Antenatal and postnatal mental health services

Commissioning guide
Implementing NICE guidance

August 2008
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Antenatal and postnatal mental health services

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission effective antenatal and postnatal mental health services.

This commissioning guide should be read in conjunction with the following NICE guidance:

- NICE clinical guideline CG45. Antenatal and postnatal mental health: clinical management and service guidance

The clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide. Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

The guide:

- makes the case for commissioning antenatal and postnatal mental health services
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide can be downloaded or accessed from the navigation menu on the right hand side of the screen. Download the openly available commissioning and benchmarking tool, there is no need to register.

For information on costs for the establishment of managed perinatal networks and specialist perinatal mother and baby units see the NICE costing report and NICE costing template for CG45 on antenatal and postnatal mental health.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.
• Topic-specific Advisory Group: antenatal and postnatal mental health
Commissioning antenatal and postnatal mental health services

Mental disorder during pregnancy and the postnatal period can have serious short- and long-term consequences for the health and wellbeing of a woman, her baby and other family members. The detection of women at risk of developing a mental disorder and the identification of those with a current mental disorder, followed by prompt intervention at all levels of healthcare provision, can help to minimise maternal morbidity and limit adverse effects on the baby and other family members.

In an average primary care trust (PCT) with a population of 300,000, the number of women experiencing mental disorder and requiring referral for psychological therapies will be approximately 300 per year (80 per 1000 deliveries). Around 140 women per year (40 per 1000 deliveries) will require referral to a specialist perinatal mental health service and of these about 15 will require admission to a mother and baby unit.

Figure 1 illustrates the likely severity of mental disorders experienced by women during pregnancy and the postnatal period and the likely service demand.

The provision of antenatal and postnatal mental health services varies considerably across England because of local factors, including the
organisation of existing mental health services, the demographic profile of the population and geographical issues.

**NICE clinical guideline CG45 on antenatal and postnatal mental health** makes recommendations on how the components of services may be adapted to meet local needs and deliver integrated care. This can be achieved by developing managed clinical perinatal networks. Specialist mental health commissioners and providers should ensure that there are properly developed links between specialist perinatal mental health services, social services and primary care services, with commissioning agreements in place to support service reconfiguration and redevelopment.

The philosophy of care set out in the **National service framework for mental health: modern standards and service models** should underpin the commissioning of all mental health services, whether specialised or non-specialised.

**Benefits**

The potential benefits of robustly commissioning effective antenatal and postnatal mental health services include:

- **improving the mother-child relationship** and subsequently the developmental and emotional state of the child
- **reducing inequalities** and improving timely access to services in primary care, mental health and maternity services
- **reducing the risk of relapse and/or recurrence of a mental disorder**
- **reducing the risk of** women with an existing mental disorder stopping medication in an unplanned way
- **reducing the number of inappropriate referrals and readmissions** and the length of inpatient stays, and offering alternatives to admission
- **reducing the risk of self-harm and suicide**
- **preventing avoidable separation of mother and baby** and promoting early return if separated
- **improving performance and patient-centred clinical care** through implementing the recommendations outlined in **NICE clinical guidelines CG45 on antenatal and postnatal mental health, CG22 on anxiety, CG90 on depression (update), CG26 on post-traumatic stress disorder, CG31 on obsessive-compulsive disorder, CG38 on bipolar disorder, CG9 on eating disorders, CG62 on antenatal care, CG82 on schizophrenia (update) and technology appraisal guidance TA59 on electroconvulsive therapy.**
• **better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

**Key clinical issues**

Key clinical issues in providing effective antenatal and postnatal mental health services are:

- **identifying women with common mental disorders** and/or who are at risk of developing a serious mental disorder
- **enabling patient choice** by providing up-to-date information about the risks and benefits of treatment before conception, when pregnant and during the postnatal period
- **providing timely and appropriate care and treatment** for women with common mental disorders
- **providing support, advice, information and training** to maternity, psychiatric and primary care services through managed perinatal networks
- **providing a quality assured service**.

