PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Community Annual Report

Cycle 3

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Foreword

I am delighted to be able to introduce this report on the 3rd cycle of the Community Perinatal Mental Health Team Peer Review.

We have had a small increase in number of participating teams, from 19 to 20, though this reflects the addition of 2 new teams and the loss of one. Again, the standards have been modified a little following feedback from participating teams, and this iterative process will continue to ensure that they remain fit for purpose.

Taken together, it is encouraging to note that, in almost all domains, there has been an improvement in meeting service standards. The report does note however, that the number of partners and family members seen by reviewers was low. Seeking their views is essential to maintaining good services and all of us need to make a particular effort to ensure their views are heard, both in the day to day running of our services, and in feedback to network reviewers.

The coming cycle will bring exciting changes. Following in the footsteps of the MBU network, the Community Team Review will move to an accreditation process. In addition, there are changes afoot across all networks run through the CCQI to ensure greater consistency of standard setting while maintaining the unique characteristics of each specialty.

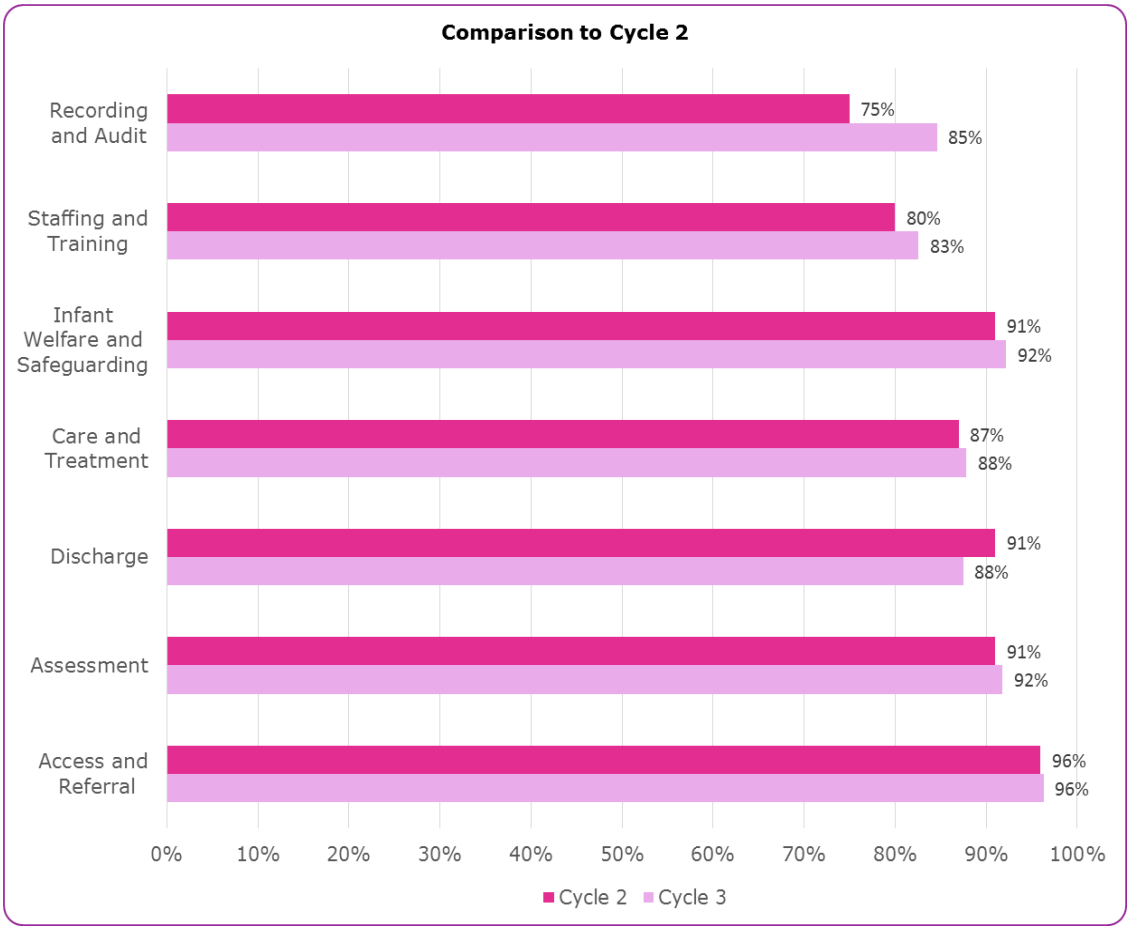
Congratulations to all services involved in the network and thanks to staff at the CCQI Perinatal Quality Network for their incredibly hard work over the past year.

