GUIDANCE DOCUMENT: Health Visiting Programme: Pathway to support professional practice and deliver new service offer
Maternal mental health pathway 3.

Examples of Anticipated Outcomes

Public Health Community – Outcomes:

Examples of anticipated outcomes and ways of measuring outcomes to assess variation in service configuration, delivery and resourcing. Such issues require local collaboration.

1. Commissioning – A joint approach to commissioning services which span this issue

2. Universal implementation of the HCP 0-5, i.e. a progressive, stepped approach with specific short term outcome focused interventions.

3. Evidence of training and development of staff in relation to maternal mental health and infant mental health and a good understanding of how to work with other agencies to deliver most appropriate services.

4. All mothers will be seen by a health visitor for mental health screening assessments at set times.

5. All children will be reviewed at set times.

6. Data collection on HCP KPIs e.g. ASQ, GAD 7 POH, HAD. Evaluation of effectiveness of staff training, i.e. evidence of implementation of knowledge and skills and did it make a difference.

Why do we need a pathway?

The pathway sets out the benefits and principles for health visitors, midwives, specialist mental health services and GPs working together in pregnancy and the first postnatal year, as the basis for the detailed, local pathway to meet the physical, mental and wellbeing needs of parents, babies and families.

The pathway provides a structured approach to addressing the common issues associated with the journey mothers experience in relation to their emotional and mental wellbeing from midwifery to health visiting services. The pathway is not policy, but guidance for staff that builds on good practice as identified by professional consensus, the Healthy Child Programme, NICE Guidance, the Frank Field report and provide a systematic solution-focused approach on which to base local practice.

Rationale

The overarching rationale for the pathway is to strengthen consistent, seamless support and care and to recognise that enhanced partnership working will support the delivery of the Healthy Child Programme and achieve quality outcomes for children and parents. Underpinning this is:

• Anecdotal evidence from the children’s workforce indicates that there is no single profession or organisation involved in ensuring best outcomes for children and families in relation to the wide spectrum of maternal mental health - this reinforces the need to have joined-up services and strong multi agency working.

• Recognition of the specialist public health role needed for health visitors and midwives in their assessment of maternal mental health in order to promote skills for parenting. These professional require knowledgeable leaders in promoting mental health & wellbeing during pregnancy and the postnatal period.

• There is now a better understanding of the importance of pregnancy and infancy on a baby’s neural development, thus laying the blueprint for a baby’s future health. Early maternal mental health support and intervention by health visitors and their colleagues can not only make a difference to the families but also to the wider community.

Opportunities Setting out an agreed framework can help identify where there are new opportunities.

Quality

• Increased equality and quality of service for all outcomes.

• Improved clinical indicators and measures of effectiveness and risk management.

• Explicit and well-defined operating standards for care provided.

• Improved service user/client satisfaction

• Improved use of shared documentation.

• Improved use of digital-based care and use of clinical guidelines.

• Baseline for future initiatives building on what works and good practice examples.

• Improved use of specialist skills and clinical judgement, building on right person, right place, right time.

• Ensure all midwives and health visitors are appropriately trained in relation to assessing mental health.

Innovation

• Implementation of the stepped approach to care delivery outlined in the HV Implementation Plan.

• Improved outcomes through “Any Qualified Provider”, increased opportunities to focus on enhanced provision for mothers, babies and families with complex needs.

• Improved training opportunities for different clinical disciplines and sectors.

• Improved multidisciplinary communication, teamwork and care planning.

• Clear measures for clinical effectiveness.

Productivity

• All pregnant women receive co-ordinated and continuous care across different clinical disciplines and sectors.

• Improved workforce engagement and productivity.

• Clear measures for clinical effectiveness.

Prevention

• Jointly delivered public health outcomes through implementation of the Healthy Child Programme 0-5.

• Improved seamless services which would address the full public health agenda, i.e., obesity, smoking cessation, maternal health, substance misuse.

• Improved parenting skills and family resilience, with relapse prevention and mental health wellbeing woven into service delivery.

Addressing the Challenges

There are challenges that cannot be addressed solely by a high-level pathway, including local variation in service configuration, delivery and resourcing. Such issues require local collaboration in the form of a clinical perinatal network which includes service leads, commissioners and health and social care practitioners to adopt the partnership pathway principles. The pathway can be adapted to meet the needs of local women, babies and families taking account of local health priorities, health needs and resource deployment. The use of a pathway will support delivery and contribute to addressing key themes including:

1. Workforce issues – training opportunities. Addressed through identification of joint training opportunities for health development i.e. Healthy Child Programme e-learning Programme, case analysis. LSCB multi agency, Safeguarding, training greater visibility of health visiting as a career.

2. Commissioning – A joint approach to commissioning services which span this issue and offers improved outcomes across the board. Addressed through the identification of clear service specification, standards and outcome measures and the JSNA and HSB Strategy.

