced that sets out the short, medium and long-term steps required to fill the gaps between the current model and the new model of pathways.

As part of this, commissioners should work with providers and people with lived experience to:

- **Apply their knowledge of local need to develop a workforce model that includes staffing complements and competences**. This should outline the number of teams, management, clinical leadership and any specific characteristics the team will need to address demographic considerations
- **Outline a service model of optimal pathways and systems**. This should map who does what, when they do it, how it is done, the outcomes that are achieved and what resources are required. It should include:
    - protocols for joint agency, including perinatal mental health networks
    - protocols for specialist assessment, including assessments for postpartum psychosis
    - provision of psychological interventions
    - provision of specialist perinatal mental health services
    - protocols for accessing MBUs
- **Compile a list of external and internal referral sources**, consulting with stakeholders to ensure that the list is comprehensive
- **Ensure that protocols and guidance are in place so that the pathways ensure equal access**. These should make it clear who should be referred and when, to ensure that the perinatal mental health care pathways can be implemented. There should also be protocols to ensure ageless services, parity of esteem and integrated services
- **Promote the use of perinatal mental health networks**
- **Encourage and support local research opportunities**
- **Provide referrers** (particularly primary care and maternity services) **with education and training programmes** to improve identification and referral rates. This should also include appropriate safeguarding training embedded in local protocols
- **Develop preventative programmes to address social and wider determinants of health.** Public Health England has published a wider range of resources to support commissioners to do this
- **Consider a public awareness campaign** to raise the overall levels of awareness and reduce stigma in the population about perinatal mental health problems. This should also focus on promoting psychosocial wellbeing of both the woman and her wider family.

In areas where there is a relatively small choice of providers (particularly in the availability of specialist perinatal mental health services), commissioners should use investment choices and levers to

influence service delivery, increase choice and stimulate the market.

6.5 Managing the local system

Once future quality standards, performance and workforce requirements have been outlined, an options appraisal for service reconfiguration, recruitment and workforce development will need to be considered jointly with providers.

This may include establishing task and finish design and implementation groups, with clear reporting structures, to support, oversee and review the development and implementation of these changes.

6.5.1 Service redesign plans

Service plans should be agreed with providers. This may involve the major or minor redesign of existing pathways. There should be arrangements to ensure:

- interventions are provided by suitably qualified staff who are properly supervised
- patient- and clinician-reported outcome measures and patient-reported experience measures are routinely collected and used effectively to improve care (see Section 5.7.2 and the appendices and helpful resources).

6.5.2 Staffing, recruitment and training plans

Providers will need to show they have sufficient staff trained in evidence-based interventions, collaborative practice and the use of outcome measures to meet the predicted need, or have a plan to develop the staff through a transformation programme. As part of this commissioners should:

- **Agree recruitment plans with providers,** including how they will address any specific demographic issues, including, where appropriate, the use of evidence-based parenting support programmes. In culturally and ethnically diverse areas, providers should actively try to ensure that the workforce reflects this same diversity
- **Agree training plans with providers**, engaging local education and training boards as necessary, and ensuring that there are sufficient numbers of trained staff by 2020/21. Training should be in line with the competency framework for perinatal mental health published by HEE.

6.6 Monitoring the new system and the impact of change

6.6.1 Agree data quality improvement and performance monitoring plans

NHS England are working with NHS Digital to update the MHSDS, and support routine, consistent measurement against the perinatal mental health care pathways contained within this guidance.

Commissioners should:

- **Agree a plan with providers to ensure the routine collection and use of outcome measures** specified in Section 5.7.2
- **Agree a data quality improvement plan with their provider** to ensure they will be able to fully report data in line with the perinatal mental health care pathways
- **Agree a schedule for performance reporting**, which may be worked into existing performance reporting and management arrangements and should be planned until at least 2020/21.

6.6.2 Electronic care records and information systems

The MHSDS will support the monitoring of the perinatal mental health care pathways (see Section 5.7.1). Commissioners should ensure that their local providers have made the necessary updates to their electronic care record system to ensure clinicians can enter the data required to

monitor performance against the perinatal mental health care pathways.

