IAPT for women in the Perinatal period – Baseline Findings

North Region
May 2017
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1 Introduction

Perinatal mental health is a key Government priority\(^1\). By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

In November 2016, £1,387,689 was allocated to NHS England North to be used for two distinct purposes. Namely;

- Map the access to and outcomes from services for women in the perinatal period in IAPT, including pathways to and from IAPT. This mapping should yield an understanding of access, treatment completion, recovery rates and key pathways into services for women in the perinatal period at a CCG level – enabling regions to understand outcomes overall and identify areas of good practice to build on. Assess gaps in quality or access, develop a plan to improve them, and take action as possible, being clear on measurable impact. If areas have submitted successful proposals in the specialist perinatal mental health community services development fund, we would expect this work to be linked to offer comprehensive access to care locally and;
- Improve IAPT access and quality locally according to local performance and priorities. The only IAPT target yet to be met nationally is recovery, and so focused action on IAPT recovery rates is expected as part of this exercise. Possible areas of focus include improving data quality around problem descriptors or completeness of anxiety disorder specific measures, support for services to implement ‘Plan Do, Study, Assess’ cycles as showcased in the national recovery workshops, peer support for improvement mediated through clinical networks or clearing of waiting times for treatment or within the treatment pathway.

This report focusses solely on bullet point 1 above and the collated findings from this exercise for Northern, Yorkshire & Humber and North West Coast clinical networks. Greater Manchester have commissioned Manchester University to undertake a wider Perinatal baseline exercise which includes IAPT, a report should be available over the coming months. This delay was the result of issues navigating and completing the procurement exercise towards the end of the financial year 16/17.

£236,504\(^2\) was specifically allocated to support a regionally coordinated mapping exercise for women in the perinatal period in IAPT against the following outcomes:

- Consistent mapping exercise across the North region led by clinical networks
- Establish a benchmark of IAPT service provision and undertake a gap analysis

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\(^{1}\) Mental Health Taskforce Report: Five Year Forward View for Mental Health, NHS England, 2016

\(^{2}\) This does not include funding allocated to CCGs/Providers to improve perinatal mental health access to IAPT, allocated to deliver perinatal training or allocated to improve data quality.
Clinical networks will:
- Disseminate and discuss the findings and recommendations for regional focus with stakeholders and develop local action plans to support improvement in IAPT services for women in the perinatal period
- Support and facilitate discussion with local CCGs/STPs to support the commissioning of services which address current service gaps and are concordant with national service standards.
- Support effective allocation of resources (non-recurrent funding / transformation funding), improve and develop data collection and inform service transformation and effective training plans.

2 Process

The North West Coast ‘NWC’ clinical network (which encompasses Cheshire & Merseyside & Lancashire & South Cumbria) were in the process of mapping perinatal mental health ‘PNMH’ services on a wider scale and offered a tried and tested template\(^3\) for this exercise. NHS England North coordinated a webinar with all clinical networks in early January 2017 to discuss and agree one consistent template (see Appendix) based on the NWC version. Each question is based on national guidelines, primarily the NICE Quality Standards, with a request that the survey was completed by managers of IAPT services.

For the purposes of this exercise some clinical networks utilised only the IAPT section of the template due to timescales but may in future conduct a wider mapping exercise similar to NWC.

Clinical Networks conducted the baseline between mid-January and March 2017 and worked to a timescale of 13\(^{th}\) April 2017 to return headline reports to the regional team.

3 Findings

43 IAPT services\(^4\) took part in this scoping exercise:
- 20/23 in Yorkshire & Humber
- 10/13 in Cumbria & North East
- 9/9 in Cheshire & Merseyside
- 4/4 in Lancashire & South Cumbria

3.1 Access

The adult IAPT access waiting standards are:
- 75% of people referred to IAPT services should start treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral
- IAPT services should be providing timely access to treatment for at least 15% of those who could benefit (people with anxiety disorders and depression)

\(^3\) Developed by Dr. Tania Stanway, Dr. Gill Strachan, Debra Wilson, Julia Charnock, Beth Luxmoore.
\(^4\) Not including Greater Manchester
NICE Clinical Guideline 192 (2014) states: “When a woman with a known or suspected mental health problem is referred during pregnancy or the postnatal period, assessment for treatment should be within two weeks of referral and psychological interventions provided within one month of initial assessment.”

