ENCLOSURE 3

Title: Specialist Community Perinatal Mental Health Service

SUMMARY:

The aim of this business case is to set out the case for investment to commission a new specialist community perinatal mental health service for the women of Bromley. This service will work with existing mental health and maternity services to provide high quality specialist mental health support to women and their families during pregnancy and the perinatal period.

The CCG does not currently commission specialist community perinatal mental health services as recommended in the national guidance (NICE CG192, RCPsych Service Standards, and Joint Commissioning Guidance). As a result Bromley was rated ‘red’ in the 2014 survey conducted by The Royal College of Psychiatrists’ Centre for Quality Improvement (appendix 1), and is in the lower quartile of London CCGs for perinatal mental health service provision.

Our ambition through this service development is that women will no longer need to comment that they felt they were “suffering in silence”, or that “nobody seemed to know what to do with me”, and that they only “got help at the point of desperation” when describing local services, as is the case at present (appendix 2).

This business case sets out the case for change and highlights how the development of a specialist community team and local care pathway will have a positive impact for women and their families, so that those in need of support can access appropriate, timely and evidenced based care and support.
KEY ISSUES:

Perinatal mental health services are concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. These problems include both new onset problems, recurrences of previous problems in women who have been well for some time, and those with mental health problems before they became pregnant.

Perinatal mental health problems are very common, affecting 20% or more of women at some point during the perinatal period. With 4,000 births per year in Bromley, this equates to more than 800 women likely to be affected per year.

Outlined below are the rates of perinatal psychiatric disorder per thousand births:

<table>
<thead>
<tr>
<th>Perinatal Psychiatric Disorder</th>
<th>Established rate per 1000 births</th>
<th>% of women affected</th>
<th>Expected Bromley cases based on 4000 births per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum psychosis *</td>
<td>2/1000</td>
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<td>8</td>
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<td>100-150/1000</td>
<td>10-15%</td>
<td>400-600</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>30/1000</td>
<td>3%</td>
<td>120</td>
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</table>

(* Indicates highest level of mental health need)

In line with national guidance, this business case proposes the development of a specialist community team to support women with the highest level of presenting mental health need (indicated by *) as well as enable the development of the local care pathway to improve access to, and support provided by mainstream services through increased awareness, training and education.

Whilst all women have access to appropriate mainstream services (GP, maternity, mental health, IAPT, health visiting), Bromley does not have a specialist community perinatal team.

The specialist team would work closely GPs as well as with maternity services during pregnancy and health visiting services post-natally, providing joint clinics for those women requiring high levels of support, care coordination for those considered to be at highest risk and medicines management advice for those on psychiatric medications.

The specialist team will take a lead in risk assessments and children’s safeguarding assessments as required, ensuring appropriate care planning is in place for women and their children. The specialist community team would also be responsible for providing education and training to health professionals in mainstream services, to increase awareness and early identification.
Two stories from women living in Bromley, who have experienced mental ill health during the perinatal period, highlight the impact that the lack of current provision and fragmented local care pathway has had on their lives. Whilst they are very different stories, both women describe **having to reach crisis point before benefitting from local services**, despite there being opportunities to intervene earlier in their care (appendix 2a).

The proposed service would have **stepped care approach** with most women continuing to being supported in primary care, with access to specialist advice or referral to specialist services for the most complex presentations.

The new service and care pathway would ensure a **clear and joined up approach** to meet the needs of any woman who identifies that they require mental health support during pregnancy or the post natal period. The service would have access to specialist mental health professionals (psychiatrist, psychologist, CPN, pharmacist, support worker), who would provide appropriate support, advice or signposting at the earliest opportunity.

As highlighted in the business case, **suicide is one of the main causes of maternal death** in the UK. Through commissioning a specialist community service the CCG would be ensuring that it was doing all it can to minimise this risk and reduce the likelihood of this tragic outcome for women in Bromley.

Whilst local service providers and health care professionals are committed to continuing to work together within available resources, **without further investment progress will limited** in improving services in the Borough.

The cost of developing a local specialist community team and community support for women in the Borough would require **£270,000 investment**. This will ensure that all women presenting with chronic, serious and severe mental health problems can receive specialist support in a timely manner (estimated to be approximately 100 per year in Bromley), with many more benefitting from a well defined care pathway, outlining the range of support services available.

In addition, the service will take a lead role in the **training and educating** of a wide range of professionals, leading to increased knowledge and awareness resulting in more women to be identified and supported to access appropriate services.

Savings directly attributable to the introduction of this service are difficult to quantify, however as outlined in the business case economic analysis demonstrates that the cost to the public sector is 5 times the investment of improving perinatal mental health services, when considering the lifetime impact of untreated mental ill-health on women and their families.

If investment is agreed, it is anticipated that the service could be fully operational **within 6 months** (subject to outcome of procurement options appraisal).
COMMITTEE INVOLVEMENT:

- Maternity and Mental Health Steering Group
- Mental Health Programme Board
- Joint Maternity Steering Group
- CCG Clinical Executive

PUBLIC AND USER INVOLVEMENT:

- The Bromley Maternity Services Liaison Committee representative has been involved in the development of this proposal.
- Two women have agreed to provide their patient experience stories (appendix 2)
- Further engagement is planned in the development of the local care pathway and service implementation

IMPACT ASSESSMENT:

- Equality Impact assessment – appendix 5
- Privacy impact assessment – appendix 6
- Quality impact assessment – appendix 7

RECOMMENDATIONS:

The recommendation is for the CCG to agree investment to support the development and implementation of a specialist community perinatal mental health team/pathway and community support service, to enhance the services available to women and their families in the Borough.

The recommendation is for the CCG to agree investment to support option 2, as outlined in the business case - the development and implementation of a specialist community perinatal mental health team and community support service.

It is requested that the Governing Body agree to delegate the decision on the most appropriate procurement process to the CCG Clinical Executive.

ACRONYMS

CCG – Clinical Commissioning Group
CPN – Community Psychiatric Nurse
RCPsych – Royal College of Psychiatry
SI – Serious incident
### DIRECTORS CONTACT:
- **Name:** Mark Needham  
- **E-Mail:** m.needham@nhs.net

### AUTHOR CONTACT:
- **Name:** Nicola Symes  
- **E-Mail:** nicola.symes@nhs.net  
- **Telephone:** 01689 866188

### GP CLINICAL LEAD:
- **Name:** Dr Sally Carson  
- **E-Mail:** sally.carson@nhs.net
## Programme Outcomes

- Development of local specialist perinatal mental health team.
- Improve knowledge and awareness of mental health issues in pregnancy and the post natal period within mainstream services.
- Improved care and support for women who experience mental health problems in the ante natal or post natal period.
- Implementation of NICE guidelines.
- Implementation of RCPych Guidelines
- Implementation of Joint Commissioning Panel for Mental Health Perinatal Guidance for Commissioners
- Implementation of IAPT Perinatal Positive Practice Guidance

## Additional Outcomes

- Improved well-being for children and families
- Increase awareness raising among professionals
- Education and development opportunities.
Business Case History

Document Location
This document is only valid on the day it was printed.

Revision History
Date of this revision: 13th April 2015

Date of next revision:

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Approvals
This document requires the following approvals.
Signed approval forms should be filed appropriately in the project filing system.