Roch Cantwell
Co-Chair Perinatal Advisory Group

Introduction

This report explores the aggregated results from peer reviews at all 20 specialist perinatal community teams who were members during Cycle 3 of the Quality Network for Perinatal Mental Health Services. These reviews took place between May 2015 and December 2015.

The graph below outlines the overall percentage met for each section of the service standards for all services who took part in Cycle 3, compared with the same data from Cycle 2 (19 services participated in Cycle 2).



All community teams involved in Cycle 3 were NHS providers; 17 were from England, two from Scotland and one from Wales. This cycle there were two new members and 18 members from the second cycle maintained their membership. 11 of the member services are co-located and/or co-managed with an inpatient Mother and Baby Unit.

Accreditation was not available to community teams in Cycle 3 and will be introduced in the forthcoming cycle.

During the peer-review visits, review teams spoke to service staff, professionals from partner agencies, patients and partners/family members in order to gain a broad understanding of the service. During this cycle we spoke to a total of:

- 130 Staff
- 49 Patients
- 17 Partners/family members

The number of patients and partners/family members available for interview was low across most services, averaging only three patients and one partner/family member per service. Consequently for many services the feedback was very limited. When there was only one person to interview; for example if there was only one partner then their comments are excluded or combined with patient comments to protect anonymity. This means that services are unable to identify feedback specific to patients or partners/family member and utilise it to improve aspects of their service. This would be something for services to consider for the next cycle. The more patients and partners/family members that the network are able to contact then the greater feedback services will have.

Standard revision took place in February and a new set of community standards will be published in April 2016 ahead of Cycle 4.

Recommendations

Recommendation 1

Access and Waiting Times

Standard and Data

Access and Waiting times is an area that was also highlighted in the last cycle's recommendations. Since then, and in line with NICE guidelines, two new Type 1 standards were added to the Assessment section of the standards relating to waiting times for assessment and intervention. These were the least met standards in this section, reflecting the challenge services face in this area. Of women referred with a known or suspected mental health problem, only 53% of services were able to assess them for treatment within 2 weeks of referral (2.7.1, Type 1). Of women referred with a known or suspected mental health problem only 63% of services were able to provide psychological interventions within one month of the initial assessment (2.7.2, Type 1).

What does the PQN suggest?

NHS England are currently developing access and waiting times standards for perinatal mental health services and these are anticipated to be published later in 2016. The Quality Network's standards will be updated to reflect the recommendations. It is clear that many services were struggling to meet the standards relating to waiting times. During the review process, it was noted that many services were seeing a majority of referrals within this timeframe and emergency referrals much quicker but that consistently being able to achieve this was the biggest challenge.
Many services reported feeling that there is a discrepancy between the number of referrals they are receiving and the resource capacity of the team to deal with these within the set timeframes. Services should continue to highlight this to managers and commissioners and compare their waiting times with guidance in order to establish where there is need for additional staffing. It would also be helpful for services to review the cases that they are not able to assess or provide intervention for within the waiting time standards. They can then identify any potential patterns or causes that could be addressed, e.g. a lack of allocated psychology time to provide interventions. This information would allow more targeted bids for resources and/or interventions. It is worth noting that positive patient feedback was consistent with timely access.

Recommendation 2

Contraception and Discharge

Standard and Data

Only 65% of services provided contraception advice in their discharge summaries in cycle 3 compared to 79% in cycle 2 (3.2d, Type 2). Several patients reported that they were not given any advice about future pregnancies and contraception when they were discharged.

What does the PQN suggest?

Contraception advice on discharge appears to be an area which a large number of services are struggling to meet. It is important that women are offered professional advice and given information regarding contraception when they are discharged from a service.

Services may find it useful to arrange training for staff from a local contraception clinic. In addition, it would be beneficial to have sexual health leaflets available for women when they are discharged from a service. This leaflet may include advice about contraception and where they can go to seek more information and advice.