**National priorities**

National priorities and initiatives relevant to commissioning antenatal and postnatal mental health services include:

- **National service framework for children, young people and maternity services** and **National service framework for mental health: modern standards and service models**
- **Maternity matters: choice, access and continuity of care in a safe service**
- **Confidential Enquiry into Maternal and Child Health: improving the health of mothers, babies and children**
- **Review of the health inequalities infant mortality PSA target**
- **Delivering race equality in mental health care: an action plan for reform inside and outside services**
- The **Care closer to home** initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.
- **Commissioning framework for health and well-being**
- **World class commissioning**
• The NHS in England: the operating framework for 2009/10
• Considering the impact of patient choice
• A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services
• Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these standards will be assessed by the Care Quality Commission in line with Standards for better health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.
Specifying antenatal and postnatal mental health services

Service components

The key components of antenatal and postnatal mental health services are:

- detection and referral of women with a mental disorder
- care and treatment of women with a mental disorder
- developing a high-quality service.

Detection and referral of women with a mental disorder

Commissioners and provider trusts should ensure that practitioners are trained to discuss contraception and explore the risks of pregnancy with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Training should include information on mental disorders, assessment and the effective use of referral routes and care pathways as recommended in NICE clinical guideline CG45 on antenatal and postnatal mental health. To identify women with or at risk of developing a mental disorder, healthcare professionals should be competent in using assessment tools, including key detection questions to identify possible depression (‘Whooley questions’), and should refer women appropriately.

Pregnant women who have experienced a previous episode of depression and/or anxiety and who present with mild or subthreshold symptoms of depression and/or anxiety can be offered individual brief psychological interventions, for example, four to six sessions of interpersonal psychotherapy or cognitive behavioural therapy. PCTs and practice-based commissioners (PbCs) need to ensure that sufficient capacity is available to allow prompt access to targeted psychosocial interventions. Commissioning a brighter future: improving access to psychological therapies – positive practice guide describes the key stages that PCTs need to consider when commissioning an appropriate range of psychological therapies to meet the mental health needs of the local community. It includes an example of how training in evidenced-based approaches and improving access to psychological therapies can help women with mental disorders who have recently given birth.

Social support, which may take the form of regular, informal individual or group-based sessions during pregnancy and the postnatal period, should be available for women who present with mild or subthreshold symptoms of depression and/or anxiety but have not had a previous episode of depression or anxiety. PCTs and PbCs need to be aware of the range of support services that are available, such as Sure Start children’s centres, maternity and child welfare services, social services and services provided by voluntary sector organisations.
Commissioners and those responsible for perinatal networks should ensure that adequate systems are in place to guarantee continuity of care and effective transfer of information to reduce the need for multiple assessments. The Map of medicine obstetrics and gynaecology pathway provides an information resource that visually organises the care pathway.

**Care and treatment of women with a mental disorder**

The recommendations for the care and treatment of women with mental disorders during pregnancy and the postnatal period are highlighted in NICE clinical guideline CG45 on antenatal and postnatal mental health. For information on specific conditions go to the relevant clinical guideline listed in the benefits section of this guide. The care of women with a mental disorder during pregnancy and the postnatal period should be the same as for anyone with a mental disorder. However, treatment decisions are complicated by the presence of the developing fetus, breastfeeding and the timescales imposed by pregnancy and birth. To minimise the risk of harm to the fetus or breastfed baby, drugs should be prescribed cautiously. As a result, the thresholds for non-drug treatments, particularly psychological treatments, are likely to be lower than those set in NICE clinical guidelines on specific mental disorders, and prompt access to these treatments should be ensured if they are to be of benefit.

PCT and PbCs may need to increase resources within their existing psychological therapies service or consider the need for an additional service specifically for women with mental disorders in the antenatal and postnatal periods. This will ensure that women requiring psychological treatment are seen within 1 month of initial assessment, and no longer than 3 months afterwards. PCTs and PbCs may wish to refer to the Improving access to psychological therapies implementation plan: national guidelines for regional delivery for more information. In addition, the antenatal and postnatal mental health services commissioning and benchmarking tool can be used to determine the level of service that might be needed locally and to calculate the cost of commissioning the service.

All commissioners should also consider the needs of other special groups such as adolescents, women with learning disabilities and women who misuse substances, and liaise with the appropriate agency to ensure a joint approach to service provision.