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<tr>
<td>Dr Andrew Parson</td>
<td></td>
<td>Chair, Bromley CCG</td>
<td></td>
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Distribution
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<tr>
<td>Jenny Selway</td>
<td>Public Health Consultant</td>
<td></td>
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<tr>
<td>Sally Carson</td>
<td>Maternity Clinical Lead</td>
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<tr>
<td>Dawn Newman-Cooper</td>
<td>Commissioning Manager</td>
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<tr>
<td>Sadie McClue</td>
<td>Safeguarding Lead Nurse</td>
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<tr>
<td>Gill Holden</td>
<td>Clinical Governance Lead</td>
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</table>

Impact Assessments
Equality and Diversity Impact Assessment – See Appendix 5
Quality Impact Assessment – See Appendix 6
Privacy Impact Assessment – See Appendix 7

Safeguarding & Quality Checklist
A brief note on each required to ensure consideration has been given and action taken where necessary.

Infection control
- The service provider will be required to have appropriate policy and procedures in place. There are no immediate infection control issues identified with this service development.
Safeguarding children (note statutory even when service is only aimed at adults)
- This service will have significant involvement in the safeguarding children agenda. They will provide mental health support to vulnerable mothers and consider the impact on their children. The team will work closely with other statutory services and health services regarding safeguarding.

Medicines
- This service will provide specialist prescribing advice to women and professionals at the pre-conception stage, pregnancy and in the post natal period, in relation to psychiatric medication, and the associated impact on the mother and child.

Equality and diversity
- The service provider will be required to have appropriate policy and procedures in place. This service will positively promote the mental health needs of women and their children.

Patient experience
- This service will significantly improve the current patient experience, by delivering a co-ordinated care pathway across agencies. This service will enable women to access specialist support and advice in a timely manner, and improve their continuity of care.
- The service will provide training and education to front line staff, raising awareness of mental health issues that can affect women in the perinatal period, thus increasing detection and treatment / support.

Business continuity
- The service provider will be required to have appropriate policy and procedures in place.

Serious incident management
- The service provider will be required to have appropriate policy and procedures in place. This would be monitored via regular quality review processes with the provider.

Risks to quality mitigated
- This service will mitigate identified risks within current service provision.

1 Background

1.1 Background

Over the last decade successive Confidential Enquiries into Maternal and Child Health (CEMACH), have highlighted the consequences of failing to identify and manage maternal mental health problems. Suicide has been identified as one of the leading causes of maternal mortality. There is growing evidence highlighting the long term risks for a child associated with maternal mental ill health both in the antenatal and postnatal period.

Bromley Clinical Commissioning Group Quality Assurance Sub-committee (QAS) requested a review of local services following a report regarding London’s maternal death and serious incidents (SI’s) in 2012/13 (published November 2013). It was reported there were 20 SI’s in this time which included 5 suicides and 4 postnatal

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1 The costs of perinatal mental health problems, Centre for Mental Health, 2014
mental health problems. It was also noted that 4 SI’s were recorded locally by South London Health Trust (SLHT).

This paper will outline the case for change, recommending the development of a local perinatal mental health service and associated local care pathway development. It is recommended that the local perinatal mental health pathway includes integrated services for the prediction, detection and treatment of mental ill health in women during pregnancy and the postnatal period (up to 1 year after delivery) and the care of women with an existing mental health problem who are planning a pregnancy.

This business case sets out the case for change and highlights how the development of a specialist community service and care pathway will have a positive impact for women and their families, so that those in need of support can access high quality, appropriate, timely and evidenced based care.

The supporting statements in appendix 2, describe the impact that this service development could have on the lives of women who have experienced mental ill health during the perinatal period (appendix 2a); the benefits of increased support that could be available to GPs (appendix 2b) and maternity services (appendix 2c) enabling them to access specialist mental health advice or services in a timely manner and the overall positive public health benefits of improved mental and emotional health and wellbeing of mothers and their children (appendix 2d).

1.2 Where are we now?

Bromley CCG

At present, community perinatal mental health support provided in Bromley is fragmented and extremely limited, is not specifically commissioned and is reliant on non-specialist mainstream services (appendix 7).

Whilst women have access to mainstream services such as GPs, midwives, health visiting, IAPT, secondary care mental health services, they are not currently designed to provide an integrated care pathway with maternity and health visiting services to provide comprehensive, co-ordinated care to women who have additional mental health needs in a timely manner. As demonstrated by the patient experience stories (appendix 2a), this can lead to the need for crisis response rather than timely early intervention.

The current model is not sustainable and is not in line with recommended clinical guidelines (NICE, CG192, December 2014).

Bromley CCG vs. Other CCGs

In April 2014, specialist Community Perinatal Mental health teams were mapped nationally, using criteria from the Service Standards developed by the Perinatal Quality Network for perinatal mental health services in association with the Royal College of Psychiatrists. CCGs across the country were scored from level 0-5 and colour coded from red (0) to green (5), dependent on provision of perinatal services. As indicated on the map below, Bromley was scored as level 0 /red, no provision (appendix 1), providing further support to the case for local change.
Stakeholder Engagement

A multi-agency maternity and mental health steering group was established by the CCG in the summer of 2014, with representation from Maternity (PRUH), Mental Health (Oxleas and IAPT), Service User representation, Health Visiting, GP, Public health and CCG commissioning to discuss local need and start early development work on the business case and local care pathway development.

Stakeholders involved in this group have provided a range of supporting statements and testimonials, as to how this proposed development would enhance existing service provision and improve the care and support available to women and their children. Of particular importance, are the two patient experience stories which highlight the gap in current service provision, and the positive impact this could have for women in the future, (appendix 2).

Subject to business case approval, this group would reconvene to oversee the development and implementation of local care pathways and service delivery.

Business Case Development

The aim of the business case is to identify additional investment to commission a specialist multi-disciplinary perinatal mental health service, to work within existing commissioned mental health and maternity services providing high quality mental health support to women and their families during pregnancy and the perinatal period.

2 Case for Change

2.1 National perspective

Perinatal mental illnesses are a major public health issue that must be taken seriously. If untreated, these illnesses can have a devastating impact on women and their families. They are one of the leading causes of death for mothers during pregnancy and the year after birth\(^2\).

Perinatal mental health problems are very common, affecting 20% or more of women at some point during the perinatal period. They are also of major importance as a public health issue, not just because of their adverse impact on the mother but also because they have been shown to compromise healthy emotional, cognitive and even physical development of the child, with serious long-term consequences.

There is an established principle that women with medical disorders in pregnancy should have access to a coordinated multidisciplinary obstetric and medical clinic, thereby avoiding the need to attend multiple

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\(^2\) The costs of perinatal mental health problems, Centre for Mental Health, 2014
appointments and poor communication between senior specialists responsible for their care. This principle should also apply to women with mental health needs.

Whilst it might appear that a relatively small number of women die from psychiatric causes (during pregnancy) in the triennia 2009–11 and 2010–12, it should be noted that deaths from psychiatric causes make a significant contribution to late maternal deaths (those occurring more than six weeks and up to one year after the end of pregnancy); 95 (23%) of the 419 late maternal deaths which occurred between 2009–12 were due to psychiatric causes.