Recommendation 3

Perinatal Specific Risk Assessment

Standard and Data

Only 55% of services are meeting the standard 'a risk assessment of mother and infant must be undertaken during the initial assessment process by the service. This should include: a risk assessment tool that is specifically designed and standardised for use by perinatal psychiatric services' (5.7, Type 1). This is an improvement of 8% from cycle 2 but it is still an area which needs to be addressed and significantly improved.

What does the PQN suggest?

Risk assessment was also one of the main issues highlighted in cycle 2's annual report so remains an issue for services.

One option is for services to use an externally developed risk assessment for example, perinatal FACE. However, teams are sometimes restricted financially or have to use trust documents. These services could ensure they are involved in developing trust documents so they are suitable for a perinatal environment. Other services might consider adding a perinatal specific section to the main trust document.

Recommendation 4

Carer Information Packs

Standard and Data

In the Care and Treatment section, only 40% of services provide carers with an information pack on perinatal mental health problems, what they can do to help, their rights as carers and information about local services they can access (4.6, Type 2). This issue is supported by comments from patients and partners/carers stating that staff have not spoken to them about how they can involve their family members in the care of their babies and themselves.

What does the PQN suggest?

Carers report that receiving an information pack can be useful as sometimes it might be difficult to take in all the verbal information given to them regarding their partner and their baby. For services who do not have a current pack or are in the process of updating theirs, it might be useful to involve a group of parents/carers who can suggest what information they would find useful and could write parts of the document.

Recommendation 5

Waiting areas

Standard and Data

Standard 5.14 remains the least met by participating teams. This pertains to a waiting area equipped with age appropriate toys that is exclusively for the use of the perinatal service during the session where a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility (Type 3). Only 28% of services were able to meet this standard in the last cycle and 31% this cycle.

What does the PQN suggest?

The waiting area for liaison or outpatient appointments is quite often a 'generic' public waiting area because the location is shared with other services. Patients frequently report that they would prefer to wait in a perinatal specific waiting area but this is often difficult for services to provide which is reflected in the standard being a Type 3. For services unable to meet the standard, they should look at ways to ensure that the space used is as comfortable for patients and their families as possible, e.g. providing age appropriate toys for siblings.

Recommendation 6

Dedicated multi-disciplinary input

Standard and Data

Within Staffing and Training, the least met standards relate to the posts within the MDT. These are having dedicated sessions from a social worker (6.8d, Type 2, 40% in cycle 3 vs. 42% in cycle 2) nursery nurse (6.8f, Type 2, 35% in cycle 3 vs. 26% in cycle 2) and OT (6.8g, Type 2, 40% in cycle 3 vs. 21% in cycle 2).

What does the PQN suggest?

There can be huge benefit in having a diverse multi-disciplinary team with a broad skillset. Teams that are fortunate to have dedicated sessions from these disciplines benefit hugely from the scope and variety of assessments and interventions that are available to patients.

