Executive summary

- Postnatal depression (PND) affects 10 to 15% of mothers, and in rare but extreme cases can result in maternal suicide.
- The Patients Association has heard from calls to our Helpline and other sources that there is variation in the quality of perinatal services provided across the country.
- A Freedom of Information Act (FOI) request was sent to 150 Primary Care Trusts (PCTs) to find information on the organisation of postnatal depression services.
- We received responses from 77 PCTs.
- We found that:
  - 78% of PCTs do not know the incidence of PND in their region
  - 64% of PCTs do not have a strategy for commissioning perinatal mental health services
  - 44% of PCTs are failing to implement NICE guidance and are not part of a clinical network for perinatal mental health
  - 45% of PCTs failed to provide information on the number of Serious Untoward Incidents related to postnatal depression in the services they commission
  - 55% of PCTs do not provide information to mothers on PND
- We recommend that:
  - The Department of Health must amend the ICD10 coding to include postnatal depression so that data can be recorded that accurately reflects the incidence of PND
  - PCTs must ensure that clinical networks for perinatal services are set up, as detailed in NICE Clinical Guideline 45
  - All PCTs should have detailed strategy in place for commissioning PND services in addition to a mental health strategy, to include local variation in service provision
  - PCTs must ensure that all expectant/new mothers are provided with written and, where appropriate, visual information on PND to facilitate early detection and improve patient outcomes
  - PCTs must commit to training Healthcare visitors in using assessment tools and psychological techniques to help identify and reduce the number of cases of PND
  - The Government needs to issue clear guidance on who will lead on the investigation and reporting of SUIs once PCTs and SHAs are abolished
Foreword by Katherine Murphy,
Chief Executive of the Patients Association

Patients are currently facing a major upheaval in their health service. The Government's Health and Social Care Bill is currently before parliament with a focus to "reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all." The Government proposes a radical overhaul of commissioning, handing over commissioning responsibilities for the majority of NHS services to GP consortia and abolishing Primary Care Trusts (PCTs), whilst at the same time making £20 billion in savings by 2014. For years, maternity services have struggled to maintain funding and avoid cuts, but with the need to make huge NHS savings, the Royal College of Midwives and Heads of Maternity services are understandably worried that these vulnerable services will be further stretched to the limit. And what of the impact to mothers? We are already hearing of variation in services across the country and incidences when vulnerable women – such as those suffering from postnatal depression – are left to fend for themselves without any support. With pressure on the NHS to deliver financial saving and the huge overhaul to the structure of the NHS, will maternity services suffer even further?

Mental health is important at all stages of life but women are particularly vulnerable during and immediately after pregnancy, with one in ten women being affected by postnatal depression. Worries and complaints about maternity services feature highly in our Helpline calls. But people face a stigma associated with mental health problems, so many women face embarrassment or shame in talking about postnatal depression. The chances are that even the calls we do receive do not capture the full picture of how widespread this issue is. One way the Patients Association helps is through our Helpline,
providing advice and signposting to organisations that can help when a caller has a concern about the health service.

We investigated the commissioning of services through a Freedom of Information Act request to PCTs in England. The findings highlight major problems, including basic failures to implement NICE guidance consistently across the country, a lack of information provision and poor planning of services in some PCT areas. Our concern is that these problems are at risk of getting worse as PCTs are abolished and the NHS deals with challenges due to service reform and budget pressures.

As an independent charity campaigning for patients in the health service, the Patients Association calls for sustained improvement across the whole postnatal depression pathway – in resources, training, expertise and commissioning – to support new mothers at this vulnerable time.

Many services did not provide information in response to our FOI request because the information was either not collected or was collected differently across provider and commissioner Trusts. We must have meaningful and accurate information on postnatal depression services to ensure high quality commissioning that serves patients' needs. We must make sure the system does not desert the patients at their time of need.

Katherine Murphy

3
Contents

Executive summary ................................................................. 1
Foreword ................................................................................... 2
1. Introduction .......................................................................... 5
2. Freedom of Information Act request ................................... 15
3. Volume of Cases – postnatal depression ................................ 17
4. Commissioning of postnatal depression services .................. 24
5. National guidance ................................................................. 28
6. Information, choice and training .......................................... 37
7. Conclusions and Recommendations ..................................... 44
Recommendations ....................................................................... 47
Appendix .................................................................................. 48
1. Introduction

“I have great fears for the future. If maternity services are struggling now, how will they cope when there is less money?” Cathy Warwick, General Secretary of Royal College of Midwives

Postnatal depression: key factors

During the perinatal period – which spans pregnancy and the 12 months after child birth - women are more likely to develop a mental health condition than at any other time in their life with 10-15% of new mothers developing postnatal depression (PND). The most serious illnesses tend to develop by six to eight weeks after birth. Hormonal fluctuations experienced during this period mixed with the responsibilities of motherhood are some of the suggested causes of postnatal depression.

The term ‘postnatal depression’ is often used as a general term for any perinatal mental disorder and may in fact refer to a variety of mental health conditions experienced by women including anxiety and depression as well as postnatal psychotic disorders and puerperal psychosis such as bipolar disorder and schizophrenia.

Postnatal depression is similar to depression at other times. It involves low mood and can affect a mother’s ability to look after herself or her baby. Infant sleep routines and a baby’s cries for attention may become difficult to cope with, along with other symptoms such as loss of appetite, irritability, sleeplessness, lack of energy, self blame and terminating breastfeeding early. In more severe and rare forms of perinatal depression

---

2 Cloutte, P. Understanding postnatal depression. 2008
mothers may actually want to harm themselves or their infant\(^4,5\). Between 2003 - 2005 in the UK there were 21 maternal suicides relating to psychiatric illness\(^6\).

Postnatal depression or perinatal mental health care is a challenging area of healthcare as it encompasses various medical specialisations, extremely sensitive data and complex commissioning pathways. A patient may be referred by a midwife or health visitor or their GP to a variety of services, depending on the severity of post-natal depression, which may include counselling, secondary care community mental health teams or perinatal services (Diagram 1). In addition, the structure of services around the country may vary considerably because of local factors including the organisation of existing mental health services, the demographic population and geographical issues\(^3\).