NICE Antenatal and Postnatal Mental Health (QS115) Quality Standard 6 (2016) states: “Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.”

Analysis highlighted that there was variance between services with regards to waiting times for both assessment and treatment however almost all services reported that they do, or are working towards, prioritising women in the perinatal period which generally shortens the waiting times stated.

<table>
<thead>
<tr>
<th>Clinical Network geography</th>
<th>Current waiting time for assessment of women in the perinatal period within IAPT services</th>
<th>Current waiting time for treatment of women in the perinatal period within IAPT services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>Ranged from no wait to 6 weeks; compared to no wait to eighteen weeks for other patient groups</td>
<td></td>
</tr>
<tr>
<td>Cumbria &amp; North East</td>
<td>Ranges from under 3 days to 2 – 3 weeks.</td>
<td>• Step 2⁵ ranges from immediate to 34 days (7 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Step 3⁶ ranges from 17 days to 6 months</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td>The variance in waiting times for assessment and treatment for women in the perinatal period ranged from 2-3 days to 18 weeks.</td>
<td></td>
</tr>
<tr>
<td>Lancashire &amp; South Cumbria</td>
<td>Less than 2 weeks from referral for all IAPT services users, not specifically PNMH; 1 provider reporting less than seven days</td>
<td>Varied from 4 weeks up to a maximum of 32 weeks in one area for all IAPT services users, not specifically PNMH</td>
</tr>
</tbody>
</table>

Most responders did not know, or have available, the average waiting time for referrals into the community mental health team (CMHT) and specialist Perinatal Community Service team, or admissions to Mother and Baby Units ‘MBU’ and adult psychiatric unit for women in the perinatal period. Reasons for this include specialist referrals being managed by a central single point of access within secondary mental health services and it was therefore rare they would have direct contact with these services. One provider stated that if a bed in the regional MBU was unavailable it may take up to 24 hours to find a bed in another unit.

The referral process into IAPT services is very broad and does not refer to PNMH needs. Additionally, the public-facing information for patients (website and leaflets) is very generic with no promotion of PNMH needs or services. Some providers only accept referrals from GPs. One of the smaller providers reported

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⁵ Initial support i.e. guided self-help or groups
⁶ CBT, counselling, Individual Psychotherapy Treatment (IPT)
strong links with the local Midwifery-led team for PNMH and accepted referrals from this team as well as self-referrals. Self-referral into IAPT is promoted nationally to encourage service users to take responsibility for their own health.

Information relating to waiting times for women in the perinatal period is not collected separately by IAPT services and Perinatal status is not recorded on the national IAPT reporting system IAPTUS, therefore many were unable to present dates as a part of the return. If Perinatal status is not reported it is not possible to demonstrate waiting times or outcomes for women in the perinatal period. **Perinatal status is not always recorded as part of the initial triage conversation** but instead discussed by the practitioner at the first assessment appointment. There is no aide memoire in place to prompt this and will therefore depend on the individual therapist’s level of awareness around PNMH to ensure this is recorded to facilitate the fast track to treatment. Not only will this effect treatment and outcomes, but could result in admission to a mental health unit rather than MBU, separating mother and baby.

In some areas, **fast tracking occurs when referred into the service by PNMH midwives however this may mean that women who self-refer are not prioritised in the same way or do not have their Perinatal status recognised immediately.** In addition, although fast tracking for women in the perinatal period takes place, not all services have protocols in place for this.