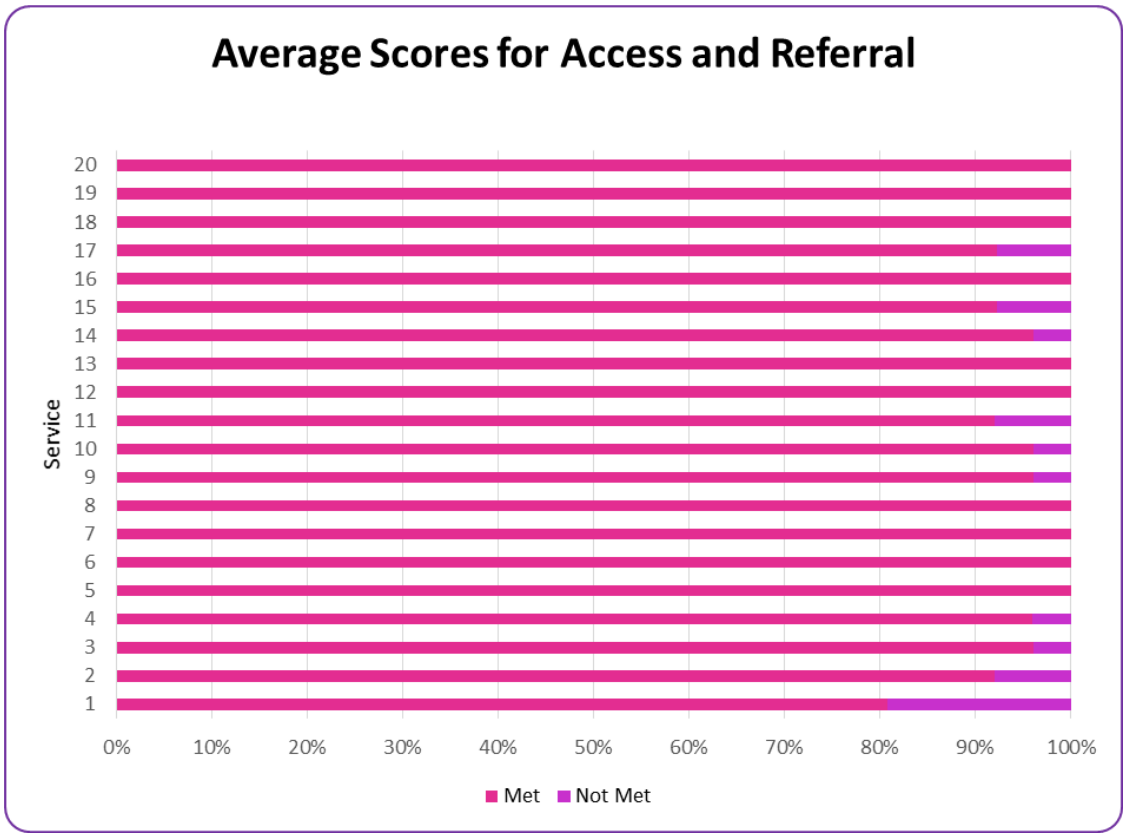
During the course of the reviews, it was reported that many teams were in the process of placing funding bids for these posts which will hopefully result in an improvement in these standards next year.

Teams putting together proposals for new disciplines in their team may find it useful to use the Quality Network. The network can provide opportunities to talk to other services who already have that discipline in place to look at job descriptions, person specifications and find out more about how the role fits into the working of the team. This will be really valuable because, not only will that service be able to give advice on what makes a successful bid, but they will also be able to advise the positive changes they have experienced having been able to have these dedicated sessions.

Access and Referral

Key Findings

- Number of criteria in Access and Referral: 26
- Average percentage of criteria met by services: 96%
- Number of criteria in Access and Referral in Cycle 2: 27
- Average percentage of criteria met by services in Cycle 2: 96%
- Range of percentages met in Access and Referral: 81% - 100%



Areas of Achievement

- 95% of services respond to requests for telephone advice from other professionals within one working day. This is an increase from 89% last cycle (1.11, Type 1).
- A clinical member of the team is available to discuss emergency referrals during working hours in 95% of services (1.12, Type 1). This is also an increase from 89% last cycle.
- 95% of services send a written acknowledgement to patients whose referral is accepted within two working weeks of receipt of referral giving details of proposed actions and details about the service. This is compared to 89% last cycle (1.17, Type 2).
- 95% of services copy the acknowledgement letter to the referrer and the patient's GP (1.18, Type 2).

'What I liked'

From Patients:

"I was given a leaflet and a brief talk about mental health in pregnancy which was very informative"

"I was reassured that mental health problems are common in pregnancy"

"I was given comprehensive information about who to contact if I felt I needed support"

"The service gave me a call before my first appointment and outlined what I should expect"

From Partners/ Family Members:

"I received information about the service when my partner first started treatment"

"Staff provided me with contact details if I felt I needed support"

Areas for Improvement

- The lowest scoring standard in this section was that services who accept referrals through a single point of access receive these referrals within one working day. This was a new standard in Cycle 2 and the percentage of services meeting this standard has risen from 80% to 85% but there is still room for improvement (1.15, Type 2).
- 90% of services have arrangements in place with another service to cover when they are unable to make emergency assessments. This is a drop from 100% in Cycle 2 (1.13, Type 1).
- 90% of services have a procedure agreed with an out of hours team to ensure patients requiring perinatal specialist care are referred the next working day. This is a drop from 100% of services previously meeting this standard in Cycle 2 (1.14, Type 1).