In 2012, The Joint Commissioning Panel for Mental Health (JCPMH), collaboration co-chaired by the Royal Colleges of General Practitioners and Psychiatrists, published a guide to the key values and principles for effective perinatal mental health commissioning. Their report states that perinatal mental health services should include a number of elements, including specialised community perinatal mental health teams.

New NICE guidance [CG192] Antenatal and postnatal mental health: clinical management and service guidance, was published December 2014, which again highlights the requirements for local services, expected roles and outcomes. [https://www.nice.org.uk/guidance/cg192](https://www.nice.org.uk/guidance/cg192)

Additional guidelines to be implemented as part of this service development include:
- RCPsych Service Standards. Perinatal Community Mental Health Services
- IAPT Perinatal Positive Practice Guide
- Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services

### 2.2 Strategic Need

The epidemiology of perinatal psychiatric disorders is well established. The rates of perinatal psychiatric disorder per thousand births:

<table>
<thead>
<tr>
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<td>400-600</td>
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<tr>
<td>Post-traumatic stress disorder</td>
<td>30/1000</td>
<td>3%</td>
<td>120</td>
</tr>
<tr>
<td>Adjustment disorders and distress</td>
<td>150-300/1000</td>
<td>15-30%</td>
<td>600-1200</td>
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</tbody>
</table>

It is envisaged that the establishment of this service would enable direct provision of specialist care and advice to those women identified as experiencing severe or chronic mental illness during the perinatal period, and through support, training and advice to the wide range of mainstream health professionals improve the care available to all women in Bromley.

Data from local providers has been gathered to establish the existing level of local service delivery and local need based on recorded presentations to current services; however, it is acknowledged that ‘perinatal’ data is not specifically collected; therefore some of the information below is likely to be under-representative.

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3 Saving Lives, Improving Mothers’ Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 (December 2014), National Perinatal Epidemiology Unit
Maternity Service Data

- The PRUH has an estimated 4,000 Bromley births per year, with an estimated 490 individuals identifying a level of current or previous mental health problems at booking – 12.2% (2014 data).

IAPT & Counselling Data

- 2014 the Bromley IAPT service received an average of 50 referrals per quarter (200 annually) for ‘new mums’, and an average 25 referrals per quarter (100 annually) for pregnant women.

Secondary Care Mental Health

- Oxleas NHS Trust identified that there were 13 women identified as perinatal on the caseload (July 2014), who were currently being supported in the community mental health teams.

Specialist Inpatient Perinatal Services (NHSE commissioned)

- 2013 – 4 admissions to mother and baby unit
- 2014 – 1 admission to mother and baby unit
- 2015 – 1 admission to mother and baby unit

Health Visiting

- Data was not available for the number of women being supported by their Health Visitor, who would welcome access to mental health support post-natally.

Primary Care

- Data was not available for the number of women being supported by their GP, who would welcome access to specialist prescribing advice.

During planning meetings, it has been identified that data capture in this area needs to be improved, and therefore it is felt that the numbers indicated by the various service providers are under-representative of the likely true level of local need, this assumption is supported by the expected prevalence data outlined above.

2.3 Benchmarking

As identified in Appendix 1, the lack of local service provision puts the CCG in the lower quartile of London CCGs, being identified as one of only 8 CCG identified as ‘red’.

We have linked with the London Strategic Perinatal Network to identify areas of good practice and learn from other service models and areas of good practice. We would utilise the London Network data to inform the development of the local pathway and effective service implementation.

2.4 Service and Quality Issues

The lack of local specialist service has been highlighted by the CCG QAS as a significant quality and service risk and a priority to be addressed.
3  Options Appraisal

3.1  Identified Options

**Option 1: Do Nothing**
The service provision level could remain as is, reliant on non-commissioned special interest. This is not compliant with national strategic expectations of local perinatal mental health services or NICE guidelines. There are significant quality and patient risks associated with maintaining the current level of service provision.

**Option 2: Develop local specialist community perinatal mental health team/pathway (RECOMMENDED)**
The second option is to provide investment to establish a local specialist community perinatal team. The benefits of developing this service are wide ranging, in the provision of high quality mental health support and care for women and their families in the perinatal period. The benefits of such services are well-documented and researched, with long-term benefits to both the mother and child.

**Option 3: Fund a specialist perinatal worker**
The third option would be to fund a single worker to provide specialist liaison to maternity services. Whilst an improvement on existing provision, it would provide limited benefit, and is not in line with nationally recommended clinical practice or service delivery.

3.2  Summary Option Appraisal

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Option Appraisal Criteria</th>
<th>Option 1 Do nothing No service</th>
<th>Option 2 Perinatal Team (RECOMMENDED OPTION)</th>
<th>Option 3 Perinatal Worker</th>
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<tr>
<td>Clinical</td>
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<td>Patient Experience</td>
<td>Access</td>
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<td>Affordability</td>
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<tr>
<td>Strategy</td>
<td>Meets National or Local Strategy</td>
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</tr>
<tr>
<td>Delivery</td>
<td>Ease of delivery</td>
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</table>
4 Financial Assessment

National research and service delivery data highlights the following:

- Taken together, of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country.
- Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.
- Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).
- The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.
- Perinatal anxiety (when it exists alone and is not co-morbid with depression) costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child.
- Perinatal psychosis costs around £53,000 per case, but this is almost certainly a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety.

This national data can be used to extrapolate the impact of financial costs (and savings) to Bromley, which with approximately 4,000 births per year, the lifetime costs of untreated illness could be significant. It is anticipated that improved services in this area would provide significant quality benefits and contribute to the wider long term economic and societal benefits for women and their children.

It is anticipated that commissioning the service outlined below, the CCG would enable local mental health services to meet the needs of the local community. The team configuration has been informed by examples of good practice evidenced elsewhere in London and nationally, and through local discussion regarding anticipated local need.

The business case includes investment in a specialist multi-disciplinary clinical team, as well as a community support service to support women and families who are most vulnerable or at risk in the community, providing on-going peer support and ‘self-help’ for women to help them remain well in the community, and prevent relapse.

Proposed Investment

The total proposed investment for this service development is £270,000.

The proposed service outlined below, is in line with national and local clinical recommendation. The costs of perinatal mental health problems considered against the potential benefits of intervention, even a relatively modest improvement in outcomes as a result of better services would be sufficient to justify the additional spending on value for money grounds.

National evidence estimates that a benchmark for investment to provide a specialist community perinatal mental health team is £55 per live birth. Bromley has an estimated 4,000 live births per annum, thus indicating a benchmark for investment in the region of £220,000.

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4 The costs of perinatal mental health problems, Centre for Mental Health, 2014
Pay Costs

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Sub-total: Pay

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<tr>
<td>241,335</td>
</tr>
</tbody>
</table>

Non Pay Costs

<table>
<thead>
<tr>
<th></th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Expenses &amp; Travel</td>
<td>6,150</td>
</tr>
<tr>
<td>Training</td>
<td>2,870</td>
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</table>

Sub-total: Non Pay

<table>
<thead>
<tr>
<th>£</th>
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<tbody>
<tr>
<td>9,020</td>
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</tbody>
</table>

Corporate Costs

<table>
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<tr>
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<th>£</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>20,036</td>
</tr>
</tbody>
</table>

Total Bromley Perinatal Service

<table>
<thead>
<tr>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>270,391</td>
</tr>
</tbody>
</table>

Model assumptions:
Specialist midwives and obstetrician investment is included within the existing maternity contract tariff
All costing’s at mid-point pay scale

Identified Savings:
Savings directly attributable to the introduction of this service are difficult to quantify, however as outlined above economic analysis demonstrates that the cost to the public sector is 5 times the investment of improving perinatal mental health services. This includes a range of costs including, employment, loss of productivity and additional health care costs relating to the mother and child.