**Developing a high-quality service**

To ensure the effective provision of a high-quality clinical service, PCTs and strategic health authorities need to establish joint working to commission services that meet local needs, based on demographic, epidemiological and geographical information. NICE clinical guideline CG45 on antenatal and postnatal mental health recommends that perinatal mental health networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers.
These networks should provide:

- a specialist multidisciplinary perinatal mental health service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal mental health teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental disorders, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved.

**NICE clinical guideline CG45 on antenatal and postnatal mental health** recommends that each managed perinatal network should have designated specialist inpatient services and cover a population in which there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates.

The **NICE clinical guideline CG45 implementation advice** offers suggested actions for commissioners on how to establish a managed clinical network. The structures within the networks may differ locally; however, a core team is required to coordinate and manage the network. The **NICE costing template** for CG45 on antenatal and postnatal mental health provides cost data for establishing a core team that consists of a clinical lead, a manager and a coordinator.

Specialist perinatal **inpatient** mental health services should provide facilities designed specifically for mothers with serious and/or complex mental illness and their babies (typically with 6–12 beds), offer inpatient assessment and treatment and be staffed by specialist perinatal mental health staff and staff who can care for infants. (A separate area on an acute or other psychiatric ward is not regarded as a specialist unit.) They should provide effective liaison with general medical, maternity, and mental health services, have a full range of therapeutic services and be able to offer opportunities for patients at high risk of postnatal mental illness to be admitted prophylactically. **Standards for mother and baby inpatient units** are available from the Royal College of Psychiatrists **Quality Network for Perinatal Mental Health Services**. This national network engages with frontline staff and applies a clinical audit method within a peer-support network.

The **Department of Health Specialised services national definitions set definition no. 22** includes definitions for specialist perinatal mental health services that include mother and baby units and **perinatal mental health community outreach teams**. Perinatal community outreach teams are
multidisciplinary consultant- and nurse-led teams that work in conjunction with inpatient units and provide alternatives to admission, follow-up support for discharged women and **consultation and liaison** with generic services. These services are currently subject to specialised commissioning arrangements that take into account the needs of a planning population larger than that of a single PCT.

Commissioners may wish to consider commissioning antenatal and postnatal mental health services in several different ways, and mixed models of provision may be appropriate across a local health economy. The following example of a service model can be found on the [NICE shared learning database](https://www.nice.org.uk/). This example is offered to share practice and NICE makes no judgement on the compliance of this service with its guidance.

The Northumberland, Tyne and Wear NHS Trust community mental health team provides a community psychiatric nursing service for women with mental disorders related to pregnancy, childbirth and early motherhood. The community psychiatric nurses have established links with primary care and mental health teams. Women referred to the service are seen at home, in GP practices or in maternity services.

Local stakeholders, including **service users**, should be involved in determining what is needed from antenatal and postnatal mental health services in order to meet local needs. The services should be patient-centred and integrated across primary care, maternity and mental health services and at all levels of healthcare provision.

The service specification needs to consider:

- The required skills, knowledge, competencies and training for all staff including non-specialist health professionals.
- The expected number of patients (this should take into account how quickly any changes in service provision are likely to take place).
- Ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally.
- Care and referral pathways.
- Information and audit requirements, including IT support and infrastructure.
- Planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the **18 week patient pathway** or equitable waiting times locally for those services currently outside 18 weeks. **NICE clinical guideline CG45 on antenatal and postnatal mental health** recommends access to assessment and psychological intervention within 1 month.
• **service monitoring criteria.**

Useful sources of information may include:

- Department of Health [Specialised services national definitions set](#) definition no. 22 commissioning for perinatal psychiatric services.

- [Improving Access to Psychological Therapies commissioning toolkit](#).

- The [Map of medicine](#) provides an information resource that visually organises the care pathway.
Determining local service levels for antenatal and postnatal mental health services

Benchmarks for a standard population

Available data suggest that the standard benchmark rate for referral for psychological therapies is estimated to be 80 per 1000 deliveries.

Available data also suggest that the benchmark rate for referral to a specialist perinatal mental health service is estimated to be 40 per 1000 deliveries. This includes 4 per 1000 deliveries who are likely to require admission to a mother and baby unit.

For an average primary care trust population of 300,000, assuming the same annual delivery rate as the national average (50 per 1000 women aged 15–49 years), the number of women requiring referral for psychological therapies is around 300 per year (80 per 1000 deliveries). Around 140 per year (40 per 1000 deliveries) will require referral to a specialist perinatal mental health service, and of these around 15 per year will require admission to a mother and baby unit.