### 3.2 Referrals & Pathways

Respondents were asked for details of referral protocols and pathways into various services dependent on severity of need – this varied in each patch with some providers not aware of specialist perinatal services that were available to them.

Women with **mild to moderate mental health** needs were offered appropriate treatments based on the IAPT stepped care model which could be delivered at Step 2 or 3, referring to their nearest community mental health team for step up or further assessment. A small number of providers offered additional PNMH specific support services. There is some evidence that IAPT services in Cheshire & Merseyside have made an incorrect assumption that the introduction of specialist community mental health services will meet the demand for PNMH support at Steps 2 and 3.

IAPT providers confirmed they refer PNMH patients to secondary care mental health services if they identify an increased risk or need for **specialist support** outside the remit of IAPT services. However many IAPT providers did not have a protocol or robust referral policy and pathway from or into specialist mental health services for women with a known or suspected mental health problem and where this was in place, it was rare this was PNMH specific. An example of where processes were in place existed due to an established PNMH team provided jointly by a mental health trust and women’s hospital. At present there is no specialist community PNMH service or MBU in Lancashire or South Cumbria.

NICE Clinical Guideline 192 indicates that all women in the perinatal period with a history of or suspected to have a severe mental health illness should be referred to a secondary mental health service for a **comprehensive mental health assessment**
and treatment. The guideline also highlights that in some PNMH conditions like post-partum psychosis the onset of symptoms can be sudden and rapid necessitating immediate referral (within 4 hours) preferably to a specialist PNMH service. Most providers had protocols in place to trigger a referral however the destination of the referral could be a GP or lead provider before reaching a specialist PNMH team. IAPT providers advised they do not refer directly to general adult inpatient psychiatric units or MBUs but would instead refer to either, secondary mental health service, crisis teams or community teams.

Mental health screening tools are in use by IAPT providers, GPs, midwives, health visitors and other health professionals however no one tool is used consistently across all disciplines which does not promote integrated working or a coherent approach to assessment and communication. NICE guideline 192 advocates the use of GAD, EPNDS or PHQ9.

Some areas could improve identifying a named link within mental health provider organisations and partner teams they refer to.

Areas of practice which could be shared include:
- North West Coast clinical network agreed pathway for PNMH in accordance with NICE QS115.
- Talk Liverpool referral process and pathway.
- Yorkshire & Humber and Cumbria & North East confirmed several respondents had referral pathways and protocols to trigger referral for moderate and severe mental health needs.
- Northern clinical network PNMH pathway guidance.

### 3.3 Treatment Completion / Recovery / Outcomes

NICE QS115 Quality Standard 6 advocates that “Commissioners (clinical commissioning groups) commission psychological interventions and specify that assessment of women referred for psychological interventions in pregnancy or the postnatal period should take place within 2 weeks of referral and treatment should start within 6 weeks of referral.”

The IAPT recovery standard is “at least 50% of people who complete treatment should recover”.

The survey showed that data to measure outcomes and recovery is collected through the following means however none of these focus specifically on women in the perinatal period or allow data to be broken down to show this particular cohort of patients:
- IAPT minimum dataset - PHQ9 and GAD tools are used to demonstrate improvement
- Patient Experience Questionnaires (however qualitative information not routinely reported on)
- IAPT routine outcome measures

Despite this, if Perinatal status is not recorded routinely in the initial referral the common denominator will not be in place to demonstrate recovery rates.
Feedback from service respondents to improve this, include:

- Outlining PNMH in commissioning contracts to support robust reporting of data and outcomes.
- One Provider is developing a PNMH specific questionnaire.
- Use current outcome measures but ensure perinatal patients can be easily identified.
- Clinical Outcomes in Routine Evaluation ‘CORE’ which is routinely used by psychology services.
- Collecting more information via – Whooley questions, Edinburgh Postnatal Score, Friends and Family Test, Choice Questionnaires, Client Feedback.
- Adding pregnancy related questions to medical tools i.e. does this symptom relate to your depression or your pregnancy.
- PCMIS Evidence Based Case Management Information System to flag PNMH so data can be captured and reported.

