Barnsley Hospital NHS
NHS Foundation Trust

CHANGING LIVES

PERINATAL MENTAL HEALTH

21/01/26

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Barnsley Hospital Quality in Care

www.barnsleyhospital.nhs.uk

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

- Lessons learned to inform maternity care from the UK and Ireland
- Confidential Enquiries into Maternal Deaths and Morbidity
- Triennal report
- Direct/Indirect/Coincidental
- Early/Late

Background - 2021-23 Report

- 2,004,184 women gave birth
- Total mortality 643
- 257 / 386
- 155 (34%) - Psychiatric causes, 88 from suicide
- 64% received antenatal care
- 2014-2016 - Maternal suicide - third largest
- 2021-2023 - most common cause

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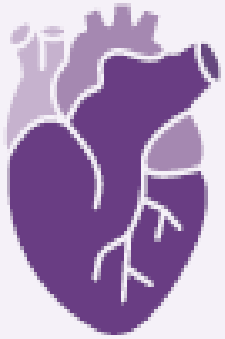
Leading causes of maternal deaths

1

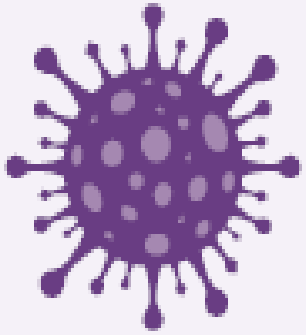
Blood clots

2



Heart disease*

3



COVID-19*

4

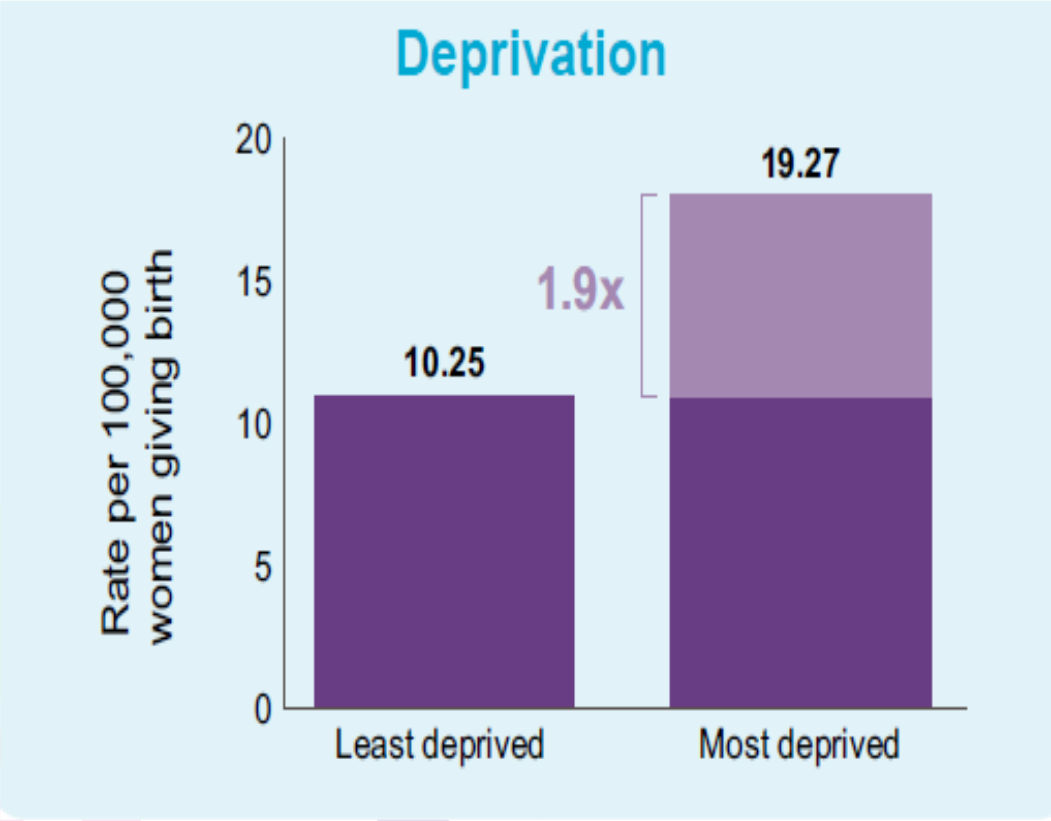
Mental health conditions

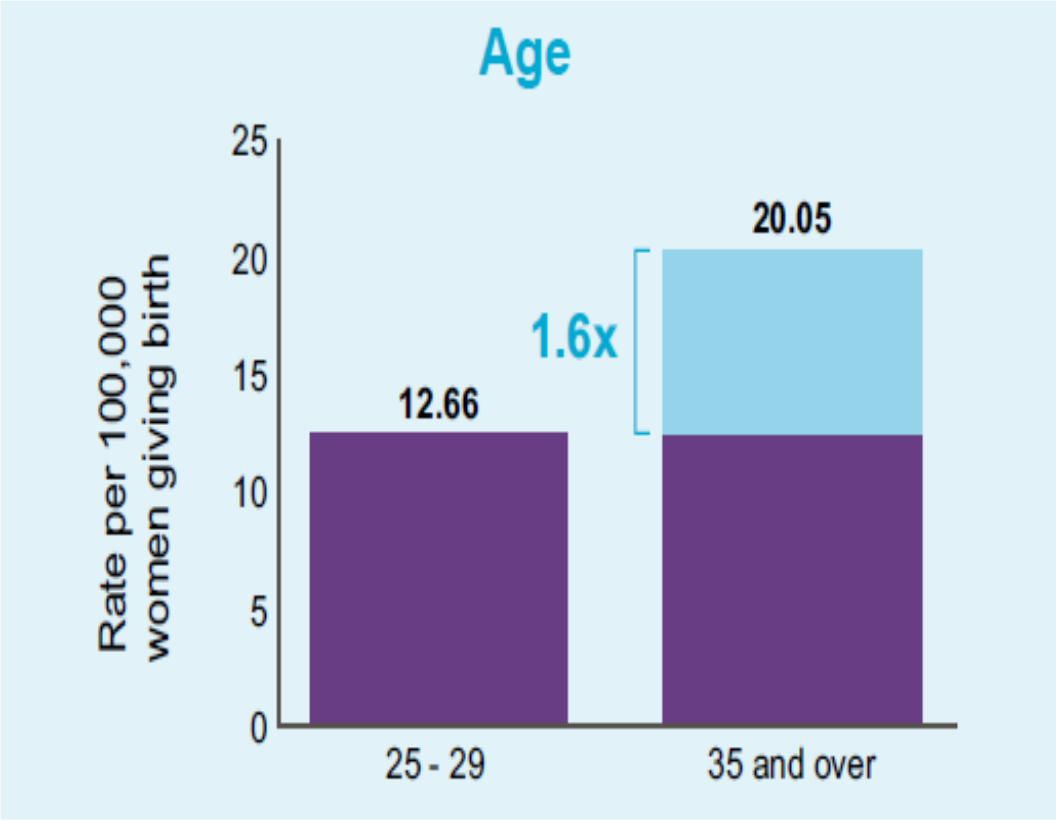
5

Epilepsy and stroke

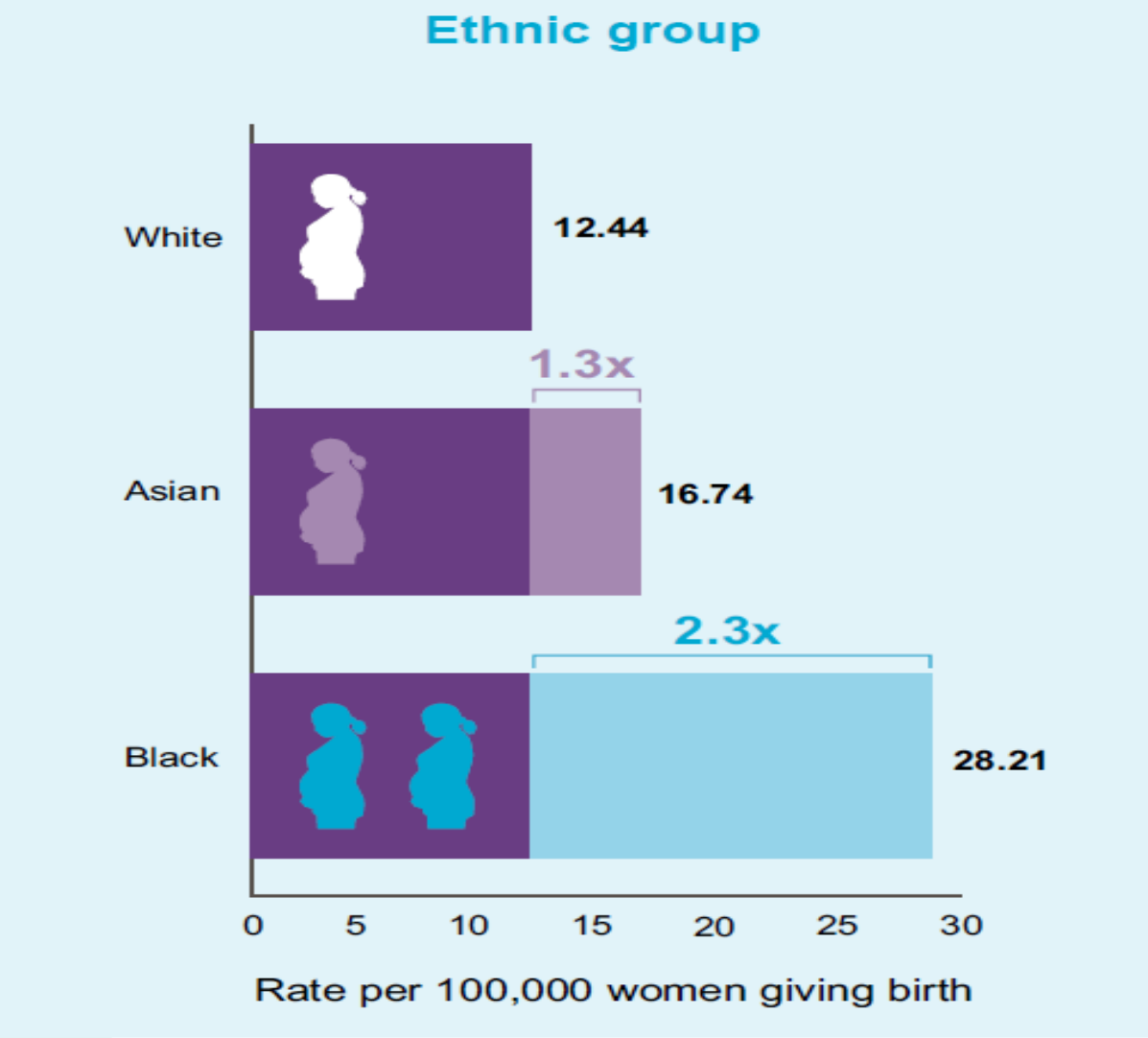
*Responsible for the same number of maternal deaths in 2021-23

Inequalities in maternal mortality





Inequalities in maternal mortality



Assessment

- 10% of women experience a mental health problem during pregnancy or postpartum
- Past H/O trauma – childhood or adult
- Evidence they had been asked about a history of mental health problems.

Assessment

- Associated – substance misuse, alcohol, smoking
- Unwilling to disclose
- Reluctant to engage
- Missed appointments in Primary care, maternity, hospital appointments – teams not aware

To note ….