3. Potential service fragmentation during pregnancy and 0-5 years - lack of specific leadership role and service definition. Addressed through clear identification and coordination of the contribution of all service providers throughout the pathway and transition timeline.

4. Utilising growing evidence base. Addressed through the identification and implementation of supporting policy and evidence and the development of clear protocols and guidelines.

5. Communication systems – fragmented within health and partner organisations. Addressed through sharing of learning and best practice, enhanced records, seamless sign posting between professions and clear referral routes. Standardisation of procedures for handover of records from midwifery to health visitor services and other service providers. This must include how to consistently transfer information.

6. Partnership working – variation in quality of maternal mental health services across England. Addressed through enhanced partnership working, formalised liaison, joint training, joint delivery of the Pregnancy, Birth and Beyond programme, HCP 0-5 and implementation of NICE antenatal and postnatal mental health guidelines through regular meetings and improved service specification.

7. Inadequate training – addressed through ensuring specific training is available on post natal depression for all health visitors.

8. Barriers to women disclosing their feelings – addressed by training for staff in respect of communication style, non-judgemental approach and training on working effectively with others.
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Suggested collaborative timeline for Midwifery and Health Visiting Services*

*It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline e.g. the information needs and emotional experiences of first time parents differ to those of experienced parents (for further information follow this link)

*GPs are very important partners throughout this timeline when a mother’s mental health is compromised

### ANTENATAL

<table>
<thead>
<tr>
<th>When</th>
<th>Booking in (8-12 weeks)</th>
<th>16-28 weeks</th>
<th>32-36 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who*</td>
<td>Midwife (MW)</td>
<td>Health Visitor (HV)</td>
<td>MW</td>
</tr>
<tr>
<td>Where</td>
<td>Home, Health Centre, Children’s Centre (CC), GP Surgery - (dependant on family need and local provision)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Action Proposals you may wish to consider developing | Midwifery team to notify health visiting team of pregnancy (admin task). Notification to include assessment of maternal mental health using three WHO questions and clinical judgement, including needs of father and referrals to other agencies and action plan; this should be a particular consideration for women and fathers with complex social factors (NICE 110). 12 weeks health needs assessment. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps. A supplementary mental health assessment may also be used e.g. HADS, EPDS and other risk assessment tools. Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period. Child safeguarding concerns to be shared with Children’s Social Care. | Health visiting or Family Nurse Partnership team to inform midwife of named health visiting team for every woman. NB: Where there is an identified mental health issue, it is recommended that an individual health visitor and midwife is allocated to the woman. Importance of Adult services working closely with Children’s services which must be informed of potential child safeguarding concerns, GPs to be involved in all cases where there is a past history of mental health issues and mental health team if mother known to them. (GP should be consulted to provide necessary background if the mother has an identified issue.) Children’s social care (CSC) should also be involved. | Ongoing review of action plan and the midwife to communicate any change in the pregnancy status and/or changes in risk to the family or child to the named health visitor/family nurse partnership team and CSC. Health promotion review. Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period. | Possible further health needs assessment, including the fathers needs and vulnerability factors e.g. relationship with partner, Where there is an identified mental health issue the midwife should work collaboratively with the Health Visitor, Family Nurse, GP, specialist mental health services, CSC and the woman and her family to assess need and ensure informed choices are made regarding future planning and medication management. (NICE 110). All women not receiving family nurse partnership to receive contact from the health visiting service and offered mental health promotion advice and information. A review /repeat of the 3 WHO questions to be carried out by the health visitor. A clear, objective indicator of level or severity of mental distress is essential to inform clinicians of next steps. A supplementary mental health assessment may also be used e.g. HADS, EPDS. Women with an identified vulnerability (e.g. maternal mental health, learning disability, feto-developmental issue, obstetric issue, domestic violence etc.) or need to have received an ‘individualised postnatal care plan’ prepared in conjunction with midwife and health visitor (NICE 37). Ask the NICE recommended prediction questions. These are felt to be most beneficial at identifying women at risk of Serious Mental Illness in the postal period. Importance of Adult services working closely with Children’s services which must be informed of potential child safeguarding concerns. |

### HCP Key Messages and Actions

- Promoting positive mental health and wellbeing of mother.
- Promoting Healthy Start for all women.
- Preparing families for parenthood.
- Promoting breastfeeding and the support available.
- Promoting the importance of the involvement of the father.
- Promoting the neurological development of child, the negative impact of stress and the importance of attachment.
- The Healthy Child Programme promotes good liaison between MW and HV to benefit early intervention.
- Promoting positive mother and father relationships.