### 3.4 Workforce Training

RCPsych CR197 (Perinatal mental health service. Recommendations for the provision of services for childbearing women) states that:

Good perinatal mental health services should include an education and training programme, which should be provided for non-specialists involved in the care of pregnant and postpartum women including general psychiatric teams, GPs, midwives, health visitors and psychological treatment services such as IAPT to ensure:

- the early identification of those at high risk
- early diagnosis
- an understanding of the maternity context
- the identification of additional clinical features and risk factors associated with perinatal disorders
- that the developmental needs of infants are met.

Audit responses showed variation in training provision and opportunities. There are pockets across the region where Providers access in-house or external training, these included masterclasses, awareness training, topic as part of a rolling programme, university PNMH modules and Institute of Health Visiting (IHV) PNMH champion training. However PNMH training is not standardised across the region. According to the Department of Health (2013) IAPT – Perinatal Positive Practice Guide there is growing evidence that treating maternal or paternal mental health problems can reduce the future incidence of mental health problems in children.

Funding was provided to clinical networks in Q4 2016/17 to enable regional and local workforce development and training plans to be developed and implemented. This included clinical networks commissioning training on behalf of their patch and in some cases providing funding directly to mental health trusts specifically to train IAPT workers in PNMH; therefore we can expect an improvement in this area during 2017/18. However it should be recognised that funding was provided late in 2016/17 financial year and teams faced significant challenges in
procuring training providers at such a late stage in the year. All clinical networks either have a training plan/strategy in place or are working towards this.

### 3.5 Local Perinatal Strategies

22/43 providers highlighted they had an overarching pathway and strategy for PNMH; although in some areas this was not reflected in the information provided about practice. Some PNMH services were able to describe clear pathways, clinical leadership and referral processes for the IAPT service to access however identifying PNMH clinical and managerial leadership within IAPT services themselves at an operational level proved difficult. Gaps were also highlighted in Executive Leads to champion PNMH at Board level.

Variation was noted in the strength of the relationships with, and awareness of, specialist PNMH services, MBU, adult mental health services and community MH teams. Those demonstrating strong links and collaboration were in the minority.

### 3.6 Information and support services

NICE Guideline 192 advocates a proactive approach indicating that women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

In general, most providers advised that pre-conception information is not provided within IAPT. Women seeking this information were likely to be referred to their GP, CMHT or specialist PNMH team. Pre-conception advice would be provided by mental health professionals to women with a known mental health need prior to pregnancy. Women seen by IAPT in the perinatal period would be pregnant or have already given birth. Therefore IAPT services should have a pathway into a pre-conception advice service for those women who may go on to have another pregnancy. Any additional pre-conception advice or information the IAPT service could offer to a woman who is already pregnant or has had a child should be consistent with that provided by a pre-conception service.

Discussing emotional wellbeing was seen as integral to most IAPT services and part of their core function, also highlighting the role of universal services in this regard, such as Midwifery and Health Visiting.

In one clinical network patch, it was found that the smaller providers offered more in-house specific PNMH information and support services, whereas the larger providers offered a generic IAPT ‘menu of service’.

It was noted that public-facing information for patients on Mind Matter IAPT website and leaflets is very generic with no promotion of PNMH needs or services.

### 3.7 Service facilities

The IAPT Perinatal Positive Practice Guide indicates that IAPT services will have to take a flexible approach when providing effective psychological therapies for individuals (or families) with perinatal mental health problems. For example, some
mothers and/or fathers may need to bring their baby to the appointment, to have longer sessions so they can change or feed their baby, a choice of appointment times/intervention or home visits⁷.

**Family friendly facilities are very dependent on where the services are delivered** and are often at the directive of the organisation providing those facilities. The audit responses also showed varying interpretations of what ‘family friendly’ means.