Crucial steps in the care pathway can limit the effects of postnatal depression. Midwives and health visitors play a fundamental role in the detection of postnatal depression through screening procedures and in the subsequent referral process (see Diagram 1) which is vital for early intervention\(^7\). Health visitors or GPs may refer patients at high risk of suicide to a ‘crisis team’ consisting of psychiatric consultants and mental health nurses depending on local service arrangements. Best practice would ensure that women suffering postnatal depression are treated by a specialist in perinatal mental health conditions and when a woman cannot be treated in the primary care setting she should be admitted to a specialist mother and baby unit within an acute hospital\(^8\).

A recent study showed the importance of specialised training for health visitors. The study compared the likelihood of developing postnatal depression in two groups of women 6 weeks after they had given birth. The first group received care from health visitors who had training in an assessment tool and either cognitive behavioural therapies or listening techniques, and the second group were cared for by health visitors

\(^4\) http://www.nhs.uk/conditions/postnataldepression/pages/introduction.aspx
\(^6\) Lewis, G. The confidential enquiry into maternal and child health (CEMACH). Why mothers die 2000-2002. The sixth report of the confidential enquiries in to maternal deaths in the United Kingdom. 2007
\(^7\) NICE. Antenatal care: routine care for the healthy pregnant woman. 2007
\(^8\) Royal College of Psychiatrists Postnatal Depression (http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx)
with no specialist training. The study showed that by deploying health visitors that were trained to assess women using the Edinburgh Postnatal Depression Scale and one of two psychological techniques, the likelihood of women developing postnatal depression was decreased by up to 30\%\textsuperscript{9}. Receiving care from health visitors with appropriate training is therefore a key factor in reducing the incidence of postnatal depression.

**Guidance on perinatal depression**

**NICE guidance**
The National Institute for Health and Clinical Excellence (NICE) has developed clinical guidelines to manage and treat perinatal mental health conditions. The Antenatal and Postnatal mental health guidance (CG 45)\textsuperscript{3} sets out evidence-based guidelines on how to organize perinatal mental health services and clinically manage postnatal depression. Its emphasis is on personalised services, informed decisions made in collaboration with healthcare professionals, early detection, effective intervention using psychological and pharmaceutical treatments, and the role of families and carers.

**National Service Frameworks**
The NICE guidance builds on the National Service Framework for Mental Health: Modern standards and service models (1999)\textsuperscript{10}, which identified the need of emotional and social support for pregnant women and new mothers, as well as on the National Service Framework for Children, Young People and Maternity Services (2004) which aimed to deliver a standardised high quality service. Based on 11 health and well-being Standards, the framework was intended to "lead to a cultural shift, resulting in services which are designed and delivered around the needs of children and families using those services, not around the needs of organizations"\textsuperscript{11}. The National Service Framework's objectives were to be delivered through: a more personalized care; increased information and choice over the support and treatment received; a new Child Health Promotion Programme; a focus on early intervention; a Common Assessment

---

\textsuperscript{9} Brugha, T. S. et al. Universal Prevention of Depression in Women Postnatally: Cluster Randomized Trial Evidence in Primary Care, Psychological Medicine. 2010, vol 40, pg 1-10
Framework; the encouragement of a healthy lifestyle; an improved access to services; and appropriately trained staff. A ten-year period was suggested as a timeframe for full implementation of these improvements, while continuous assessment of the quality of NHS and local authority services was considered necessary.

Of particular relevance to this present report is Standard 11: Maternity Services and an in-depth guidance on this Standard was published in 2007. The standard is summarized as “Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.” As part of the vision for this standard it is hoped to see “Flexible individualised services designed to fit around the woman and her baby’s journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women”. The standards for postnatal mental health needs are:

- All professionals involved in the care of women immediately following childbirth need to be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs.
- All professionals directly involved in the care of each woman who has been identified as at risk of a recurrence of a severe mental illness following birth, including the woman and her family (as appropriate), are familiar with her individual ‘relapse signature’ (the early signs of the developing illness).
- Each woman who has been identified as at risk of a recurrence of a severe mental illness has a written plan of agreed multi-disciplinary interventions and action to be taken.
- Strategic Health Authorities and all NHS Trusts plan for the provision across Strategic Health Authorities boundaries, of sufficient capacity for specialist inpatient psychiatric mother and baby treatment so that all women who require it can be admitted with their baby (unless there is a specific contra-indication) to a Specialist Mother and Baby Psychiatric Unit.

The most recent guidance including maternal mental health services is the Healthy Child Programme: pregnancy and the first five years of life (2009), issued by the Department of Health. Healthy Child Programme: pregnancy and the first five years of life. 2009.
of Health. Healthy Child Programme guidance is an update of Standard One (incorporating Standard Two) of the National Service Framework for Children Young People and Maternity Services (2004). It was brought about to acknowledge the scientific, social and policy advances which have taken place since 2004. The merits of this document lie in its evidence-based content, recognising the importance of forming a strong child–parent bond in the first years, as well as the need for an in-depth recurring health and development assessment. The Healthy Child Programme draws on evidence showing that mental health problems in parents can have adverse effects on child development, and reminds of the need for such psychological conditions to be effectively tackled. In terms of specific reference to postnatal depression, the Programme re-emphasizes NICE guidelines including the need for women to be asked appropriate and sensitive questions to identify depression or other significant mental health problems. In addition, for women identified with maternal depression, the Programme states the need for; offering listening visits, cognitive behavioral or interpersonal therapy, dyadic therapies (i.e. baby massage), parent-infant groups to include fathers and the recognition and referral of women with serious mental health problems.

In their response to the NHS reform consultation Liberating the NHS: Greater choice and control. A consultation on proposals.¹⁹, The Royal College of Obstetricians and Gynaecologists (RCOG) argue that the postnatal services in the UK are in need of improvement, in order to increase breast feeding rates and detect serious psychiatric problems at an earlier stage. The RCOG state that these services “need the input of midwives, health visitors, obstetricians, the primary care team and the mental health services”. The RCOG argue in favour of greater choice in maternity care (safe, sustainable and inclusive of all people), as well as of appropriately designed perinatal networks. However, they see a successful implementation of this agenda within a central commissioning framework, rather than within a model of small consortia. The response goes on to say that “Small consortia would be unable to provide and afford the appropriate clinical services and therefore negate the choice agenda. In addition
perinatal networks are likely to develop on significant population bases, far in excess of those envisaged for commissioning.”