5 Proposed Model of Care

The National care pathways recommend a stepped care approach with most women continuing to being supported in primary care, with access to specialist advice or referral to specialist services for the most complex presentations. Outline care pathways are included in Appendix 3a and Appendix 3b, which would be adapted for local services during the implementation period if funding is agreed.

Two specific groups of women will require care and treatment to be provided by mental health services.

1. Women with a history of significant mental ill health who are considered to be at risk of relapse or recurrence of their illness associated with pregnancy and the postnatal period.
Pre-conceptual counselling forms a significant part of care for these women, including advice on medication and risk of relapse. This group of women require their care to be provided by a consultant psychiatrist and community mental health team, who are responsible for ensuring that each woman has a personal care plan in place.
2. Women who become acutely unwell during pregnancy or the postnatal period.
If there is a high level of concern or if there is evidence of a rapid deterioration in mental health, particularly within the first two weeks after childbirth, the woman requires urgent assessment by mental health services.

Whilst more work would need to be completed locally to apply local detail to the recommended national care pathways, policies and procedures, the function of the specialist perinatal mental health team would fulfil the following roles:

- Assessment and management (or management advice) for women suffering from puerperal psychosis and other severe postnatal mental illness.
- Provide support to women through out-patient clinics, community treatment and support and facilitate access to (NHSE commissioned) speciality inpatient units as required.
- Advise on, and as necessary, manage patients with continuing psychiatric disorder who become pregnant while under the care of other adult psychiatrists.
- Liaise with primary health care professionals to provide prescribing advice and assist in the management of less serious psychiatric conditions.
- Provide obstetric liaison services, assessing mental health problems associated with pregnancy and the post-partum period.
- Provide support, care planning and risk management advice for women at risk of developing an illness post-partum owing to previous major mental illness.
- Contribute to the education and training of other health professionals.
6 Impact Assessment

This development will impact specifically upon women during pregnancy and the postnatal period (up to 1 year after delivery) and the care of women with an existing mental disorder who are planning a pregnancy; for whom the prediction, detection and treatment of mental disorders during and post pregnancy is very poor in Bromley.

This service would have a significant and positive impact for women and their families, and enable them to easily access specialist mental health support in a timely manner, reduce crisis presentations, and help support women to remain well in the community.

As demonstrated in the service user stories, appendix 2, it would be anticipated that this new service would avoid the need for a women in future to say:
“...Despite being proactive in asking at the earliest possible opportunity I did not get the support I needed”
“...I do not want any other woman to have to feel so alone during her pregnancy, so unsupported”
“....it really feels as though I had to almost lose my life before any real joined up approach was agreed.....”

This service would have the opportunity to provide significant health and social care benefits to women with mental health needs in the Borough, and provide them with support to give their children the best start in life.

Looking at the appendix 1 below, this would move Bromley from Level 0 (Red) to Level 3 (Amber) with immediate effect, working towards achieving level 4 (Green) within 12 months as local care pathways, protocols, awareness, training and education are embedded within local services.

7 Benefits Realisation

<table>
<thead>
<tr>
<th>Id</th>
<th>Description</th>
<th>Outcome</th>
<th>Measure</th>
<th>Benefit Owner</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Specialist Community provision</td>
<td>Increased support to vulnerable women and children in the community</td>
<td>Number of women supported</td>
<td>CCG Service User</td>
<td>0</td>
<td>tbc</td>
</tr>
<tr>
<td>2.0</td>
<td>Specialist Prescribing advice</td>
<td>Improved prescribing practice and advice for pregnant women / pre-conception / ante-natal and Breast Feeding advice</td>
<td>Prescribing review</td>
<td>Primary Care Maternity (PRUH) Service User</td>
<td>0</td>
<td>tbc</td>
</tr>
<tr>
<td>3.0</td>
<td>Patient and family experience</td>
<td>Increased support and specialist expertise. Improved health and well-being</td>
<td>Patient experience questionnaire</td>
<td>Patient</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>4.0</td>
<td>Joint Obstetric / mental health clinics</td>
<td>Improve joint working to support vulnerable women during pregnancy and postnatal period</td>
<td>Joint care planning</td>
<td>Service User Maternity (PRUH) Oxleas</td>
<td>0</td>
<td>tbc</td>
</tr>
</tbody>
</table>
Further detailed work regarding the above benefits, including service standards, patient experience and key performance indicators will be completed in collaboration with service users and other stakeholders as part of the final service specification development and in advance of service implementation. These indicators will be used as part of the contract monitoring process and service evaluation.

8 Procurement and Implementation

The new service would need to be commissioned from an established mental health provider, that can demonstrate high levels of competence in the provision of community mental health services, and effective liaison with other local providers, specifically maternity services, health visiting, social care and primary care.

The nature of the new service would require the perinatal team to have strong links with existing mental health services but to also liaise effectively with other local partners.

A key consideration in relation to the commissioning and delivery of this service will be the need for effective care co-ordination for women presenting with the highest levels of risk, noting the importance of continuity of care for the women currently under the care of local mental health services. (Local mental health services are currently provided by Oxleas NHS Foundation Trust.)

If the business case is agreed the procurement options for this service to be considered are:

- Commission from the existing service provider (Oxleas NHS FT), via a contract variation.
- Review alternative procurement options (such as open tender), assessing other potential service providers.

Initial review of other services and potential providers indicates that there are some regional providers, and some out of area Mental Health service providers who could provide the service. However, they may not have the local knowledge of services in Bromley and integration with other local services and agencies in the Borough to deliver the level of continuity of care that is required.

Further discussion and options appraisal regarding procurement is required. It is requested that the Governing Body agree to delegate the decision on the most appropriate procurement process to the CCG Clinical Executive.

Preliminary work on developing the local care pathways has commenced, this work will utilise the national good practice models included within appendix 3a and 3b. This will be finalised subject to funding approval and appointment of the agreed service provider.

A Gantt chart has been included in appendix 4, outlining the proposed delivery timetable for this service.

Once this service is operational, effective contract management and monitoring arrangements will be established with the agreed service provider. This will include monitoring against agreed activity plan, key performance indicators and clinical outcomes. There will be additional oversight from the Maternity Joint Commissioning Group.
9 Risks

The following risks to implementation have been identified. This will be developed further as part of the implementation project plan.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Probability</th>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>L</td>
<td>Delay recruitment of specialist staff</td>
<td>Liaise with local specialist inpatient service re possible secondment options.</td>
</tr>
<tr>
<td>L</td>
<td>L</td>
<td>Securing agreement of multi-agency care pathways</td>
<td>Escalation to ensure Executive support and commitment from all agencies.</td>
</tr>
<tr>
<td>H</td>
<td>M</td>
<td>Lengthy and expensive procurement</td>
<td>Contract variation</td>
</tr>
</tbody>
</table>

10 Recommendation

The recommendation is for the CCG to agree investment to support the development and implementation of a specialist community perinatal mental health team/pathway and community support service, to enhance the services available to women and their families in the Borough.