'What could be better'

From Patients:

"GPs and other frontline professionals need more information about the perinatal services available and the referral process"

"I was only given verbal information about the service. It would have been useful to have written information too because it is difficult to take in conversations when you're unwell"

"When I first started treatment with the service I wasn't given information about the service and what it offers"

"I didn't know what to expect at my appointment, it would be good to have some more information beforehand"

From Partners/ Family Members:

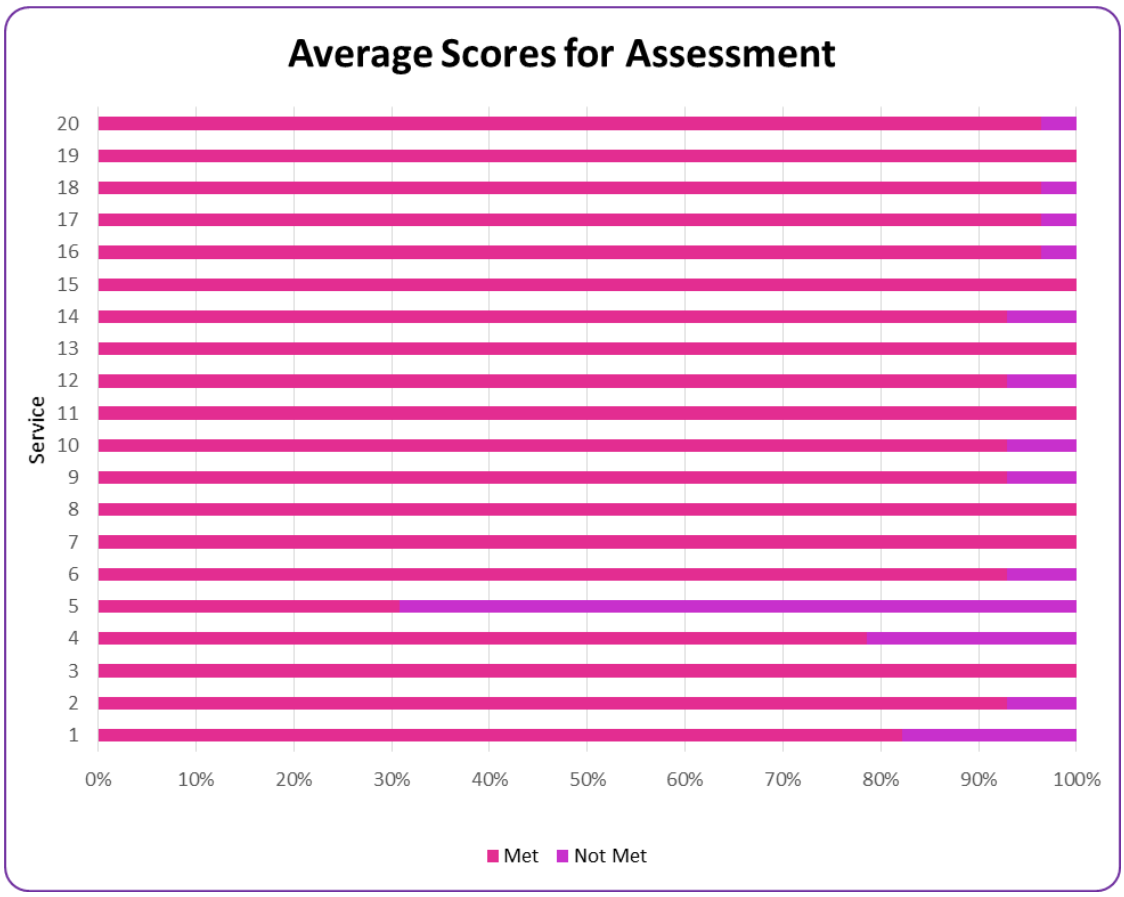
"The information I was given about the service was verbal rather than written"

"I only got information about the service from my partner"

Assessment

Key Findings

- Number of criteria in Assessment: 28
- Average percentage of criteria met by services: 92%
- Number of criteria in Assessment in Cycle 2: 29
- Average percentage of criteria met by services in Cycle 2: 91%
- Range of percentages met in Assessment: 31% - 100%



Areas of Achievement

- 19 of the 20 services offer women a choice of where their assessment takes place (2.3, Type 3).
- Women referred with new onset conditions after 28 weeks pregnancy and within 6 weeks of delivery are discussed with referrers within 5 working days by 85% of services which is an increase from 74% in Cycle 2 (2.5.1, Type 1).
- 95% of services gather information on contraception in the initial assessment which is an increase from 68% in the last cycle (2.11c, Type 1).