Appropriate and timely information, early detection and intervention are among the vital factors for the effective treatment of postnatal depression. However, a major barrier to achieving this is the fact that, as with many mental health conditions, postnatal depression carries a stigma which in many cases restricts mothers coming forward with their depression. This makes early detection and intervention very difficult to manage.

**Current status of maternity services**

Maternity services have been shown in recent years to be struggling to cope with demand. A 2007 review of maternity services by the Healthcare Commission showed problems of low staff levels, lack of in-service training, poor communication with women and inadequate IT and data collection amongst the 21% of Trusts deemed to be ‘least well performing.’ One of the key concerns of the Commission was that “Women experienced poor communication, care and support after their babies were born”. The report also found that although women’s physical and emotional health should be assessed prior to transfer from hospital and again at six to eight weeks after birth, in half of the Trusts, 11% of women may not be receiving postnatal checks. This is a time when new mothers can raise any issues or concerns that may be worrying them and it is also a time when postnatal depression is most likely to occur.

The Royal College of Midwives (RCM) has expressed fears over the future of services and the effect of NHS budget pressures. A recent RCM survey conducted in November 2010 of Heads of Midwifery found 47% of the 83 respondents expected to make job cuts, and 67% said they did not have enough staff to cope with demand. Nearly a third (29.6%) of maternity units have seen a fall in their budget and just under a third (32.5%) have been asked to cut their staffing levels in the past year, according to a survey of UK Heads of

---


Midwifery (HOMs) by the Royal College of Midwives (RCM). In response to this survey, the general secretary of the RCM, Cathy Warwick, voiced these fears: “I have great fears for the future. If maternity services are struggling now, how will they cope when there is less money.”

Furthermore, the RCM recently launched a campaign to “Protect maternity Services” from cuts stating that “Managers must not be allowed to take the easy option and salami-slice frontline budgets like the one for maternity care. This is especially so as the number of babies being born has continually outstripped any rise in the number of midwives, even when the NHS budget was booming.”

The proposed reforms of the NHS, outlined in the Government’s Health and Social Care Bill 2011, will have a huge impact on maternity services. Following consultation on the reforms, the Government announced that maternity care commissioning will be handled by the proposed new GP commissioning consortia which will also commission mental health services. But the Government states that, “maternity services need a different approach to reflect their special nature and circumstance,” and a greater role has been proposed for the new NHS Commissioning Board in “promoting quality and extending choice for pregnant women.” Specifically, within the Choice consultation, the Government has proposed to extend maternity services and allow choice to women throughout their pregnancy and after childbirth by developing new provider networks.

Research shows that GPs do not currently feel comfortable commissioning mental health services, and it is therefore essential that training and support must be provided before GP consortia take over commissioning of mental health services. However, as of yet there is very little detail around how GP consortia will be trained to take on commissioning of services. The “Strategic Commissioning Development Unit (SCDU)” which is part of the Department of Health will provide commissioning packs to

---

16 http://www.rcm.org.uk/college/campaigns-events/protect-maternity-services/
17 Liberating the NHS: legislative framework and next steps. 2010
support GP consortia but at present there is not a pack available on maternity services and there are not details regarding when, if at all, this will be available\textsuperscript{20}. The mental health charity MIND also expressed its concerns over commissioning consortia not having sufficient expertise to commission mental health services to a Health Select Committee hearing on GP commissioning.\textsuperscript{21}

**Financial cost of treating PND**

The economic cost of treating postnatal depression on the public purse is estimated at £35 million per year.\textsuperscript{22} This includes the increased contact time with GPs, social workers and community psychiatric nurses.

**Serious Untoward Incidents**

The National Patient Safety Agency (NPSA) has developed a national framework for serious incidents in the NHS\textsuperscript{23}. This has been completed following consultation and collaboration with key NHS stakeholders including the Care Quality Commission, the Department of Health, The Medicines and Healthcare products Regulatory Agency, the NHS Litigation Authority, Monitor and the Independent Advisory Service.

The publication replaces individual Strategic Health Authority and Commissioning Primary Care Trust, Serious Untoward Incident policies and provides guidance for the whole system from notification, to management and learning from serious incidents.

As part of the guidance it states that one of the key aims of the Serious Incidents reporting is to disseminate key learnings and so reduce the risk of recurrence both where the original incident occurred and elsewhere in the NHS. As part of this policy, it

---

\textsuperscript{20}http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_117500

\textsuperscript{21}MIND Briefing on Commissioning Mental Health Services. 2010


would be expected for PCTs to have clear details on any Serious Incidents occurring in provider organisations that they commission services from.
Diagram 1: Care pathway for postnatal depression

- **Holistic consultation by midwife or health visitor**
  - Assessment
  - History of postnatal mental health problems
  - Predicting factors and typical features
  - EPDS to form part of this initial assessment where culturally appropriate

- **A - Mild**
  - Monitor treat/support at Primary Care level.
  - Counselling/self help information may be appropriate.

- **B - Moderate**
  - GP Assessment
  - Initiate treatment with antidepressant (see supporting info)
  - Liaise with HV/MW
  - Consider referral to Social Services for 'child in need'. Improvement in symptoms observed within 4-6 weeks
  - NO
  - Refer to Local CNHT
  - YES
  - Refer if patient already know to CNHT/has an existing psychosis, bipolar or severe depressive illness
  - Refer to Perinatal Services

- **C - Severe**
  - Referral Criteria to Secondary Care
  - Ideas of self harm with intent
  - Ideas of self harm without intent if thoughts intrusive
  - Ideas of harm to baby/ambivalence to baby
  - Intrusive negative thoughts that are distressing/affect functioning
  - Self neglect or neglect of baby secondary to depression
  - Agitation/slowing of responses/hypomania
  - Evidence of psychosis

---

2. Freedom of Information Act request

The Freedom of Information Act request below was sent to 150 Primary Care Trusts:

1. In the last 5 years, how many postnatal depression cases were treated by a mental health service commissioned by your PCT?