This service would enable the mental health needs of women to be better recognised, assessed and supported during pregnancy and the postnatal period.

Through the provision of high quality support, the likelihood of crisis presentations would be reduced and women will be supported to remain well in the community.

There are evidence based guidelines to support this proposal as well as a wider evidence of impact on and benefits to child health


This service development is supported by a wide range of stakeholders including service users, GPs (see appendix 2b), mental health and maternity services and public health (see appendix 2c), safeguarding and local authority children and family services.

It is considered that this service would provide the opportunity for a clear, integrated care pathway to be developed, improving the emotional and mental well-being of mothers and their children.

May 2015

NICOLA SYMES
SENIOR CONTRACTS MANAGER (VULNERABLE ADULTS)
BROMLEY CCG
APPENDIX 1

Specialist Community Perinatal Mental Health Teams (London)

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>COLOUR</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Green</td>
<td>Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 <a href="http://www.rcpsych.ac.uk/pdf/Perinatal%20quality%20network%20standards%201st%20edition.pdf">http://www.rcpsych.ac.uk/pdf/Perinatal%20quality%20network%20standards%201st%20edition.pdf</a></td>
</tr>
<tr>
<td>4</td>
<td>Green</td>
<td>Specialised perinatal community team that meets Joint Commissioning Panel criteria <a href="http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf">http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf</a></td>
</tr>
<tr>
<td>3</td>
<td>Orange</td>
<td>Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours</td>
</tr>
<tr>
<td>2</td>
<td>Yellow</td>
<td>Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time</td>
</tr>
<tr>
<td>1</td>
<td>Red</td>
<td>Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only</td>
</tr>
<tr>
<td>0</td>
<td>Red</td>
<td>No provision</td>
</tr>
</tbody>
</table>

Disclaimer: Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact [https://www.everyonesbusiness.org.uk](https://www.everyonesbusiness.org.uk) if you suspect any inaccuracy or know of recent developments that may alter the levels of provision listed here.

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby.

[www.everyonesbusiness.org.uk](http://www.everyonesbusiness.org.uk)
**Level 5, Dark Green:** The specialised community perinatal mental health team must meet all the following standards, developed by the Perinatal Quality Network for Perinatal Mental Health Services Service Standards April 2014:

1. Access and referral
2. Assessment
3. Discharge
4. Care and treatment
5. Infant welfare and safeguarding
6. Staffing and training
7. Recording and audit

**Level 4, Light Green:** The specialised perinatal community mental health team must meet the Joint Commissioning Panel criteria, as detailed below:

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. It should:

- respond in a timely manner and have the capacity to deal with crises and emergencies and assess the patients in a variety of settings including their homes, maternity hospitals and outpatient clinics
- have close working links with a designated mother and baby unit
- manage women discharged from inpatient mother and baby units
- Work collaboratively with colleagues in maternity services (including providing a maternity liaison service) and in adult mental health services with women with prior or longstanding mental health problems.

A good community perinatal mental health service will offer pre-conception counselling to women with pre-existing mental health problems and those who are well but at high risk of a postpartum condition.

**Level 3, Amber:** The perinatal community service operate throughout working hours with at least a specialist perinatal psychiatrist with dedicated time and a specialist perinatal mental health nurse with dedicated time with access to a perinatal psychiatrist throughout working hours

**Level 2 Yellow:** Specialist perinatal psychiatrist and specialist perinatal nurse with dedicated time

**Level 1, Pink:** Specialised perinatal psychiatrist or specialist perinatal mental health nurse with dedicated time

**Level 0, Red:** No provision

---

6 [Guidance for commissioners of perinatal mental health services: Joint commissioning panel for mental health](http://www.jcpmh.info/pdf/perinatal_web.pdf)
APPENDIX 2a

Service User Experience Stories

In preparation of this business case, the Bromley Maternity Services Liaison Committee (MSLC), were asked if any women having experience of current services would like to contribute. Their stories are below:

Testimonial A

For the majority of my pregnancy, my mental health was relatively good. I originally carried twins, but lost one at 10wks. For that reason, I had regular appointments with a consultant at my local hospital, rather than my local GP. This meant that I rarely saw the same midwife or consultant twice. One midwife said it was not ‘obvious enough’ on my notes that I had lost one of the babies I was carrying, so wrote “TWIN PREGNANCY” across the top of my file. As a result, in virtually every appointment, I was congratulated on expecting twins and I had to repeatedly explain that I had lost one.

I had told the midwife at my first appointment that I had a history of depression and she explained that, if I needed it, there was a midwife specially trained in mental health in expectant mothers and they could put me in touch with her if I felt I wanted extra support.

I didn't feel I needed this straight away, but in the last month of my pregnancy I experienced a sudden and dramatic increase in anxiety and depression. Because it came so close to my due date, I found that nobody really knew what to do with me. As I had seen so many midwives, there was nobody that had seen me throughout who could notice the change in me. I broke down in front of one midwife, who said I should get in touch with my GP. The specialist midwife I had been told about before was not available at short notice.

I saw my GP (again, in tears), who asked me what I wanted her to do and I asked to be prescribed antidepressants. This she did, but about an hour after our appointment, she called and said she had spoken to a mental health service (stepping stones), who had concerns about me starting antidepressants. I was booked in for an emergency appointment with stepping stones and advised not to start my prescription until I had spoken to them.

My mum came with me. I was in tears and admitted to the person I saw, in front of my mum, that I had suicidal thoughts. I was told it was largely due to hormones and that once I had the baby I would probably improve. They advised me not to take antidepressants, because there may be side effects for the baby and that I would not likely see an improvement before the baby arrived anyway.

By the time I went into labour, I had been averaging no more that 2-3 hours’ sleep a night, for about a month, because of the anxiety. I was physically and emotionally exhausted, so my mood plummeted further after I'd had my son. Two weeks after I left the hospital, I visited my GP begging for someone to
take my baby away. I was referred back to stepping stones and admitted to green parks hospital for three days. On returning home, I made a serious suicide attempt. I referred myself back to green parks and a couple of days after that I was finally given antidepressants.

From that point, I was given a lot of support, but it really feels as though I had to almost lose my life before any real joined up approach was agreed between stepping stones, my GP and the counselling I was then given by Oxleas.

Testimonial B

Having suffered in silence ante and postnatally in my first pregnancy I decided to seek help early when I became pregnant again. Highlighting the need for mental health support during my 12 week booking in appointment with my midwife warranted a referral to the midwife with a special interest in mental health. However it was a further two months before I could have an appointment to see her. Being overstretched so much it meant all she could do was signpost people to further interventions however she had no idea where to send me to. She suggested a community mental health team but was not sure on the way to refer because their policies were changing. In the end with no contact being made with me I had to go back to my GP to ask for further support. I eventually managed to get some help two weeks before my due date. This was from a lady who was interested in caring but had no specific experience with dealing with postnatal depression.