'What I liked'

From Patients:

"I like that the assessment took place at my home, it was more convenient and comfortable for me"

"I didn't have to wait very long before my first meeting"

"The team liaised well with other professionals involved in my care"

"I have a care plan and have been involved in developing this to support my independence"

"I have a named mental healthcare professional and I know how to contact them"

"My birth plan has been discussed with me in great detail"

"The team always kept me in the loop as to what was going on"

"The team always get back to me if I call"

From Partners/ Family Members:

"The service saw my partner in good time after she was referred"

"My partner received a care plan and staff asked me for my opinion when developing it"

Areas for Improvement

- Two new standards were added to the Assessment section this cycle relating to waiting times for assessment and intervention. These were the least met standards in this section.
- Of women referred with a known or suspected mental health problem only 53% of services were able to assess them for treatment within 2 weeks of referral (2.7.1, Type 1).
- Of women referred with a known or suspected mental health problem only 63% of services were able to provide psychological interventions within one month of the initial assessment (2.7.2, Type 1).

'What could be better'

From Patients:

"I was not given a choice of where my assessment could take place"

"Communication between the perinatal team and other professionals was not good"

"My care has been talked about but I have no documentation of this or anything written"

"I almost had too much information thrown at me about different services"

"I wasn't given a personalised birth plan"

"I don't know if I have a care plan"

From Partners/ Family Members:

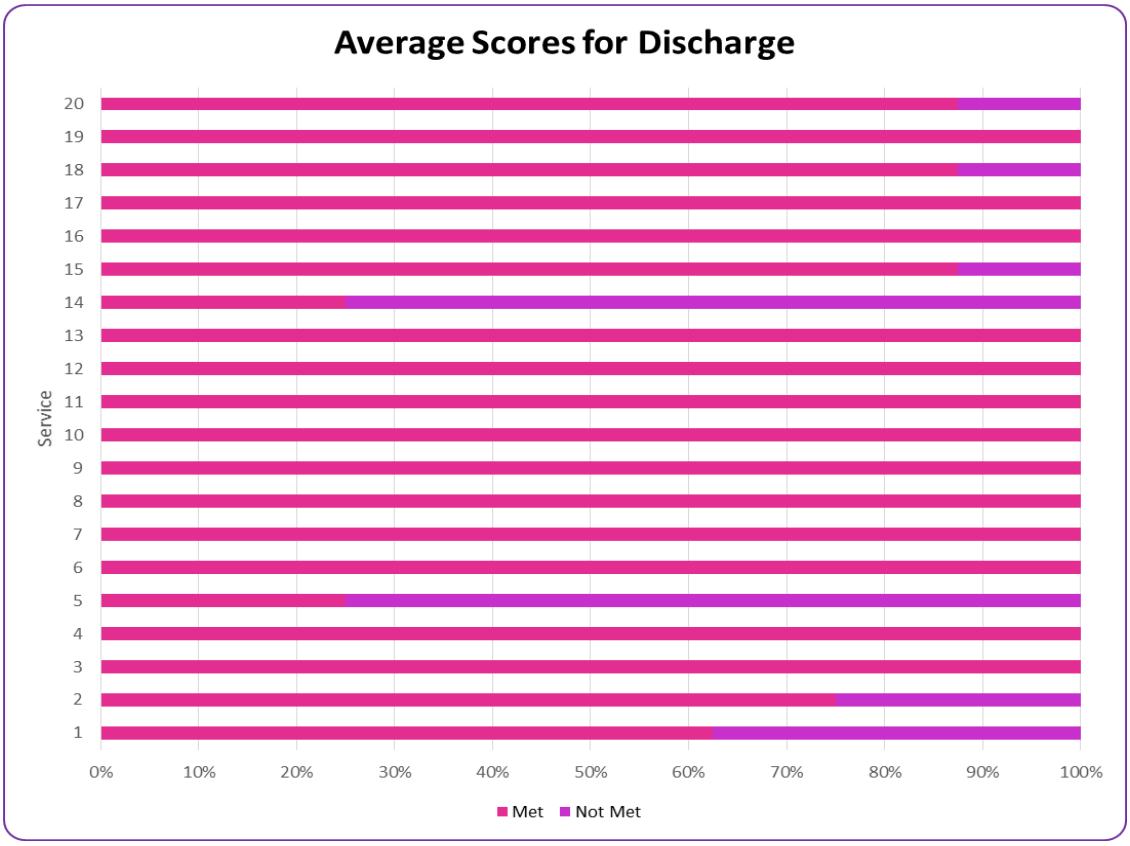
"I don't know if my partner has a care plan"