2. How many postnatal depression related serious untoward incidents (SUIs) have been reported in the last 5 years?

3. Under Patient Choice, do patients have the right to admit themselves to specialist mother and baby units if they do not wish to receive ‘Crisis Team’ care at home?

4. What is your referral rate to specialist mental health mother & baby units every year for the last 5 years?

5. What is your commissioning strategy for mental health? Does it include a specific strategy for postnatal depression and detection of suicide risk?

6. Is your PCT part of a clinical network for perinatal mental health, if so which one?

7. What methods of evaluation do you have or use to secure adherence to the NICE guidance 'Antenatal and postnatal mental health' - CG 45? How often do you evaluate your PCTs adherence to NICE CG 45?

8. What methods of evaluation do you have or use to secure adherence to the NICE guidance 'Depression' - CG 90? How often do you evaluate your PCTs adherence to NICE CG 90?

9. Do you have a named individual to lead on the implementation of NICE guidelines?

10. What systems do you use that provides a seamless transfer of information between the multi-professional services e.g. passing information from midwives in hospital to health visiting staff in the community? Please give examples.
11. What measures do you have to monitor and review performance of your postnatal mental health services?

12. Do you have a lead clinician of perinatal services?
   If so, what grade are they and are they an expert in the field of Perinatal Psychiatry?

13. Do you use the ‘Whooley’ Questions as recommended in NICE CG 45 for screening mothers for antenatal or postnatal depression?

14. Does your commissioned mental health services supply written information or use decision aids when explaining the risks of postnatal depression?

15. What level of training does your PCT provide health visitors in regards to assessing mental health conditions and in giving psychological support during the antenatal and postnatal period?
   How many health visitors does your PCT provide?

We received responses from 77 out of the 150 PCTs contacted, a response rate of 51%. However, not all PCTs provided a complete response to the request.
3. Volume of Cases – postnatal depression

Question 1: In the last 5 years, how many postnatal depression cases were treated per year by a mental health service commissioned by your PCT?

The aim of this question was to determine the number of users of postnatal depression services within each PCT area. This question received a very poor response rate, with just 17 PCTs providing figures on case numbers (a response rate of 22% of the 77 PCTs that responded to our FOI). The number of cases treated per PCT ranged from under 2 cases per year to 325 cases per year over a 5 year period from 2005/06 to 2009/10 (see Figure 1).

The number of PND cases treated per population of PCT ranged from less than 1 case per 100,000 patients to 110 cases per 100,000 patients (data not shown).

Due to the stigma attached to coming forward and seeking treatment for mental health issues, it is likely that these figures do not represent the full extent of postnatal depression incidence.

Figure 1. Number of Postnatal Depression cases treated each year by PCTs

![Number of Postnatal Depression cases treated each year by PCTs](image)
This response rate is of grave concern as it suggests that the 60 PCTs (78%) who did not answer this question do not have access to this data and are not aware of the number of patients suffering from PND in their area. If commissioners do not have baseline numbers of sufferers in their locality we question how they will be able to plan services effectively.

Many PCTs stated that they were unable to provide details on the number of cases of PND as they do not record cases of PND separately from other "types" of depression. Within ICD 10 coding - this is a method for the coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, the code set allows more than 14,400 different codes and permits the tracking of many new diagnoses throughout the NHS - post natal depression is not an ICD 10 diagnostic category and, therefore, the information on how many cases are treated is not routinely collected.

“[Our PCT] does not collate data on depression split down by cause”

“We do not record cases of post-natal depression separately from other "types" of depression and so do not have this information. ICD10 coding does not reasonably differentiate.”

This question shows that current ICD10 coding does not allow for recording of PND cases. If PCT commissioners do not understand the baseline number of cases of PND in their locality, we question how GPs - who will be responsible for maternity and mental health services as set out in the Health and Social Care Bill – will be able to take on the commissioning of this complex service.
**Question 2: What is your referral rate to specialist mental health mother & baby units each year for the last 5 years?**

This question aimed to determine the prevalence of mothers using specialist mother and baby units within secondary care and whether there is a greater frequency in using these units in certain regions of England. The specialist wards offer room for both mother and baby and are important as they allow bonding between mother and baby to continue whilst the mother is being treated in hospital. NICE guidelines state that, “*Women who need inpatient care for a mental disorder within 12 months of giving birth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so.*”

We received 29 responses to this question, a response rate of 38% from the 77 PCTs who answered our survey. As with question 1, this poor response rate suggests that the majority of PCTs do not collect data on mother and baby unit referrals. Furthermore, of those PCTs that responded, the data was incomplete with not all PCTs having data for every year for the past 5 years. It is therefore not possible to compare the referral rates to mother and baby units with the number of diagnosed cases of PND per PCT.

Of those Trusts that did respond, the number of admissions to specialist mother and baby units ranged dramatically from an admission rate of less than 1 patient per year to one PCT stating they had an admission rate of 929 patients in the year 2009/10 (see Figure 2).

There is a huge disparity between the services mothers receive across the country. Depending on their locality, the most vulnerable mothers who require specialist care will receive varied rates of referral to mother and baby units.
Figure 2: Average number of referrals to mother and baby units per year between 2004/05-2009/10

Average number of referrals to mother and baby unit per year (2004/05-2009/10)
Question 3: How many postnatal depression related serious untoward incidents (SUIs) have been reported in the last 5 years?

According to the Confidential Enquiries Report for Mothers and Child Health, the number of suicides by women during the perinatal period has declined from 29 in 1997-1999 to 21 known suicides in 2000-2002. Improvements in the identification of susceptible women during the antenatal period, subsequent referral and management of cases are suggested causes of this reduction. However, it was stated in this report that coroners may often under report suicides to save the feelings of the family.

Out of the 77 PCT responses, 42 PCTs responded to this question, a response rate of 55%. Of those, 36 PCTs had no SUIs related to PND over the last 5 years, whereas 5 PCTs had one SUI within the last five years relating to PND and 1 PCT had 6 SUIs (Figure 3).