I was so determined that this pregnancy was going to be different. That I would feel well. That I would feel pleased I was pregnant. That I would get support earlier on. Despite being proactive in asking at the earliest possible opportunity I did not get the support that I needed. This is not in response to people not caring this is just a lack of resources, lack of specialist knowledge and lack of specialist support. I was lucky I have a supportive family who ran around and helped me. Others are not so lucky. I was to not ask for help so early and get to the point of desperation for support to be offered. That is so sad.

I hated myself. I was disgusted myself. I was a complete failure. I hated what was happening to me in my body. And it was made worse by everyone around you saying 'How excited you must be!' It's like rubbing your nose in it.

When I think about having another child the decision is certainly influenced by the impact that it might have on my mental health care and the lack of support that is out there currently. I do not want any other woman to have to feel so alone during her pregnancy so unsupported.

I can only imagine the desperation that some women are going through out there who are really struggling with her pregnancy and there is no support there. There is a huge need from specialist care and to break the taboo of mental illness in pregnancy.
APPENDIX 2b

GP supporting statement

Impact and benefit of additional support for Primary Care from a Perinatal Mental Health Service/Pathway

As GPs we see 2 groups of women who would use the Perinatal Mental Health Service

1) Those with pre-existing mental health issues
2) Those who develop MH issues at some point in the perinatal period.

Also, we often have the partners, children and other family members that may require support at this time on our patient lists.

Both the above groups of patients need early and easy access to advice and support and having a Perinatal Mental Health pathway and service will facilitate obtaining this with appropriate management at the earliest possible opportunity (pre-conceptually if appropriate) in a holistic and un-fragmented way, more along the lines of a MDT approach.

We currently have no tool or guidance by which GPs, women, their partners and family are able easily access professional mental health advice with a comprehensive plan of care for the perinatal period and sign posting of where, when and from whom to seek help, if needed. This can lead to frustrating and potentially dangerous delays in seeking and obtaining help at any stage in the pregnancy and post-natal period.

Therefore, the impact and benefit for primary care of a comprehensive perinatal Mental Health Service and pathway will be that women will be better informed and supported from an earlier stage in their pregnancy. This will encourage and empower them to manage their condition themselves to a greater extent but give them the security and confidence that should they need further help, they and their primary care team would have a clear and timely route through which to access advice and support from an appropriate mental health professional.

Dr Sally Carson
APPENDIX 2c

Midwifery Supporting Statement

Date: 08/04/15

The Princess Royal University Hospital
Farnborough Common
Orpington
Kent
BR6 8ND

Tel: 01689 863000
Direct Line: 01689 864916

Re Perinatal Mental Health Service for Bromley

I am writing in support of the planned perinatal mental health business case to support current service provision for women and their families where mental health issues are identified.

The demand and requirement for this service is also driven by local and national guidelines and clinician’s request:

- National
- NICE
- Confidential Enquiry into Maternal Deaths
- RCOG guidance
- Local
- Serious Incidents
- Clinician demand

Currently in Bromley there is no dedicated service available re perinatal mental health from the psychiatric services. Women who are identified as having a pre-existing or new mental health issue and who require advice / help / treatment and support are referred to local general psychiatric services. These can either be at primary level with the GP and counselling / IAPT (Working for Wellbeing) service or with the local mental health service based at Stepping Stones in Bromley.

Women who are currently already in the mental health services when they become pregnant remain with their allocated mental health team but there is no one currently within the Bromley service who specialises in this area to offer any extra support and advice to these teams.

Women when they book for delivery at the Princess Royal University Hospital are routinely asked regarding their mental health, this is also continually assessed by the midwives throughout the ante and postnatal period.
Midwives and obstetricians currently do not have a dedicated perinatal psychiatric team to whom they can refer or liaise with. Stepping Stones accept referrals from both obstetricians and midwives and staff are able to speak to the liaison and intake team for general advice and re potential referrals. This means that different staff are involved rather than a seamless service and also that this can result in a lack of multidisciplinary communication and team working between the maternity and psychiatric services.

Women have expressed concerns that the process can be long and that they are not able to access services and advice in a timely manner which can exacerbate the mental health issues such as severe anxiety.

Women who require specific advice and support re medication and choices often present with these questions during the antenatal period and it would be invaluable to have access to the services of a specialist pharmacist/ mental health team to aid with advising and supporting women this. Currently women are advised to speak to their GP, psychiatrist and can access the Oxleas pharmacy helpline. The maternity ward pharmacist is very helpful but also has time restraints due to her other roles.

I currently facilitate a clinic once a week that was set up with an obstetrician to support women with moderate to severe mental health issues. When set up in 2006 we identified then that the clinic should not be just facilitated by staff from the obstetric/midwifery department alone but that it should be multidisciplinary ensuring that women get the best possible care/ advice and support. This did not unfortunately occur. However In 2015 it is vital and clear from all available advice and good practice that clinics should be facilitated by the correctly trained professionals with where possible joint multidisciplinary clinics and a clear plan of when and who pregnant women should be seeing for support and advise .

A perinatal mental health service with dedicated staff as part of the team would ensure all staff would have a clear pathway for referral and care in the ante and postnatal period. Women would be able to be seen, assessed and given appropriate care and advice in one setting which would reduce waiting times and the associated issues and also facilitate safe multidisciplinary working and planning between the obstetric and perinatal mental health team. Women and their families would be able to be supported and followed up as appropriate. If a mother required home visits and support a perinatal mental health care co-ordinator would be invaluable.

The perinatal team would be able to produce perinatal care plans in agreement with the women and their families that would be available and invaluable to all staff involved in the women’s care and to ensure the safety of both the mother and her baby.

Safeguarding issues would be discussed and addressed with much greater joint working and where available a representative from the perinatal mental health team should be available to attend the maternity safeguarding meeting to provide input and advice.

Women who are already under mental health services may not be transferred to the perinatal mental health team but they would be available for advice and extra support.

PMO Doc (2) BC Business Case Version 1.1
This service is vital to ensure that all pregnant women in Bromley have the opportunity to access “Gold standard” care regarding their mental health with excellent multidisciplinary team work and planning and sharing of information. Staff will have the opportunity to refer to and be actively involved in the women’s care which should be seamless and holistic.

Yours sincerely,

Linda Penn

Specialist midwife safeguarding/ Special Interest in mental health.
APPENDIX 2d

Public Health Supporting Statement

Perinatal mental illness is a very important Public Health problem because of the long term effect on the child. If maternal ill health is not treated, this can result in adverse effects on the child’s brain development and on the development of their stress response hormone system. Addressing the consequences of these changes later in the child’s life is not straightforward. Prevention of these problems by supporting mothers’ mental health through pregnancy and early parenthood is now rightly a priority.

Maternal mental ill health can also have an effect on her developing relationship with her baby. This relationship is important in the social and emotional development of the child so that babies can recognise and regulate their own emotions. This first attachment relationship needs to be stable for the child to develop social competence and resilience which helps them to cope in later life. Even relatively mild mental illness, if untreated, can inhibit mothers’ abilities to interact with babies in an appropriate way.

Any woman who is pregnant and has been identified by maternity services as having mental health problems will be contacted by her Health Visitor before the baby is born. This helps with providing continuity of carer through the transition from maternity to child health services. This support, working closely with primary care, will continue after the involvement of the Perinatal Mental Health services which support the mother until her child is 1 year old. Training and support in this role will be a benefit of having a perinatal mental health service.