- Promoting positive mental health and wellbeing of mother.
- Providing information re local Children’s Centre services and consent to contact.
- Providing smoking cessation support.
- Promoting breastfeeding and the support available.
- Providing information re screening/immunisations, child development, maternal nutrition e.g. folic acid and other dietary or lifestyle advice as required.
- Preparing families for parenthood.
- Promoting the importance of the involvement of father.

- Promoting positive mental health and wellbeing of mother.
- Preparing families for parenthood.
- Promoting the importance of parent and baby mental health/attachment.
- Providing safe infant feeding information.
- Promoting breastfeeding and the support available.
- Signposting parents to Parent Education.
- Promoting the importance of the involvement of the father.
- Delivering the Pregnancy, Birth and Beyond programme in partnership.
| Your Community | Targeted to meet the identified needs of the community, Your Community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwives work together to develop and promote community based support for expectant and new parents such as preparation for parenthood groups and activities that meet the needs of local families. |
| Universal Services | Universal Services are for all families. Health visitors deliver the Healthy Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services/resources. |
| Universal Plus | Targeted according to assessed or expressed need, universal plus gives a rapid response from the HV team when families need specific expert help, for example, all women identified with a mild to moderate mental health issue to be offered a range of support, e.g. wellbeing advice, short term guided self help such as solution focused approaches, motivational interviewing, CBT and medication and baby massage. |
| Universal Partnership Plus | Targeted according to identified need, Universal Partnership Plus provides ongoing support from the team or family nurse partnership plus a range of local services working together with families to deal with more complex issues over a period of time. These include services from Sure Start Children’s Centres, the third sector, specialist mental health services, GP, housing, welfare and social care. |

Key messages from partners

- Assessment is not in itself an outcome, nor is it necessarily reliable. Its success depends on the honesty of, and trust felt by, the informant and this depends on non-judgemental attitudes, empathy, and good continuity of care on the part of the care provider. New mothers need a champion, not a judge. They need the opportunity to develop a relationship with their HV. Ideally, all women should always see the same Health Visitor and information about post-natal depression should be widely disseminated.

- Health visitors are crucial lynch pins of care given to women at risk of or experiencing post natal depression, but need new structures that provide much better continuity of care, and specialised training in post natal depression which must also be child-centred.

- Mothers and their health visitors need to know the alternative forms of support open to them, from assessment to recovery from postnatal depression.

- Where barriers exist to effective working, these issues need highlighting and addressing to ensure successful partnerships.
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**Maternal mental health pathway 3.**

**Suggested collaborative timeline for Midwifery and Health Visiting Services**

*It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline e.g. the information needs and emotional experiences of first time parents are likely to differ to those of experienced parents (for further information follow this link)*

*GPs are very important partners throughout this timeline when a mother’s mental health is compromised.*

<table>
<thead>
<tr>
<th>Postnatal</th>
<th>Please note that NICE guidelines relate to subsections of the work described only.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td><strong>Birth visit to 10-14 days</strong></td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>Midwife (MW)</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Obstetric/Midwifery unit/Home/CC</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>MW to update the HV on the health and emotional and social status of both mother and baby. Ask NICE recommended predication questions (only ask again if answers ‘no’ at midwife booking appointment) - evidence from audits say women disclose more with repeated asking. Prompt referral to Perinatal Psychiatry Services (puerperal psychosis). Adult services to work with children’s services in the event of child safeguarding concerns.</td>
</tr>
<tr>
<td><strong>HCP Key Messages and Actions</strong></td>
<td>• Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Supporting the importance of parent and baby mental health/attachment. • Providing information on smoking cessation, development and growth. • Promoting attuned, sensitive parenting that supports baby’s early development. • Promoting importance of father and wider family (involvement.)</td>
</tr>
<tr>
<td>Your Community</td>
<td>Targeted to meet the identified needs of the community. Your Community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwives work together to develop and promote community based support for expectant and new parents such as preparation for parenthood groups and activities that meet the needs of local families.</td>
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<td>Targeted according to identified need, Universal Partnership Plus provides ongoing support from the team plus a range of local services working together with families to deal with more complex issues over a period of time. The health visiting team to contribute to a care package led by specialist mental health services, this might include services from Sure Start Children’s Centres, the third sector, GP, housing, welfare and social care.</td>
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</tbody>
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High-level core principles
- Health and wellbeing of mother, baby and family.
- Baby and parent-centred approach to care and support.
- Fathers/partners to be fully included.
- Sensitive to needs of different communities e.g. those who have English as a second language.
- Partnership working within the changing health and social care agenda and recognising core values of the family service.
- Pregnancy and infancy are critical to setting out a child’s life trajectory for physical and emotional health, learning and development.
- Local service provision taken into account in designing a collaborative shared pathway to identify the optimum points for partnership working.

Key principles and components
Figure 1 illustrates the key issues and core principles that professionals need to address to provide a seamless transition and readiness for parenthood.