What is alarming about this result is that 45% of PCTs do not have the information available to them as to the causes of SUIs in their PCT within the last 5 years. The National Services Framework for Reporting and Learning from Serious Incidents Requiring Investigation clearly states that learnings and insights must be made from all SUIs. However, PCTs will not be able to achieve this if they are unaware of the nature of the SUIs occurring at the providers they are commissioning services from. There is a clear need for PCTs to accurately record the nature of SUIs.
Figure 3: Number of postnatal depression-related Serious Untoward Incidents by PCT

Number of Postnatal Depression-related SUIs in the last 5 years

Number of PCTs

Number of SUIs

0 1 More than 1
Question 4: Under Patient Choice, do patients have the right to admit themselves to specialist mother and baby units if they do not wish to receive ‘Crisis Team’ care at home?

This question explores patient involvement in the decisions around their treatment for postnatal depression. In particular, in cases where patients, their carers or family members feel strongly that they should be admitted, can they make that decision themselves.

We received 40 responses to this question from the 77 PCTs - a response rate of 53%. Only 5 PCTs of the 40 PCTs responding to the question stated that they allow self-referrals. The majority stated that admission had to be by a clinical decision, though a number emphasised that the clinical decision was a joint decision which takes on board the views of the patient.

Furthermore, one PCT stated that:

“Patient Choice does not formally apply to mental health as it does to acute services.”

One of the aims of the NHS White Paper\textsuperscript{25} is to begin to introduce choice of treatment and provider in some mental health services from April 2011, and extend this wherever practicable. Furthermore, it is also aimed to increase information availability and accessibility to enable choice of treatment, including decision aids, particularly in mental health and community services. There needs to be clear guidelines from the Department of Health as to how this policy will be achieved in relation to postnatal depression services.

\textsuperscript{25} Department of Health. Equity and excellence: Liberating the NHS. July 2010.
4. Commissioning of postnatal depression services

Question 5: What is your commissioning strategy for mental health and does it include a specific strategy for postnatal depression and detection of suicide risk?

The purpose of this question was to understand whether PCTs have a mental health commissioning strategy and whether it includes postnatal depression or detection of suicide risk. This data aims to assess the strategy employed by PCTs when commissioning PND services both within their area and across different PCT boundaries.

Of the 77 PCTs who responded to our FOI, 70 answered this question with 63 stating they did have a specific mental health strategy. Only 28 PCTs have a strategy specifically for postnatal depression and detection of suicide risk – it is of grave concern that 64% of PCTs (49/77 PCTs surveyed) did not have a specific strategy for commissioning PND services. Of particular concern is that 6 of the 10 PCTs with the highest incidence per capita of PND had no specific commissioning strategy for PND services in place.

Brief further details of PCTs mental health and PND commissioning strategy were provided by 61 PCTs with the following themes and priorities identified:

- Services to be provided closer to home, relying on fewer hospital beds
- To develop clinical networks to share knowledge and resources across the PCT
- Early intervention and prevention
- Recovery focused
- Become NICE compliant
- User, carer and advocate involvement
- Personalisation of services
• Suicide prevention and reduction

Specifically for PND services strategies included:

• Consider the development of specialist perinatal services
• All 9 PCTs across the region are signed up to a plan which aims to achieve the standard that all women who suffer from perinatal psychiatric disorders are seen by a specialised community perinatal team
• Improve pathways of maternal mental health and women and children's services
• Improve access to psychotherapy services

NICE guidelines clearly state that PND services are particularly complex and subject to local variation due to the interplay between locally existing services. To ensure the effective provision of high quality clinical services it is essential that there is a clear referral and management protocol for services with a well defined pathway. It is therefore completely unacceptable that 64% of PCTs have not followed NICE guidelines and have a clearly defined commissioning strategy for PND that reflects the specifics of the services and pathway in their region.
**Question 6: Is your PCT part of a clinical network for perinatal mental health, if so which one?**

NICE guidance\(^\text{12}\) states that services should develop clinical networks to improve access for women to specialist perinatal mental health services. This question aimed to establish the implementation of this guidance. We received 65 responses to this question and of these **43 PCTs stated that they are a part of a clinical network for perinatal mental health services.**

Clinical networks encourage specialist knowledge and skills to be shared across services within that region. Though it is encouraging to see that many PCTs have opted for clinical network formation, the responses show that **44\% of PCTs are still failing to implement NICE guidance that was issued three years ago by failing to be part of a clinical network for perinatal mental health.** In the recent NHS White Paper consultation on Choice\(^\text{18}\), the Government outlined how it will focus on establishing clinical networks for maternity services. Although this focus is welcomed, there is very little practical information regarding how this will be achieved. **PCTs are already failing to form networks even though it is part of NICE guidance, it is not enough for the Government to just restate this policy – they need to outline how they will support PCTs to form networks.**
Question 7: Do you have a lead clinician of perinatal services? If so, what grade are they and are they an expert in the field of Perinatal Psychiatry?

The purpose of this question was to explore the management of perinatal health services by finding out whether PCTs had a clinical lead for these services and if so, how specialised they were. A lead clinician provides a focal point for service delivery and organisation and their expertise in the particular field can contribute to the performance of their team.

We received 58 responses to this question, and the majority of these PCTs do have a lead clinician (39 out of the 58 PCTs, or 67%). Out of the PCTs with a lead, 35 provided information as to the grade and specialism of their clinical lead. Of these, 22 PCTs have specialist perinatal psychiatrists as the lead but 7 PCTs have a lead that is not a specialist in psychiatry and 9 PCTs have a non-consultant lead (see Figure 4).

Figure 4: Grade of the lead clinician of perinatal services

![Grade and specialism of lead clinician](image-url)
5. National guidance

Questions 8 (a) and 9 (a): What methods of evaluation do you have or use to secure adherence to the NICE guidance ‘Antenatal and postnatal mental health’ (CG 45) & ‘Depression’ (CG 90)?

These questions aimed to provide qualitative information on the methods used by PCTs to gain assurances on the implementation of best practice guidance, in particular NICE Guidance on Antenatal and postnatal mental health (CG 45) and Depression (CG 90). We received 54 responses to this question and a number of key evaluation methods emerged:

Contract monitoring processes
Many PCTs use regular meetings between PCT and provider Trusts where key performance indicators are monitored and reviewed. In some responses it was noted that providers had to present quarterly, colour-coded, self-scoring assessment of their compliance with NICE guidance.