Some mental health problems may not present during pregnancy. Health visitors now routinely check all mothers 6 weeks after the birth for evidence of mental ill health. A perinatal mental health service will be essential to assess and treat women identified by this process.

Dr Jenny Selway
APPENDIX 2e

Testimonial from Bromley Children’s Project

Of the declared parental disabilities / additional needs, MNH/depression tops the table at 56%, the closest rivals to this are deafness and dyslexia both of report at 8%. As you can see MNH/depression is a staggeringly high by comparison and this is only those parents who (1) recognise they have it, and (2) choose to share that on their registration form. Consequently it is clearly under-represented would show as a much higher value if all parents who were struggling with their mental health and emotional wellbeing declared it to us.

Rachel Dunley,
Bromley Children Project Manager
Early Intervention Family Support & Parenting & Parenting Classes
Children and Family Centres
Information Advice and Support Service (formerly Parent Partnership)

The care pathway below is an indicative care pathway, based on national good practice guidance. Following the decision on future commissioning of local services in Bromley, work will commence to adapt this proposed care pathway in line with local need and resources.

[Diagram of care pathway]


The care pathway below is an indicative care pathway, based on national good practice guidance. Following the decision on future commissioning of local services in Bromley, work will commence to adapt this proposed care pathway in line with local need and resources.
### INITIAL SCREENING FOR EQUALITY IMPACT ASSESSMENT

At this stage, the following questions need to be considered:

<table>
<thead>
<tr>
<th>Name of Policy / Strategy / Service redesign etc.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the name of the policy, strategy or project?</td>
<td></td>
</tr>
<tr>
<td>Perinatal Mental Health Service</td>
<td></td>
</tr>
<tr>
<td>2. Briefly describe the aim of the policy, strategy or project. What needs or duty is it designed to meet?</td>
<td></td>
</tr>
<tr>
<td>The service is to meet the needs of women and their families affected by mental ill health during the perinatal period, and the health and wellbeing of their child. This service will increase awareness of individuals with mental health needs, ensuring that women experiencing mental ill health can be supported to thrive. Pregnancy and maternity are protected characteristics under the Equality’s Act 2010</td>
<td></td>
</tr>
<tr>
<td>3. Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any group/s?</td>
<td>No</td>
</tr>
<tr>
<td>4. Is there any evidence or other reason to believe that different groups have different needs and experiences that this policy is likely to assist i.e. there might be a relative adverse effect on other groups?</td>
<td>No</td>
</tr>
<tr>
<td>5. Has prior consultation taken place with organisations or groups which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address? Yes, both nationally and locally it has been highlighted that the lack of local specialist service provision to support women who have mental ill-health during the perinatal period has been highlighted. The development of local specialist provision will address this issue.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Signed by the manager undertaking the assessment: Nicola Symes

Date Completed: 3rd February 2015

Job Title: Senior Contract Manager – Vulnerable Adults

**On Completion of Stage 1 – A full impact assessment (Appendix 2) will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above**
APPENDIX 6

Quality Impact Assessment Stage 1
The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients/staff/organisations. Where adverse impacts score >8 is identified in any area this will result in the need to then undertake a more detailed QIA. This will be supported by the Governance team.

<table>
<thead>
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<th>Title and Lead for Scheme</th>
<th>Perinatal Mental Health Service</th>
</tr>
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<tbody>
<tr>
<td>Brief Description of Scheme</td>
<td>The development of a specialist community perinatal mental health service in Bromley, supporting women with mental health needs during pregnancy and antenatal period.</td>
</tr>
</tbody>
</table>

Answer positive/negative (P/N) in each area. If N then score the impact/likelihood/total in the appropriate box. If score >8 insert Y for full assessment.

<table>
<thead>
<tr>
<th>Area of Quality</th>
<th>Impact Question</th>
<th>P/N</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Full Assessment Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty of Quality</td>
<td>compliance with NHS Constitution, partnerships, safeguarding children and adults, NICE Guidance, duty to promote equality</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Experience</td>
<td>patient survey results, patient choice, personalised &amp; compassionate care</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Safety Systems in place to safeguard patients to prevent harm Infection prevention</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Evidence based practice Clinical leadership Clinical engagement High quality standard</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>Self-care and health equality</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity &amp; Innovation</td>
<td>Best setting to deliver high quality clinical and cost effective care Eliminating resource inefficiencies Improved care pathway</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: Nicola Symes  
Designation: Senior Contract Manager  
Date 8/4/15
APPENDIX 7 Privacy Impact Assessment

ANNEX A

Privacy Impact Assessment Questionnaire

This PIA questionnaire must be completed wherever there is a change to an existing process or service, or a new process or information asset is introduced that is likely to involve a new use or significantly changes the way in which personal data is handled or processed.

Once completed please send this questionnaire to: SLCSU.InformationGovernance@nhs.net

<table>
<thead>
<tr>
<th>Work stream:</th>
<th>Perinatal Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work stream Lead</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td>Designation</td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>Email</td>
</tr>
<tr>
<td>Overview: (Summary of the project)</td>
<td>Perinatal Mental Health Pathway</td>
</tr>
<tr>
<td>Implementation Date:</td>
<td>TBC</td>
</tr>
</tbody>
</table>

1. Screening questions

<table>
<thead>
<tr>
<th>Q</th>
<th>Category</th>
<th>Screening question</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Technology</td>
<td>Does the project introduce new or additional information technologies that can substantially reveal an individual’s identity and has the potential to affect that person’s privacy?</td>
<td>N</td>
</tr>
<tr>
<td>1.2</td>
<td>Technology</td>
<td>Does the project introduce new or additional information technologies that can substantially reveal business sensitive information, specifically: have a high impact on the business, whether within a single function or across the whole business?</td>
<td>N</td>
</tr>
<tr>
<td>1.3</td>
<td>Identity</td>
<td>Does the project involve new identifiers, re-use or existing identifiers e.g. NHS or NI number, or will use intrusive identification or identity management processes?</td>
<td>N</td>
</tr>
<tr>
<td>1.4</td>
<td>Identity</td>
<td>Might the project have the effect of denying anonymity and pseudonymity, or converting transactions that could previously be conducted anonymously or pseudonymously into identified transactions?</td>
<td>N</td>
</tr>
<tr>
<td>1.5</td>
<td>Multiple organisations</td>
<td>Does the project involve multiple organisations, whether they are public sector agencies i.e. joined up government initiatives or private sector organisations e.g. outsourced service providers or business partners?</td>
<td>Y</td>
</tr>
</tbody>
</table>
The purpose of this assessment is to confirm that privacy laws and information governance standards are being complied with, or highlights problems that need to be addressed. It also aims to prevent problems arising at a later stage, which might impede the progress or success of the project.

Answering “Yes” to any of the screening questions above represents a potential IG risk factor please proceed and complete the next section.