"The team did not ask for my opinions about a care plan"

Discharge

Key Findings

- Number of criteria in Discharge: 8
- Average percentage of criteria met by services: 88%
- Number of criteria in Discharge in Cycle 2: 8
- Average percentage of criteria met by services in Cycle 2: 91%
- Ranged of percentages met in Discharge: 25-100%



Areas of Achievement

- In all services, women requiring continued psychiatric care are handed over to the appropriate team at the final review (3.1, Type 1).
- All teams refer any safeguarding concerns to children's social services (3.5, Type 1).

'What I liked'

From Patients:

"I think my discharge plan has been well organised and I feel prepared now that my care plan is coming to an end"

"My discharge was gradual and the team waited to see how much I could cope with"

"Upon discharge I was given advice about contraception and future pregnancies"

"The unit provided good signposting around other support I could access if I needed it"

From Partners/ Family Members:

"My partner was given good contacts when she left the service of who she could call for support and advice"

"I feel that my partner's discharge was well planned"

Areas for Improvement

- Several standards relating to discharge summaries have scored lower this cycle.
- Only 65% of services provide contraception advice in their discharge summaries (3.2d, Type 2). This shows a 14% decrease in services meeting this standard in comparison to cycle 2.
- Services including risk assessment (mother and child) in discharge summaries has dropped from 95% to 85% (3.2b, Type 1).
- Services including assessment of the patient's mental state and referencing any concerns for intervention and support in relation to mother-infant care or older children in discharge summaries have both dropped from 95% to 90% (3.2a, Type 1 and 3.2f, Type 2).
- Services including advice regarding further pregnancies (including risk and benefits of medication) in discharge summaries has dropped slightly from 89% to 85% this cycle (3.2c, Type 2).

'What could be better'

From Patients:

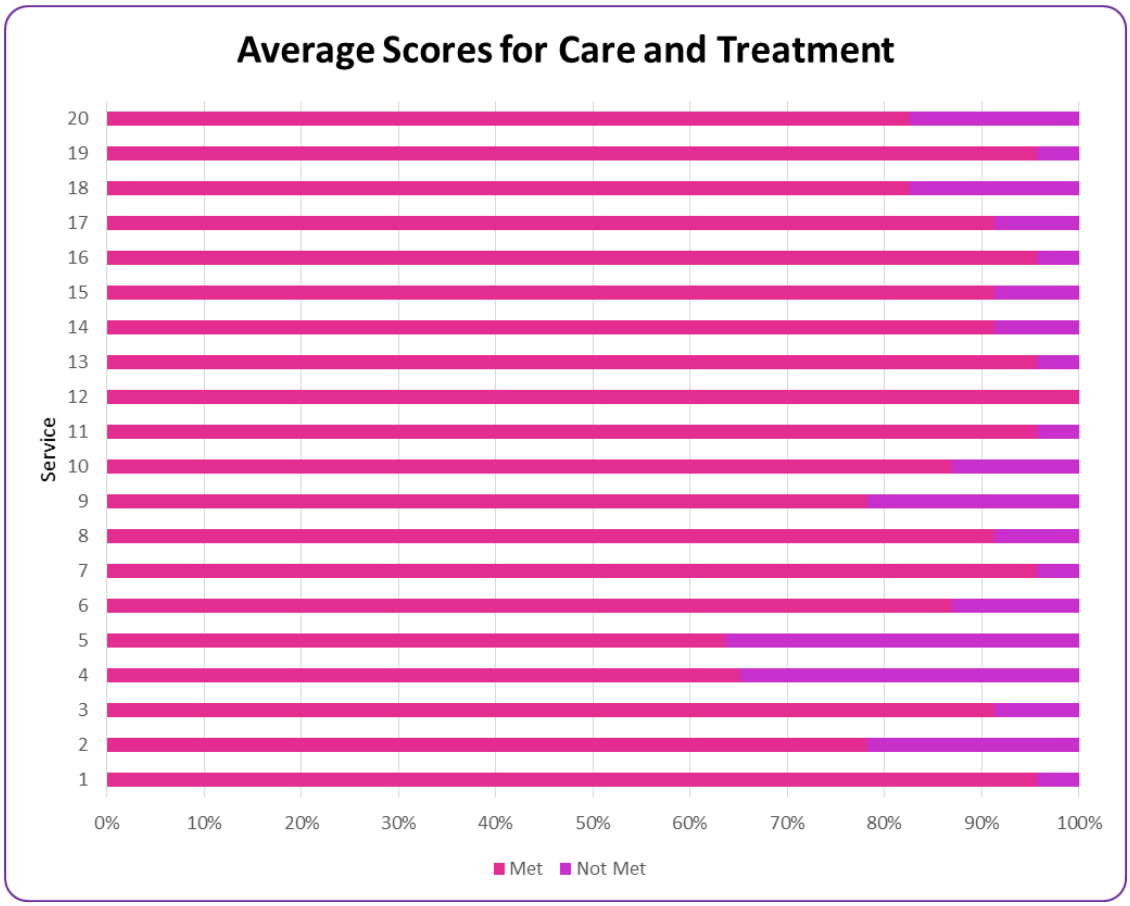
"My discharge felt quite rushed and I went downhill again quite rapidly"