Achieving a seamless journey for the mother and child
Essential service components;
- Working in partnership;
- Respecting diversity;
- Practising ethically;
- Challenging inequality;
- Promoting recovery;
- Identifying mothers needs and strengths;
- Providing FAMILY centred care;
- Making a difference; and,
- Promoting safety and positive risk taking.

Partnership working
Partnership working between health visitors and all other professionals involved will ensure that the antenatal and postnatal maternal mental health care is coordinated, systematic and documented, thus ensuring children and families received coordinated, consistent and seamless care.

Proposed objectives for delivery
- Develop a local perinatal mental health network to ensure coordination and cooperation of stakeholder planning of service delivery.
- Develop joint caseload review meetings organised to underpin continuous flow of information about vulnerable families throughout pregnancy.
- Offer joint clinics/preparation for being a parent sessions for parents to build relationships with health visitor; breastfeeding support, relationship building and health promotion/social and emotional assessment.
- Share evaluation/use of the Common and shared assessment processes, such as, the Common Assessment Framework (CAF).
- Pool resources and engagement in joint commissioning.
- Offer joint home visits between health visitor and other involved health professionals for families with complex needs.
- Enhance joint working by joint training and sharing of information to improve outcomes for families.

Communication and information
Good communication is essential throughout the whole of the pathway. It is essential that mothers and other family members are offered the appropriate information at the right time and pace for them; this is in itself a challenge. The development of a strengthened pathway provides an opportunity to evaluate outcomes that measure quality and undertake audits using information about the impact for users/clients rather than the impact of processes.

Proposed suggestions for improved communications:
- Share learning and best practice.
- Improve use of technology and systems to ease access to records and assist recording.
- Develop a seamless approach to signposting and messaging about the roles and services from midwifery to health visiting.
- Standardise procedures for handover of records from midwifery services to health visiting services.
- Build on learning from mobile working pilot and roll out good practice.
- Standardise computer systems to ease access to records and assist recording.
- Ensure awareness of cultural sensitivities to mental health and the use of appropriately trained interpreters and materials e.g. How are you feeling? Booklets.
- Use educational tools e.g. literature, DVDs, groups etc.

Role definition
Throughout the timeline the expectations of mothers and families will need to be managed. It is therefore important to understand the role of the health visitor and all other health professionals involved to ensure that families seeks expert advice from the appropriately trained professional.

Proposed suggestions for delivery
- Clarify the roles and responsibilities of health visiting, midwifery and adult mental health service teams in the delivery of maternal mental health care and their responsibilities towards child safeguarding.
- Provide clear information for parents, families and other health and social care professionals and partners.
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Supporting Policy

- The Healthy Child Programme (2009), is the preventive programme for all children and includes schedules for screening, immunisation and assessment. The HCP supports health, and learning and development outcomes for children, and recognises that some will need higher levels of input to reach their potential. The HCP is led by health visitors and commences in pregnancy.
- The Health Visitor Implementation Plan: A Call to Action (2011), sets out the revitalised universal offer of health visiting support for all children and their parents and challenges midwives and health visitors to articulate and recognise their different professional perspectives and collaborative contributions to ensure quality outcomes for children and parents.
- The Supporting Families in the Foundation Years (2011), document underlined and emphasised the importance of the foundations years, (from pregnancy to age five) and the value of offering parents support, advice, and information antenatally and after birth.
- Midwifery 2020: Delivering Expectations (2010), set the direction for midwifery and outlined that timely communication is crucial to the success of such partnership working.
- Maternity and Early Years: Making a good start to Family Life (2010), sets out the Governments ambition for better integrated care in response to feedback from families that they would like ‘stronger continuity of care after birth’.
- Good partnership working is seen as one of the key elements in responding to the recommendations of the Allen (2011), Munro (2010), Tickell (2011) and Field (2010) reviews.
- Public Health White Paper Update and Way Forward (2011), Professionals such as health visitors and midwives will have a role in helping to develop local approaches to public health, by providing links between public health and the NHS and displaying leadership in promoting good health and addressing inequalities.
- Supporting Families in the Foundation Years (2011).
- Parents’ views on the maternity journey and early parenthood (2011), this can be used in conjunction with the suggested timeline for advice as to how to deliver the messages to ensure a family and baby-centred approach.
- NHS Future Forum
- Frank Fields review, The Foundation Years; preventing poor children becoming poor adults (2010).

Acknowledgements

This pathway has been developed in partnership with a range of stakeholders across the NHS and other organisations. Thanks are extended to all contributors, specifically the following: MIND, the Department for Education and the Royal College of GPs.

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Members all have extensive experience in working in inter-professional partnerships and were nominated by their professional bodies; the Royal College of Midwives and Community Practitioner Health Visitors Association/Unite.

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