Service complaints & compliments
Feedback from service users – including complaints and compliments - are collated.

Incident/risk management
The Trust’s risk reporting database has a role to play in monitoring the progress of NICE implementation action plans, which are regularly reported to the Executive management team.

Training packages
This method aims to improve NICE adherence through training staff members in the tools and techniques presented by NICE as best practice.

**Internal service audits**

Some respondents stated that provider Trusts had to audit their work against relevant NICE guidance and this information must form part of the Trust’s annual report. The audits usually take place biannually – although this may vary widely depending on the individual Trust. Some Trusts complete a gap analysis against the guidance if necessary and an action plan is produced and tracked using the Trusts’ risk register which is monitored by governance committees until complete.

**NICE implementation groups**

Some PCTs have a NICE and national guidance operational group which discusses and helps implement national guidance. The group identifies key deliverables such as training requirements, pathway development and policy formulation which is then discussed at a strategic level and a plan of implementation formed.

It is encouraging that a range of methods are being used by the 70% of PCTs that responded to this question. However, 30% of PCTs did not respond to this question suggesting that they do not audit NICE guideline CG45, despite NICE developing a guide specifically to aid PCTs in carrying out an audit of this guideline.  

---

Questions 8 (b) and 9 (b): How often is adherence to NICE guidance evaluated?

We received a total of 54 responses to these questions. The results to this question showed that there are clearly significant variations between PCTs in the frequency of internal audits and monitoring of NICE guidance. Quarterly reviews were carried out by the majority of respondents (see Figure 5), however, **11 out of 54 PCTs state that they do not regularly review NICE adherence in this area.** It is part of the PCT commissioners’ responsibility to ensure that the care they commission is being provided according to available evidence-based and national guidance\(^\text{28}\). Ensuring that there is appropriate monitoring of NICE adherence is therefore essential and it is alarming that 20% of PCTs do not do this.

**Figure 5: How often NICE guidance is evaluated by PCTs**

<table>
<thead>
<tr>
<th>How often is adherence to NICE guidance evaluated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PCTs</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>18</td>
</tr>
<tr>
<td>20</td>
</tr>
</tbody>
</table>

\(^{28}\) NICE [2009] How to use NICE guidance to commission high quality services NICE: London
Within the proposed NHS commissioning reforms, commissioning will move to GP consortia that will set local priorities for GP commissioning based on NICE guidance and also NICE quality standards (a set of 5-10 specific, concise quality statements and associated measures that act as markers of high quality, cost-effective patient care). However, there is very little detail in the Health and Social Care Bill as to how GPs will be audited to ensure they are commissioning based on NICE guidance. Without auditing, there is real concern that services – particular complex services that are not already commissioned by GPs such as PND – will be poorly commissioned.

---

29 Equity and excellence: Liberating the NHS. July 2010.
Question 10: Do you have a named individual to lead on the implementation of NICE guidelines?

This question aimed to determine whether there is an individual responsible at PCT-level for the delivery of NICE guidance. With various staffing groups involved in the service delivery of perinatal mental health care there will be various leads in charge of different aspects of the service. However, a named individual would improve accountability in the service as a whole and improve integration of the different components.

We received 68 responses to this question and 51 PCTs stated they have a named lead for NICE implementation. However, this means that 34% of PCTs do not have a named lead with one respondent stating that this was the responsibility of the Trust and not the PCT.

However, PCTs are accountable for putting NICE guidance into practice and the PCT must ensure there is a clear process in place for reviewing and assuring NICE guidance implementation. There needs to be a clear definition of roles and responsibilities between provider Trusts and PCT commissioning bodies. With the Health and Social Care Bill moving the commissioning of maternity services to GP consortia, there needs to be a clear definition of roles and responsibilities i.e. GP consortia must have a clear lead for maternity services.
Question 11: Does your PCT ensure the use of the ‘Whooley’ Questions as recommended in NICE CG 45 for screening mothers for antenatal or postnatal depression?

The Whooley questions (for the questions in full see Appendix) are simple screening methods which can detect postnatal depression and lead to a subsequent referral to the patients GP for follow up. This screening technique is an opportunity to screen without the need for a more formal assessment and is recommended for use at initial contact by health visitors or midwives.30

The existence of other methods for screening mothers for perinatal depression means that the data for this question may not capture the full extent of screening. For example training health professionals to use the Edinburgh Postnatal Depression Scale (EPDS) is an additional method of screening for postnatal depression. However, the Whooley questions are recommended by NICE guidance, and therefore remain an important part of postnatal depression assessment.

We received responses from 62 PCTs and the vast majority (55 out of 62) responding to this question commission mental health services that use Whooley questions. It was also encouraging to see that many PCTs state that although providers use Whooley questions, they also use additional assessment techniques such as the EPDS.

The Whooley questions are often used as a first line assessment and then further investigation was used to determine the appropriate treatment course to refer the patient to. In some PCTs, midwives were trained to use Whooley questions and health visitors were trained to conduct more formal mental health examinations if follow up was deemed necessary.

30 NICE CG45 para 1.6.5 p 28; and NICE Antenatal and Postnatal Mental Health CG 45 available at http://www.nice.org.uk/nicemedia/pdf/CG045SlideSet.ppt
“The midwives (who are employed by the NHS Foundation Trust) ask the 2 Whooley questions during the antenatal period. They will inform Health Visitors of any pre-existing maternal mental health conditions and any identified condition arising during the antenatal period.”
Question 12: What measures do you have to monitor and review the performance of your postnatal mental health services?

The question aims to establish how PCTs are ensuring high quality postnatal mental health services are being delivered. We received 49 responses to the question (64% of the 77 PCTs responding to our FOI) and the key themes which emerged from responses to this question are:

- Contract monitoring processes i.e. monthly meetings with providers
- Through patient involvement i.e. surveys
- Complaints and SUIs
- Audits
- Formal Accreditation
- External review

The PCTs that did not have a specialist perinatal mental health service referred to the methods used to review their mental health service as a whole.