For an average general practice size of 10,000, assuming the same annual delivery rate as the national average (50 per 1000 women aged 15–49 years) the number of women requiring referral for psychological therapies is around 10 per year (80 per 1000 deliveries). Around 5 women per year will require referral to a specialist perinatal mental health service.
Figure 1 illustrates the likely severity of mental disorders experienced by women during pregnancy and the postnatal period and the likely service demand based on the opinion of the topic-specific advisory group on antenatal and postnatal mental health services.

For the purpose of this benchmark, the base population is the number of deliveries in England in 2005–06. This base population is also used in the associated commissioning tool. It has been chosen for the following reasons:

- prevalence estimates of postnatal mental disorders are expressed in rates per 1000 deliveries
- delivery data are readily available to commissioners to support service planning.

This benchmark could also be applied to the number of live births, which some commissioners may choose to use to plan demand for services. The number of live births (rounded to the nearest 100) by primary care organisation can be obtained here.

The delivery data presented in the tool have been aggregated so that women who deliver outside their PCT area are counted against the primary care organisation of the referring GP. This is to ensure that, as far as possible, delivery data and live birth data are comparable.

Examine the assumptions used in estimating these figures.

These services are likely to fall under the programme budgeting category 205X (other mental disorders).

Use the antenatal postnatal mental health services commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

Further information

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- The Improving Access to Psychological Therapies programme workforce capacity tool, which has been developed to help commissioners estimate the number of new workers required to manage demand for psychological treatment in their area.
- Annex A of the Commissioning framework for health and well-being, which outlines the process and data needed to undertake a joint strategic needs assessment.
• Department of Health [Delivering quality and value – focus on benchmarking.]
• NICE [Health equity audit – learning from practice briefing]
• PRIMIS+, which provides support to general practices on information management and the recording and analysis of data, and a comparative analysis service focused on key clinical topics.
Assumptions used in estimating a population benchmark

The assumptions used in estimating a benchmark for referral for psychological therapies of 80 per 1000 deliveries and referral to a specialist perinatal mental health service of 40 per 1000 deliveries are based on the following sources of information:

- **epidemiological data** on common mental health disorders in the general population
- **current detection rate** of mental disorders in the antenatal and postnatal period
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

**Epidemiological data**

According to the report *NHS maternity statistics, England: 2005–06*, about 593,400 NHS hospital deliveries took place in England in 2005–06. A further 15,900 deliveries took place at home. This suggests that there were around 609,300 deliveries in England in 2005–06.

For the purpose of this benchmark, the base population is the number of deliveries in England in 2005–06. This base population is also used in the associated commissioning tool. It has been chosen for the following reasons:

- prevalence estimates of postnatal mental disorders are expressed in rates per 1000 deliveries
- delivery data are readily available to commissioners to support service planning.

This benchmark could also be applied to the number of live births, which some commissioners may choose to use to plan demand for services. The number of live births (rounded to the nearest 100) by primary care organisation can be obtained here.

Prevalence estimates from the *psychiatric morbidity survey report (2001)* have been used to estimate the proportion of women who may have mental disorders during pregnancy. The report gives the point prevalence estimates for the following mental disorders:

- mixed anxiety and depression
- depressive episode
- generalised anxiety disorder
- obsessive compulsive disorder
• panic disorder.

Mixed anxiety and depression is defined in the psychiatric morbidity survey report (2001) as a ‘catch-all’ category that includes people with significant symptoms that cannot be coded into any of the other conditions included in the survey. We have assumed that women with post-traumatic stress disorder are counted within this group.

Applying the age- and sex-specific rates of the above disorders to the numbers of deliveries in each age band suggests that around 20% of deliveries are to women with one or more of the above conditions. This takes into account a possible overlap between the disorders covered by the psychiatric morbidity survey.

There is little evidence that the prognoses of disorders that develop during pregnancy or the postnatal period are significantly different from those that develop at other times. Similarly, there is little evidence that the underlying course of most pre-existing mental disorders is significantly altered during pregnancy and the postnatal period[1]. Therefore, the estimate of 20% is thought to be an appropriate indication of mental disorders among women during pregnancy and the postnatal period because it reflects the prevalence of common mental disorders in the English population. The prevalence of depression alone in the postnatal period has been estimated to be around 10%[2].