Whilst making allowances for the differing interpretation, ‘family friendly’ provision remained inconsistent across the region with only a small number of services developing or delivering initiatives to achieve this. Issues highlighted include low use of on-site crèches making them unsustainable and concerns that children’s centres are at risk due to local authority changes.

Where services were able to provide family friendly facilities this was often due to sharing accommodation with GP practices and Primary Care Health Centres who work to the Department of Health ‘You’re Welcome’ Standards (sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people).

### 3.8 Good practice / Impact of work to date

#### 3.8.1 Lancashire & South Cumbria

- In Blackpool, the Lottery Funded Mums and Babies in Mind initiative has led to IAPT professionals working closely with Health Visitors, Specialist PNMH Midwives and Adult Mental Health services as part of an integrated perinatal and infant mental health team. This team of dedicated professionals has enabled women to access a wide suite of joined up services specifically tailored to the needs of families in the perinatal period.
- Lancashire Women’s Centres are providing family friendly service hours and appointments that are more likely to meet the needs of young families.
- Across Lancashire Care’s Minds Matters service, a plan is in place to train key IAPT staff to act as Perinatal Mental Health champions. This will help to raise awareness of the needs of women in the perinatal period across the service.
- There is good engagement from IAPT services with the work of the North West Coast Clinical Network.

#### 3.8.2 Cheshire & Merseyside

- The Provision of weekly CPD sessions by a Senior Clinical Psychologist to all IAPT staff within Halton & Knowsley IAPT services.
- The use of an overarching strategy and pathway for primary care PNMH across Cheshire.
- Clear protocols and pathways for triggering a referral to specialist PNMH provision in Liverpool.

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⁷ Also suggested by NICE CG123 - Common mental health problems: identification and pathways to care
- IAPT staff acting as PNMH ‘Champions’ at both Steps 2 and 3 within St Helen’s IAPT Service.
- Specific PNMH training provided to all IAPT staff working in Warrington IAPT Service.
- Regular triage meetings held between IAPT services and secondary care services which allow for discussion regarding specialist assessment within Access Sefton.
- The provision of PNMH clinics within the Liverpool Women’s Hospital.

3.8.3 Yorkshire & Humber

- Consistent approach to completing IAPT minimum data set.
- Good engagement with IAPT Providers’ Network, within the Mental Health Clinical Network for Yorkshire and the Humber, with a culture of sharing best practice.
- Clear pathways within IAPT of service provision and when to refer to secondary Mental Health.
- Many services are aiming to prioritise perinatal women. All perinatal women are assessed within six weeks of referral.
- A broad range of IAPT therapies are offered in Yorkshire and the Humber.

3.8.4 Northern

- The Perinatal Mental Health Clinical Network was established in 2016 which is looking at ways of working with, developing and supporting IAPT services.
- IAPT providers continue to have a good link with the IAPT Clinical Network.
- Commissioners and Clinical Networks are building on the PNMH engagement process that has already begun with IAPT providers.
- IAPT providers are more aware of the gaps in their knowledge and skills in respect of PNMH and have begun to address this.
- The majority of IAPT providers have protocols in place to identify and fast track women in the PNMH stage to assessment and treatment.
- The pathways within IAPT services for referral on to more intensive services is clear, with protocols to identify who and when patients should access secondary services.

3.9 Key issues / challenges

3.9.1 Lancashire & South Cumbria

- Consistent recording of perinatal status for all (mothers and fathers. Research indicates that mental health issues may arrive for fathers in the perinatal period also).
- A lack of accredited, quality assured PNMH training for IAPT professionals.
- Raising awareness of PNMH issues and developing the IAPT workforce.
- IAPT data returns and reported outcomes are not specific to PNMH, resulting in an inability to differentiate access standards and outcomes for women in the perinatal period.
- Inclusion of PNMH indicators in contracting arrangements.
- Development of PNMH pathway for IAPT services.
- Poor family-friendly provision which may impact on the ability for women in the perinatal period to access IAPT services.
- A paucity of clearly identified clinical leadership or agreed pathways for specialist support for women in the perinatal period within IAPT services.
- Developing better communication between health professionals across the whole PNMH pathway i.e. shared communication between midwifery and IAPT where women have self-referred to IAPT.
- Consistent use of the same screening tools across all disciplines (PHQ9 and GAD7).