The methods by which PCTs monitor and review performance are similar to assurance for NICE guidance implementation i.e. regular contract monitoring and clinical quality review groups. Regular service reviews also used a set of indicators, according to which the PCT assessed whether standards are being met.

Many PCTs use soft data such as patient user satisfaction surveys to gauge the performance of their services as well as their complaints and SUIs processes. One PCT stated that they use their clinical network to carry out audits and case studies to monitor performance. Another PCT’s perinatal community team measured its performance by carrying out studies and questionnaires twice a year through GPs and psychology trainees.
One PCT stated that it will undergo a formal accreditation process by the Royal College of Psychiatrists, under the Quality Network for Perinatal Services, which will help to maintain standards, institute peer review of services and provide resources to service providers. Other external monitoring groups such as the Care Quality Commission (CQC) play a role in monitoring performance on providers.

---

6. Information, choice and training

Question 13: What systems do you use to provide a seamless transfer of information between the multi-professional services e.g. passing information from midwives in hospital to health visiting staff in the community? Please give examples.

An important part of delivering a good service for women during the perinatal period is using systems that promote clear communication between the various healthcare professionals who provide the perinatal service. This question aimed to produce qualitative information on the systems that are in place in PCTs. We received 56 responses to this question, which is a response rate of 73% of the 76 PCTs responding to our FOI request.

The key themes arising from qualitative analysis of the responses were:

*Information sharing protocols/systems*

In most cases information transfer begins with midwives contacting health visitors to notify them of a pregnancy. However, one interview with a service manager from women’s and children’s services suggested that communications systems between midwives and health visitors were not the most robust. If a midwife forgets to contact the health visiting service the women may lose out on an antenatal visit from a health visitor. The antenatal visit is a key time to start the dialogue of perinatal mental health and also to assess whether or not a woman is susceptible to postnatal depression. Once the baby is born midwives produce a discharge summary which is handed to the health visitor via the mother. From the survey results it was noted that some Trusts used discharge summaries which contained the Whooley questions (see Appendix 1) to be filled in by the midwives. According to our FOI, some midwives do not always complete the discharge summaries.
Linking with other professionals
There is variation in the ways in which midwives link with health visitors during case hand over. These range from face to face, telephone liaison, electronic or paper based exchange of notes. If a woman is deemed vulnerable or at risk of PND there will often be a more in depth discussion between the health visitor and midwife.

Joint planning
Some PCTs use pre-discharge planning meetings at the hospital for mothers with a known history of severe postnatal depression. To facilitate this, many PCTs foster good relationships with voluntary services and charities such as MIND and Homestart. This proactive case finding and communication can improve practice.

Future information technology systems
One PCT is developing a region-wide Child Health record department and implementing a new electronic records system for child health services. Other Trusts are looking to develop similar IT based systems in the future to improve the communication between professionals.

There appear to be a range of initiatives in place to enable the passing of information between hospital services and community based services. Although the majority of handovers of patients between midwives and health visitors will be straightforward, there are concerns that without a robust or formal process in place vulnerable women – such as those with mental health issues – may be lost in the system.
Question 14: Does your commissioned mental health services supply written information or use decision aids when explaining the risks of postnatal depression?

Providing mothers with written information about their postnatal depression helps them to make informed decisions about their care. We received responses from 45 PCTs (58% of the 77 Trusts that responded to our FOI). Of these, 26 provided written information, 9 provided written information and pictorial decision aids and 10 PCTs provided no written information to mothers (Figure 6). PCTs were also asked to provide details of the information provided by the services they commission, and the following themes emerged from these responses:

- **Leaflets setting out signs and symptoms**
  In one PCT, the Mental Health Trust has developed ‘New Baby, New Feelings’ leaflets which go out in the birth packs and are used as a tool by the health visitor to discuss postnatal depression. These leaflets provide information to mothers on when to seek help, symptoms and self-help. Every woman is to receive this leaflet. The leaflet is available in CD format for Urdu, Punjabi, Slovakian and Polish speakers.

- **Decision aids**
  One PCT’s services used mood cards to help them identify postnatal depression. One PCT stated that they have translated their leaflets into three of the most widely spoken languages in the area and when required the pictorial tool is used with an interpreter.

- **Education groups**
  One PCT provides an education group which explains the risks of postnatal depression to patients who can then keep a copy of the PowerPoint presentation.
In the recent NHS White Paper consultation on information, the Government recognised the need for meaningful and accessible information to improve patient outcomes\textsuperscript{32}. It is essential that PCTs provide information in a range of formats so that this is accessible to women using the PND service. Furthermore, in NICE guideline CG45, it states all women should be given culturally sensitive information at each stage of the assessment, diagnosis, course and treatment of PND. It is alarming that of the 77 PCTs who responded to our FOI, 55% do not (or do not know if they) provide information to women who are at risk/are suffering from PND. The Coalition Government in their NHS White Paper\textsuperscript{25} and Information consultation\textsuperscript{32} state the need to improve the provision of meaningful and accessible information in order to improve outcomes. The majority of PCTs do not provide written information to women regarding PND, despite NICE guidelines clearly stating the need for information provision. With GP consortia to take over responsibility for commissioning maternity services, the number of leads of maternity services will increase from 152 to possibly over 300. There needs to be clear

---

guidance from the Government on how information provision will be tied up across the various consortia to prevent an increase in variability of information provision when the number of maternity leads increases.
Question 15: What level of training does your PCT provide health visitors in regard to assessing mental health conditions and in giving psychological support during the antenatal and postnatal period? How many health visitors does your PCT provide?

Providing extra training to health visitors in assessment techniques like the EPDS, cognitive psychological therapies and listening skills can lead to up to a 30% reduction in the number of women who go on to develop postnatal depression. This question aimed to find out whether PCTs commissioned services that provide extra training for health visitors.

We received 57 responses to this question - of those, 17 PCTs do not provide extra training for health visitors in perinatal mental health. There are significant clinical gains to be achieved if health visiting teams are developed further and there is also a potential to improve financial efficiency through reduced numbers of contacts with GP and secondary care services.