The electronic care record system should enable collection and submission of data in the following areas:

- whether access to treatment has been timely
- whether treatment accessed is in line with NICE recommendations (see Section 4 and Appendix A in the appendices and helpful resources)
- routine measurement of outcomes (see Section 5.7.2 and appendices and helpful resources

> ***We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone… we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.***
>
> The Five Year Forward View

6.6.3 Create and agree a benefits realisation plan

This should identify key benefits and set out how they will be delivered, measured and reported, in the context of a multi-year development trajectory. Key benefits of providing specialist perinatal mental health services should include:

- timely access to services for women
- improved care for women and their families and carers through delivering NICE-recommended interventions
- improved experience of service for women in need of perinatal mental health care
- the reduction and prevention of avoidable mental health problems and relapse in women with severe mental illness
- increased numbers of women who are able to access care.

Definitions of terms and abbreviations

Table 1: Definitions

Term	Definition
Biopsychosocial assessment	A comprehensive assessment that obtains information about a new/expectant mother and her baby's physical and psychological health, and any adverse circumstances that maintain the woman's presenting symptoms. It will also include her symptoms, behaviour, diagnosis and current treatment. Biopsychosocial assessments should be consistent with the Service User Experience in Adult Mental Health NICE guideline and quality standard.
Carer	Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and include those who care for people with mental health problems, long-term physical health conditions and disabilities.
Complex mental health problem	A function of the interaction between different factors that may vary in nature, intensity and duration. Factors include: the nature, severity, chronicity and prognosis of the mental health problem; the degree of cognitive and/or functional impairment of disability; the nature of the interventions being delivered and the setting in which they are provided; and the social and environmental factors that influence access to or delivery of care.
Emergency	An unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.
Expert Reference Group	A group of experts with a range of experiences, expertise and qualifications, established by the NCCMH to support the development of the implementation guidance and pathways. The Expert Reference Group included topic experts from commissioning and public health, service providers (including health and social care professionals from primary and secondary care services) and service managers, academics, health educators and women with lived experience.
Mental health crisis	A situation that the person experiencing the crisis or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.
Mother and baby unit (MBU)	A specialist service commissioned by NHS England providing inpatient care for women with severe mental illness or complex needs who cannot be managed in the community, during the last trimester of pregnancy and the first 12 months after childbirth. Their primary function is to enable women to receive care while remaining with their babies. An MBU should be staffed by a multidisciplinary team including consultant perinatal psychiatrists, nurses and support workers, psychologists and psychological therapists, allied health professionals (such as occupational therapists), health visitors and nursery nurses.
Perinatal mental health problem	In this guidance, defined as any mental health problem that occurs during pregnancy and the first 12 months after childbirth.
Postpartum psychosis	The sudden onset of psychotic symptoms after childbirth. Sometimes referred to as 'puerperal psychosis'.
Severe mental illness	In this guidance, defined as severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder and postpartum psychosis.
Specialist community perinatal mental health team	A team within a specialist community-based service for women with mental health problems during pregnancy and the postnatal period. The team should be multidisciplinary and include consultant perinatal psychiatrists, nurses, psychologists and psychological therapists, allied health

Term	Definition
	professionals (such as occupational therapists), nursery nurses and social workers.
Urgent	An urgent situation is serious but it is not immediately life-threatening and an individual may require timely advice, attention or treatment.
Urgent and emergency mental health care plan	A document put together jointly by the person requiring urgent and emergency mental health care and mental health professionals, which includes details of treatment options, goals, advice, and coping and self-management strategies. A crisis plan can also be included as an element of this care plan.

Table 2: Abbreviations

Abbreviation	Full term
CCG	Clinical commissioning group
CCQI	College Centre for Quality Improvement
HEE	Health Education England
IAPT	Improving Access to Psychological Therapies
ICS	Integrated care system
MBU	Mother and baby unit
MHSDS	Mental Health Services Data Set
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms
STP	Sustainability and transformation partnership

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