3.9.2 Cheshire & Merseyside
- A lack of accredited, quality assured PNMH training for IAPT professionals.
- IAPT data returns and reported outcomes are not specific to PNMH, resulting in an inability to differentiate access standards and outcomes for women in the perinatal period.
- Poor family-friendly provision which may impact on the ability for women in the perinatal period to access IAPT services.
- A paucity of clearly identified clinical leadership or agreed pathways for specialist support for women in the perinatal period within IAPT services.
- The potential for the wider health and social care economy to incorrectly believe that the creation of specialist community PNMH team negates the need to provide PNMH IAPT services.
- The potential for the wider health and social care economy to incorrectly believe that the ad-hoc piecemeal provision of limited PNMH services (Liverpool Women’s Hospital for example) negates the need for further PNMH provision.

3.9.3 Yorkshire & Humber
- Variation in waiting times for both assessment and treatment.
- Identification of those women who are in the perinatal period.
- Variation in accessing and the provision of workforce training in Perinatal Mental Health.
- Variation in levels of management and leadership for Perinatal Mental Health within IAPT services.
- Lack of pre-conceptual care.

3.9.4 Northern
- While there are pockets of good practice, no CCG in the North East and Cumbria meets all of the good practice recommendations for PNMH across the whole pathway of care.
- Practitioners are not always aware of PNMH services available in their area and no providers were able to identify a named link within their mental health provider or MBU.
- The standard of services across the region is very variable.
- Services for fathers and wider family members are a rarity.
- Training and development of staff in PNMH is ad hoc across the region within IAPT, specialist and universal services.
- A regional strategy to improve outcomes for mothers, fathers and families in the perinatal period, based on the recommendations in this report, is required. Any actions agreed by the Perinatal Mental Health Clinical Network that involve or impact on IAPT services will need to be fed into the IAPT Clinical Network.
3.10 Opportunities for Improvement

3.10.1 Leadership, Strategy and Integration

- Expand or further develop existing clinical networks – both IAPT forums/IAPT provider networks and PNMH networks to raise awareness of findings, promote perinatal clinical and executive management leadership within IAPT services and PNMH clinical champions, encourage development of PNMH strategies (where not already developed) and consider delivery of joint initiatives.
- Facilitate enhanced relationships and dialogue between IAPT services, specialist PNMH services, midwifery and health visiting teams.
- Ensure use of the same screening tool across the whole PNMH pathway and all disciplines i.e. PHQ9 & GAD7 as advocated by NICE.

3.10.2 Service mapping

- Further service mapping of access and referral pathways into IAPT to gain a deeper understanding of IAPT service models and links with primary care.
- Further service mapping of the wider PNMH system and pathways to gain a broader understanding of the issues.

3.10.3 Service facilities, information and support services

- Development of an agreed definition of what makes a ‘family friendly’ service including examples.
- Support the development of IAPT services to then meet the ‘family friendly’ definition.
- Consistent pre-conception care available for women with mental health needs and/or previous perinatal mental health needs across the pathway (led by the mental health pre-conception service and offered to IAPT services to distribute).
- Support development of referral pathways into mental health pre-conception services from IAPT services.

3.10.4 Sharing good practice and Engagement

- Sharing good practice identified through this baseline across clinical network areas and nationally.
- Inclusion of IAPT elements within PNMH local conferences and vice versa.
- Engagement events or development of PNMH IAPT user groups with women and their families to evaluate their experience and inform service development.