One technique of further training that emerged from responses was ‘train the trainer’ courses after which course attendees can go on to train fellow members of staff and disseminate knowledge gained of assessment, identification and level 1 interventions such as listening skills and cognitive behavioural therapies.

The question identifying numbers of health visitors provided per capita aims to determine whether regional variations exist in the support provided to pregnant and postnatal women. We received 60 responses to this question and the figures show a huge variation in the number of health visitors per capita per PCTs ranging from 1 Health Visitor per 12,288 patients to 1 Health Visitor per 3,310 patients.
Figure 14: Number of patients per health visitor per PCT
7. Conclusions and Recommendations

This report presents the current view of how PCTs are delivering perinatal mental health services and treating PND across the country. The report highlights a number of concerns around current PND service provision particularly on the issue of data coding for PND, PND specific commissioning strategies, adherence to NICE guidelines, the lack of provider networks, information for new mothers and training of health visitors.

**Coding postnatal depression**

One of the most alarming findings of this report was that PCTs were unable to provide data regarding the incidence of PND in their locality (78% of PCTs did not have this data), the referral rate to specialist mother and baby units (62% of PCTs unable to provide data) and the number of SUIs related to PND in the last 5 years (45% did not provide data).

Many PCTs said that while they recorded cases as ‘depression’, postnatal depression was not recorded as a specific subset. **This means that many PCTs have no accurate information about postnatal depression case volume.** Including postnatal depression as a specific ICD 10 code would help provider Trusts to collect accurate information on postnatal depression case numbers and the outcomes of treatments or SUIs related to postnatal depression. With an accurate record of PND cases, PCTs would be able to commission services according to their population needs. With a move to GP commissioning it is essential that the baseline level of PND is identified. GPs will be commissioning maternity services for the first time and it is essential that they have a clear picture of the demographics in their area if they are to commission services effectively.


**PND commissioning strategies**

There was a lack of commissioning strategies specific to PND services with 64% of PCTs not having a specific strategy in place. Of particular concern was that 6 of the 10 PCTs with the highest incidence of PND cases per capita did not have a PND strategy. World Class Commissioning\(^3\) clearly states that PCTs should be commissioning services that accurately reflect the needs of the local population. However, if commissioners do not know the incidence of PND in their locality and do not have a strategy in place for PND, we question how they can meet the needs of PND sufferers in the community.

Furthermore, NICE guidelines\(^3\) state the essential components of antenatal and postnatal mental health services, but stresses that these need to be adapted to meet local needs and existing mental health services. Without a local PND strategy in place it is unlikely that PCTs will be able to achieve this.

**NICE guidance implementation and perinatal networks**

Our report shows that the majority of PCTs are failing to implement NICE guidance\(^3\) with 44% of PCTs not being part of a clinical network and 33% of PCTs not having a lead clinician for perinatal health. Having a lead for perinatal services, ensures that there is a member of staff at the Trust who is accountable for implementing NICE guidance and can support and focus the team. Being part of a perinatal services network ensures information transfer, referral and management protocols and definition of roles for professional groups. The Government have recognised the importance of clinical networks in delivering a joined up service and for offering choice to mothers and have made it a priority in the recent NHS White Paper for the formation of clinical perinatal networks\(^29\). However, there needs to be more detail from the Government as to how this will be achieved as this initiative has been unsuccessful as part of NICE guidance and

---

there is no detailed information from the Government as to how this will be achieved as part of the NHS reforms.

**Information for new mothers**

Of the 77 PCTs who responded to our FOI, 55% do not (or did not know whether they) provide information to mothers about PND. The NHS White Paper\textsuperscript{25} and Information consultation\textsuperscript{32} both emphasise that information is the key to improving the state of the nation’s health. However, we are concerned that information provision is already variable throughout England and with GP consortium to be responsible for maternity services, this variability may increase. Mothers and their families who do not receive information are not able to identify the early signs and symptoms of PND, which is counter to the priority of early detection identified by NICE guidance\textsuperscript{3}.

**Serious Untoward Incidents**

45% of PCTs who responded to our survey did not have information on the number of SUIs that occurred in the services that they commission that are attributable to PND. This goes against the national framework for serious incidents that was developed by the NPSA which focuses on the need to share information on SUIs to prevent them from occurring elsewhere in the NHS\textsuperscript{23}. Without this information, PCTs are unable to learn from each other and the mistakes made at one PCT may be repeated elsewhere. With the abolition of PCTs and SHAs, it is unclear from the Government as to who will lead on the reporting and investigating of SUIs.
Recommendations

- The Department of Health must amend the ICD10 coding to include postnatal depression so that data can be recorded that accurately reflects the incidence of PND

- PCTs must ensure that clinical networks for perinatal services are set up, as detailed in NICE Clinical Guideline 45

- All PCTs should have detailed strategy in place for commissioning PND services in addition to a mental health strategy, to include local variation in service provision

- PCTs must ensure that all expectant/new mothers are provided with written and, where appropriate, visual information on PND to facilitate early detection and improve patient outcomes

- PCTs must commit to training Healthcare visitors in using assessment tools and psychological techniques to help identify and reduce the number of cases of PND

- The Government needs to issue clear guidance on who will lead on the investigation and reporting of SUIs once PCTs and SHAs are abolished
Appendix

The Whooley questions are derived from research\textsuperscript{34} carried that found directed questions to be as sensitive in case finding for postnatal depression as more detailed techniques. The questions are:\textsuperscript{35}

1. ‘During the last month, have you often been bothered by feeling down, depressed or hopeless?’
2. ‘During the last month have you often been bothered by having little interest or pleasure in doing things?’

This is also supplemented with a third question\textsuperscript{36} if the answer to either of the first two is ‘Yes’:

3. ‘Is this something with which you would like help?’ which has three possible responses: ‘No,’ ‘Yes, but not today,’ and ‘Yes.’

---

\textsuperscript{34} Whooley, M. A., Avins, A. L., Miranda, J., et al. (1997) Case-finding instruments for depression. Two questions are as good as many. Journal of General Internal Medicine, vol 12, pp 439–445

\textsuperscript{35} as defined in NICE CG 45 (para 5.4.3 p116)