Research suggests that in around 0.2% of deliveries, the woman may require an inpatient admission for a psychotic episode, and in a further 0.2% of deliveries the woman may need to be admitted for treatment for non-psychotic depression. Research also suggests that 0.2% of deliveries are to women with schizophrenia who will require advice and care from a specialist perinatal mental health service[2].

We have assumed that women admitted into secondary care for non-psychotic depression are counted within the 20% of deliveries estimated above.

**Current practice**

IMS Disease Analyzer is a database that holds patient data from a sample of GP practice systems. Data were extracted on the basis of Read codes on a broad range of mental disorders including those not covered by the psychiatric morbidity survey, such as bipolar disorder and schizophrenia.

The validity of conclusions based on data extracted from IMS Disease Analyzer was assessed by comparing the rate of recorded births derived from the extracted data with the rate of deliveries among women in the general population. The two sets of data had comparable delivery rates per 1000 female population.

Analysis of the data suggests that:
• around 25% of women who were identified as having given birth had a diagnosis of one or more mental disorders of differing severities recorded on their medical records at any time in the past

• around 8% of women who were identified as having given birth had a diagnosis recorded on their medical records as having a mental disorder in the antenatal period

• around 14% of women who were identified as having given birth had a diagnosis recorded on their medical records as having a mental disorder in the postnatal period

• around 6% of women were identified as having both presented to their GP in the antenatal and postnatal period and having a diagnosis of a mental disorder recorded on their medical records.

This suggests that around 16% ([8% + 14%] – 6%) of women may require some form of intervention for a mental disorders during the antenatal and/or postnatal period. This estimate takes into account the overlap between women who present during pregnancy and those who present during the postnatal period.

The quality of data used in the analysis of diagnosed mental disorders relies on the information recorded within patients’ medical records. In particular, poor detection and/or recording of mental disorders by healthcare professionals may lead to underestimation of the total numbers of women in contact with services who have a mental disorder.

**Expert clinical opinion**

The consensus opinion of the topic-specific advisory group was:

• Based on clinical practice and literature review, around 20%, or 200 per 1000, deliveries may be to women with a range of mental disorders with varying degrees of severity.

• Between 3% and 5% of deliveries are to women who have severe and/or complex mental disorders and may require advice and care from a specialist perinatal mental health service. A small proportion of these women may require admission to a mother and baby unit. The rate of admission per 1000 deliveries to a mother and baby unit is estimated to be:
  • 2 per 1000 deliveries for psychosis
  • 2 per 1000 deliveries for non-psychotic depression
  • 2 per 1000 deliveries for chronic and complex mental disorders.

• Areas served by specialist community perinatal mental health outreach teams may be expected to have a lower rate of admission to a mother and baby unit of around 4 per 1000
deliveries. For the remaining 16% of deliveries, the proportion that are to women who may require and take up referral for psychological treatment is estimated to be around 50%. However, this is subject to a high degree of uncertainty and local variation.

Conclusions

Based on the epidemiological data and other information outlined above, it is concluded that 12% of deliveries or 120 per 1000 deliveries are to women who may require additional support and/or appropriate onward referral. This is based on the following assumptions:

- Around 20% of deliveries will be to women who experience mental disorders of varying degrees of severity. This is based on the prevalence of common mental disorders from the psychiatric morbidity survey report, analysis of data from IMS Disease Analyzer (accounting for a probable degree of under-recording and detection) and the expert opinion of the topic-specific advisory group.

- Around 4% of deliveries (midpoint of the estimates provided by the topic-specific advisory group) will be to women who have severe and/or complex mental disorders and are vulnerable to admission to secondary care. These women will require advice and care from a specialist perinatal mental health service. They include the estimated 4 per 1000 deliveries to women who will require admission to a mother and baby unit.

- Of the remaining 16% of deliveries, around half (or 8%) are to women who will require and take up the offer of psychological therapies.

Therefore the benchmark rates are estimated to be:

- 80 per 1000 deliveries (8%) to women who require referral for psychological therapies

- 40 per 1000 deliveries (4%) to women who require advice and care from a specialist perinatal mental health service; this includes 4 per 1000 deliveries to women who are likely to require admission to a mother and baby unit.