3.10.5 Access, Referrals and Pathways

- Encourage and support the development and clear understanding of PNMH pathways, protocols and service specifications where they are not in place. The North West Coast clinical network PNMH pathway (maternity pathway highlighting the referral points into IAPT or MH services, it does not detail the pathway for women receiving treatment from IAPT or mental health services) and Northern clinical network PNMH pathway guidance could be shared as examples.
- A universal IAPT referral process, to ensure that all IAPT services can accept referrals from all health professionals (i.e. including Midwives, Obstetricians,
Health Visitors, etc. who are likely to come into contact with women in the perinatal period) as well as self-referrals could help to reduce delays in women accessing services and support those women who may struggle to self-refer.

- Implement procedures for identification and recording of Perinatal status of service users at the time of referral.
- Include Perinatal status as part of assessment documentation.
- Agreement of a single screening tool to be used between different health professionals / disciplines and service providers.
- Ensure IAPT providers are aware of the purpose of the MBU as part of PNMH pathway development for IAPT services supporting IAPT practitioners to access the right support for a woman with an escalating mental health need.

3.10.6 Data and outcomes

- Perinatal status recorded for all IAPT service users.
- Consistent recording of Perinatal status for all (mothers and fathers).
- Develop existing outcomes for perinatal patients – see section 4.3.
- Develop data mechanisms within the IAPT minimum dataset to identify women referred to IAPT in the perinatal period and allow reporting of outcomes for both mothers and fathers.
- Include Perinatal status as a mandatory field on IAPT booking systems.
- Outline PNMH and associated data requirements in commissioning contracts to support robust reporting of data and outcomes.

3.10.7 Training and Workforce

- Utilise HEE PNMH competency framework to inform training needs for IAPT staff around PNMH.
- Adoption of ‘PNMH champion’ roles in IAPT services.
- Work in partnership with Universities to develop accredited PNMH training for IAPT professionals.
- Raise awareness and improve training amongst all IAPT staff around PNMH including the need for rapid referral in some instances of PNMH deterioration, and early identification and support.
- Policy for efficient referrals into IAPT services from any health professional or self-referral to improve channels of communication between services.
- Development of communication and joint training between IAPT with midwives or health visitors.

4 Recommendations for next steps

The below is dependent on clinical network funding arrangements in 2017/18 and local planning / alignment to STPs which may impact ways of working and capacity in future.

- Liaison with central Perinatal and IAPT teams to determine how to progress consistent areas of need best tackled at a national level and understand if issues are reflected in other regions.
• Regional review of this report by Perinatal and IAPT leads to determine how to progress common areas of need best tackled at a regional level and include actions in the regional programme plan.
• Individual clinical network baseline findings shared with existing PNMH and IAPT fora within local governance structures to determine how to progress geography-specific areas of need and include in local business plans.
• Clinical networks and PNMH clinical leads support STPs to understand local data to support future decision making of PNMH services.
• Reconvening of North clinical networks following the above to ensure consistent understanding of next steps.
• Share report with Nursing team and Maternity PMO for information.

5 Appendix I – Scoping tool
Only accessible with permissions to regional Mental Health SharePoint site

6 Appendix II – Survey Responders

<table>
<thead>
<tr>
<th>IAPT Service Provider</th>
<th>IAPT Service</th>
<th>Health Economy</th>
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<tbody>
<tr>
<td>Lancashire Care NHS Foundation Trust</td>
<td>Mind Matters</td>
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### 7 References

- **North East and Cumbria Perinatal Mental Health Scoping Report 2017**
  
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- **North West Coast Clinical Network: IAPT for Women in the Perinatal period – Baseline Findings. Report for Lancashire & South Cumbria March 2017**
  
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<th>Recommendations for the provision of services for childbearing women</th>
<th><a href="http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr197.aspx">http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr197.aspx</a></th>
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