*Depending on the provider
### 2. Privacy Impact Assessment

#### 2.1 Is this a new or changed use of personal and/or business sensitive information that is already collected?

<table>
<thead>
<tr>
<th>New/Changed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

*See note 3 for guidance*

#### 2.2 What data will be collected?

**Personal Confidential Data**

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
<th>DoB</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Administration data**

<table>
<thead>
<tr>
<th>Address</th>
<th>Postcode</th>
<th>NHS No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Another unique identifier *(please specify)*

If Oxleas are the provider then new patient numbers will be needed for **new patients only**. If Oxleas are not the provider, this will be needed for all patients.

**Other data *(Please state):***

**Sensitive data**

- Racial or ethnic origin: Y
- Political opinion: N
- Religious belief: N
- Trade Union membership: N
- Physical or mental health or condition: Y
- Sexual life: Y
- Commission or alleged commission of an offence: Y
- Proceedings for any offence committed or alleged: Y

**Will the dataset include clinical data? (please include)**

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

**Will the dataset include financial data?**

| N |

**Description of other data collected**

- Social services history
- Safeguarding for children
- Partner/other family member history
- Domestic violence records

---

1 Sensitive personal data as defined by section 2 of the Data Protection Act 1998 Additional statutory requirements apply
### Business sensitive data

<table>
<thead>
<tr>
<th>Financial</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Contract conditions</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Decisions impacting:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Description of other data collected

- Anonymised data activity
- Clinical outcomes
- Adherence to clinical care pathways
- Adherence to MDS and KPIs

### 2.3 List of organisations involved in processing the data? If yes, list below

<table>
<thead>
<tr>
<th>Name</th>
<th>Data Controller (DC) or Data Processor (DP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCH</td>
<td>DC</td>
</tr>
<tr>
<td>Mental Health Provider</td>
<td>DC</td>
</tr>
<tr>
<td>BHC (Health Visitor)</td>
<td>DC</td>
</tr>
</tbody>
</table>

### 2.4 Has a data flow mapping exercise been undertaken?  
*If yes, please provide a copy, if no, please undertake – see Note 4 for guidance*

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### 2.5 Does the Work involve employing contractors external to the Organisation?  
*If yes, provide a copy of the confidentiality agreement or contract?*

<table>
<thead>
<tr>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
</tbody>
</table>

---

2 The InformationGovernanceToolkit is a self-assessment tool provided by Connecting For Health to assess compliance to the Information Governance

Privacy impact Assessment Procedure
Ratified 6/02/14
### 2.6 Describe in as much detail why this information is being collected/used?

Ensuring appropriate clinical care is given to women with an adequate service provision

### 2.7 Will the information be collected electronically, on paper or both?

|        | Electronic | Y | Paper | Y |

### 2.8 Where will the information will be stored?

Handheld notes and within the provider

### 2.9 Will this information being shared outside the organisations listed above in question 3?

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

If yes, describe who and why:

The local authority may share information with London Borough of Bromley with patient consent

### 2.10 Is there an ability to audit access to the information?

Y

### 2.11 What roles will have access to the information? (list individuals or staff groups)

Patient; perinatal/maternity clinical team; mental health clinical team; social care (as required); BHC; commissioners (anonymised format) and Public Health (anonymised format)

<table>
<thead>
<tr>
<th>Username and password</th>
<th>Y</th>
<th>Smartcard</th>
<th>Y</th>
<th>key to locked filing cabinet/room</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure 1x Token Access</td>
<td>Y</td>
<td>Restricted access to Network Files</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other: Provide a Description Below:

### 2.12 Is Mandatory Staff Training in place for the following?

|         | Yes/No | Dates |

---

3 For example Direct Patient Care, Statistical, Financial, Public Health Analysis, Evaluation. See NHS ConfidentialityCodeofPractice Annex C for examples of use.

4 Examples of Storage include bespoke system (eg SystmOne, SharePoint), Spreadsheet or database in Network Drive, server location, filing cabinet (office and location), storage area/filing room (and location) etc.
### 2.13 Are there any new or additional reporting requirements for this project?

- What roles will be able to run reports?

  Provider informatics department

- What roles will receive the report or where will it be published?

  Provider clinical teams; Public Health; commissioners. Published in annual reports

- Will the reports be in person-identifiable, pseudonymised or anonymised format?

  Anonymised

- Will the reports be in business sensitive or redacted format (removing anything which is sensitive) format?

  Business sensitive

### 2.14 If this new/revised function should stop, are there plans in place for how the information will be retained / archived/ transferred or disposed of?

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### 2.15 Have any Information Governance risks been identified relating to this project? (if Yes the final section will need to be completed)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
</tbody>
</table>

### 2.16 Are individuals informed about the proposed uses of their personal data?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### 2.17 Are arrangements in place for recognising and responding to requests for access to personal data?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### 2.18 Will individuals be asked for consent for their information to be collected and/or shared?

If no, list the reason for not gaining consent e.g. relying on an existing agreement, consent is implied, he project has s251 approval or other:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
<tr>
<td>Risk</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Lack of a clear consent model for PMH service</td>
</tr>
<tr>
<td>2. Data Flows and referral process must be clarified</td>
</tr>
<tr>
<td>3. Patients may not be aware that their data may be shared with the new service.</td>
</tr>
<tr>
<td>4. Data for direct care purposes may end up being used for Commissioning if the CCG decides to directly provide this service to patients.</td>
</tr>
<tr>
<td>5. Fair Processing Notices may not adequately cover processing for PMH service</td>
</tr>
<tr>
<td>6. Excessive data sharing between providers</td>
</tr>
<tr>
<td>7. Difficulties in obtaining consent from patients who lack capacity</td>
</tr>
<tr>
<td>8. Provider Contract may not include IG requirements</td>
</tr>
<tr>
<td>9. Provider may not be compliant with IG toolkit level 2</td>
</tr>
<tr>
<td>10. Third party providers – Challenge as they may not have adequate policies protocols and procedures.</td>
</tr>
</tbody>
</table>
Appendix 7

**PRUH Psychiatric review required:**

**ANC/Maternity Unit**

**Medical/Obstetric Assessment**

Pregnant women or Post Delivery

Is it a Psychiatric Emergency/Urgent concern e.g. Danger to self or others /deterioration of Mental Health.

If in doubt contact Psychiatric Liaison Team to discuss, bleep 144

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**If 18 years or over** Contact Bromley Mental Health Liaison Team, **Bleep 144.**

24 hour service based at Princess Royal University Hospital

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**If 18 or under** during working hours contact CAMHS 020 8315 4436

If out of hours (5pm – 9am / weekends / Bank Holidays) contact duty Doctor on 01689 880000 or bleep 412. Or duty nurse at Green Parks House 10pm – 8am on bleep 405

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4. If Psychiatric emergency Duty Team Social Care will need to be informed, 020 84644848.

5. If any safeguarding children concerns, refer to social care, Referral and Assessment Team (RAT) 020 8461 7058.

6. Inform Obstetric Team.


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Collect Data and fax referral to:

1. >18 years-Bromley Liaison Intact Team, (LIT) Stepping Stones if Bromley resident. For referral advice contact LIT 020 8466 2500

2. Out of Area refer to appropriate CMHT.

3. <18 years-refer to Child Adolescent Mental Health Service 020 8315 4430

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1. Protos User Messenger and Maternity Concerns Form.

2. Inform GP.

3. If Obstetric Team wishes to speak to Psychiatric Consultant- Bleep and request 144.