Use the antenatal and postnatal mental health service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.
References


The commissioning and benchmarking tool

**Download the antenatal and postnatal mental health services commissioning and benchmarking tool**

Use the antenatal and postnatal mental health services commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service as described below.

**Identify indicative local service requirements**

The indicative benchmark based on the national average of women who require antenatal and postnatal mental health services is **12%**. This includes 8% (80 per 1000 deliveries) who require and take up psychological therapies and 4% (40 per 1000 deliveries) who require advice and care from a specialist perinatal mental health service.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population has a significantly lower or higher prevalence of mental disorders you may need to provide services for relatively fewer or more people.

The commissioning and benchmarking tool is specifically designed to support commissioners who wish to commission services for the 8% (80 per 1000 deliveries) of women who require referral for psychological therapies. For information on costs associated with perinatal networks and inpatient service provision refer to the [NICE costing report](#) and [NICE costing template](#) for NICE clinical guideline CG45 on antenatal and postnatal mental health.

**Review current commissioned activity**

You may already commission antenatal and postnatal mental health services for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required.
Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level and to model the required changes over a period of 4 years. Use the tool to calculate the level and cost of psychological therapies that you intend to commission and to consider the settings in which the service may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and **take into account the views of local people**. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account patients’ and carers’ views and those of other stakeholders when making commissioning decisions.

An antenatal and postnatal mental health service needs to:

- be effective and efficient
- be responsive to the needs of patients and carers
- provide treatment and care based on best practice, as defined in NICE clinical guideline CG45 on antenatal and postnatal mental health
- deliver the required capacity
- be integrated with other elements of care for women with mental disorders during pregnancy and the postnatal period
- define agreed criteria for referral, local protocols and the care pathway for women requiring mental health services before and after delivery
- be patient-centred and provide equitable access, ensuring that women are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- demonstrate how it meets requirements under equalities legislation
- demonstrate value for money.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- Service and performance targets, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that patients and carers do not experience unnecessary delays), complaints procedures.
- Clinical governance arrangements, including incident reporting.
Clinical quality criteria: appropriateness of referral, consenting procedures, clinical protocols.

Audit arrangements: frequency of reporting, reporting route and format, and dissemination mechanisms; this should include auditing the proportion of eligible women requiring antenatal and postnatal mental health services who are provided with care, and monitoring of patient outcomes and complications (see audit criteria for NICE clinical guideline CG45 on antenatal and postnatal mental health for further information). Commissioners will need to monitor prescribing patterns locally.

Health, safety and security: infection control, waste management, confidentiality procedures, legislative requirements.

Accreditation requirements: Standards for mother and baby inpatient units are available from the Royal College of Psychiatrists Quality network for perinatal mental health services. The network engages with frontline staff and applies a clinical audit method within a peer-support network.

Patient satisfaction: patient and carer perspectives and perceptions of service provision, complaints.

Patient outcomes: fewer women admitted to general psychiatric wards, reduced length of stay on inpatient mother and baby units, reduced number of readmissions to mother and baby units, improved patient safety and reduced the risk of fetal abnormality.

Staff competencies: individual and team baseline requirements, monitoring and performance.

Information requirements, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).

The process for reviewing the service with stakeholders, including decisions on changes necessary to improve or to decommission the service.

Achieving targets associated with equalities legislation.

Further information

General information on quality and corporate assurance can be obtained from the following sources.

The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication
‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

- **NHS Alliance online resources** NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

- The **DH commissioning framework** provides guidance on the commissioning process in the context of the NHS reform agenda.

- NHS Institute for Innovation and Improvement support for commissioners, includes **Commissioning for Health Improvement** products to accelerate the achievement of world class commissioning; **The Productive Leader** programme to enable leadership teams to reduce waste and variation in personal work processes, and **Better care, better value indicators** to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

- **10 Steps to your SES: a guide to developing a single equality scheme.** This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

**Specific information** on quality and corporate assurance for an antenatal and postnatal mental health service can be obtained from the following sources:

- **‘Better metrics’** is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See ‘mental health’ metric 9.06 and ‘children and maternity’ metric 3.0.

- **Skills for health** works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the **mental health** and **maternity and care of the newborn competency framework**.
Topic-specific Advisory Group: antenatal and postnatal mental health services

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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