- "Honeymoon Phase" – Pregnancy and early neonatal period
- Loss of a child – miscarriage, termination of pregnancy, stillbirth, neonatal death, removal
- Social services involvement due to previous history
- Relationship breakdown/Domestic abuse

Key messages

from the confidential enquiries 2025

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A constellation of biases

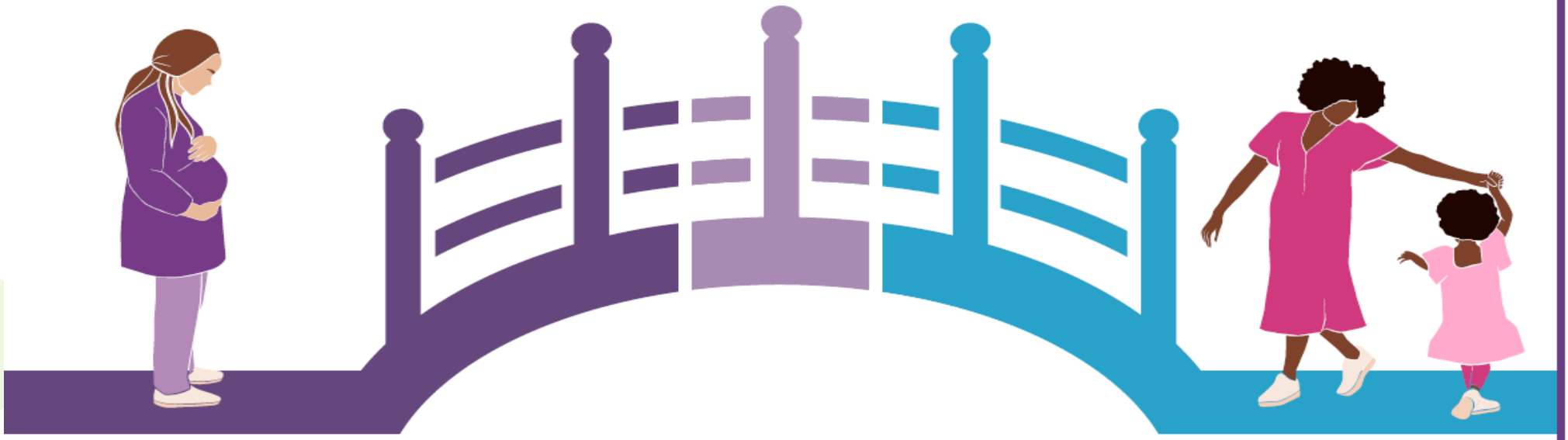
The 2025 MBRRACE-UK report looks at the care of **643 women** who died during or up to one year after pregnancy in the UK and Ireland

Of these women, **583 (91%)** faced multiple interrelated challenges

Key messages
from the report 2025

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Bridging the gaps in maternity care



National recommendations for the care of women with medical and social challenges

Key messages

- Ready for pregnancy – pre-existing health conditions, smoking, weight
- Perinatal Mental Health Team – psychiatric conditions, pregnancy loss
- Individualised care – social service involvement, domestic abuse, deprivation

Bridging the gaps in maternity care

- Urgent referral pathways – triage high risk, Refer in early pregnancy
- Information sharing – domestic abuse, safeguarding
- Discharge summaries – continuity of care plans for Primary Care

And ….

- Continue previous care – service, medication
- At least one consultation – 1 to 1
- Mental health causes attributed to symptoms of cardiovascular disease
- Prescribing – risk of self harm – SSRIs preferred
- Recognise decline – red flags – extremely rapid

Red flags

- Recent significant change in mental state
- Emergence of new symptom
- New thoughts or acts of violent self harm
- New or persistent expressions of incompetency as a mother or estrangement from the infant

A multiparous woman in her 30s had a history of severe depression, anxiety, eating disorder, post-traumatic stress disorder, substance use and previous suicide attempts. She had many complex social risk factors and was known to social services as her older children were under child in need plans. After her booking appointment, a referral was made to perinatal mental health services but it did not sufficiently convey the woman's significant mental health history or other risk factors. This referral was declined when she had a miscarriage. Further referrals to the primary care recovery service for trauma-focussed cognitive behavioural therapy were dependent on her remaining sober and were delayed. She was not under the care of secondary psychiatric services. In the months after her miscarriage she expressed suicidal ideations and feelings of social isolation that were exacerbated after her children were removed from her care. She died by suicide four months after her miscarriage.

Our team

- Consultant Obstetrician and Gynaecologist
- Specialist Midwife
- Crisis team
- Perinatal mental health team
- Staff training
- Information leaflets
- Team working – GP, Perinatal mental health team

Thank You