"I wasn't given advice about future pregnancies and contraception when I was discharged"

Care and Treatment

Key Findings

- Number of criteria in Care and Treatment: 23
- Average percentage of criteria met by services: 88%
- Number of criteria in Care and Treatment in Cycle 2: 23
- Average percentage of criteria met by services in Cycle 2: 87%
- Range of percentages met in Care and Treatment: 64%-100%



Areas of Achievement

- All services are able to advise patients, partners and family on early mother-infant care and attachment (4.3a, Type 1).
- 90% of services are advising carers how to obtain a carer's assessment (4.5, Type 2).
- 95% of services have access to psychological interventions which is an increase from 79% in Cycle 2 (4.1b, Type 1).
- 95% of teams inform the local MBUs of all women at risk of potential admission (4.10.1, Type 1) which is an improvement from 83% in the last cycle.

'What I liked'

From Patients:

"I have been able to access a range of therapies, such as an anxiety management course and baby yoga"

"I have done some cognitive therapy and have just finished a mindfulness course which has been great"

"My partner and family have been involved in the treatment and care of my baby and they have been given leaflets around this"

"Staff provided me with written information on perinatal mental health problems and other relevant local services"

"I get a lot of 1:1 support and my named nurse ensured I had a tour of the MBU due to anxiety which I found really helpful"

"I believe the staff go over and above to make sure I am given the best possible care"

"My nurses talked to my husband about what's happening, where he can get support, how he should handle situations and some contact numbers he could call if he needed"

From Partners/ Family Members:

"I was kept very involved in discussions about my partner's care"

"The team advised me about carer's assessment and fought hard for me to get one"

"The partners' group is a really good idea"

"I was given written information about perinatal mental health problems which was helpful and informative"

"Staff advised me about what I could do to support my partner, baby and older child"

Areas for Improvement

- Only half of services were able to provide access to creative therapies (4.1e, Type 3).
- 40% of services provide a carers pack with information on perinatal mental health problems, what they can do to help, their rights as carers and information about local services they can access (4.6, Type 2).
- Only 25% of services in this cycle provide age appropriate information on perinatal mental health to older children (4.8, Type 3).

'What could be better'

From Patients:

"Staff haven't talked to me about how I can involve my partner or family members in the care of myself and my baby"

"I don't have access to group therapy and I would like to be able to discuss my issues within groups"

"There is no access to therapy, just 'talking therapy' with my nurse. I would like more psychology"

From Partners/ Family Members:

"I do feel like there could be something more for partners at the acute end of things"

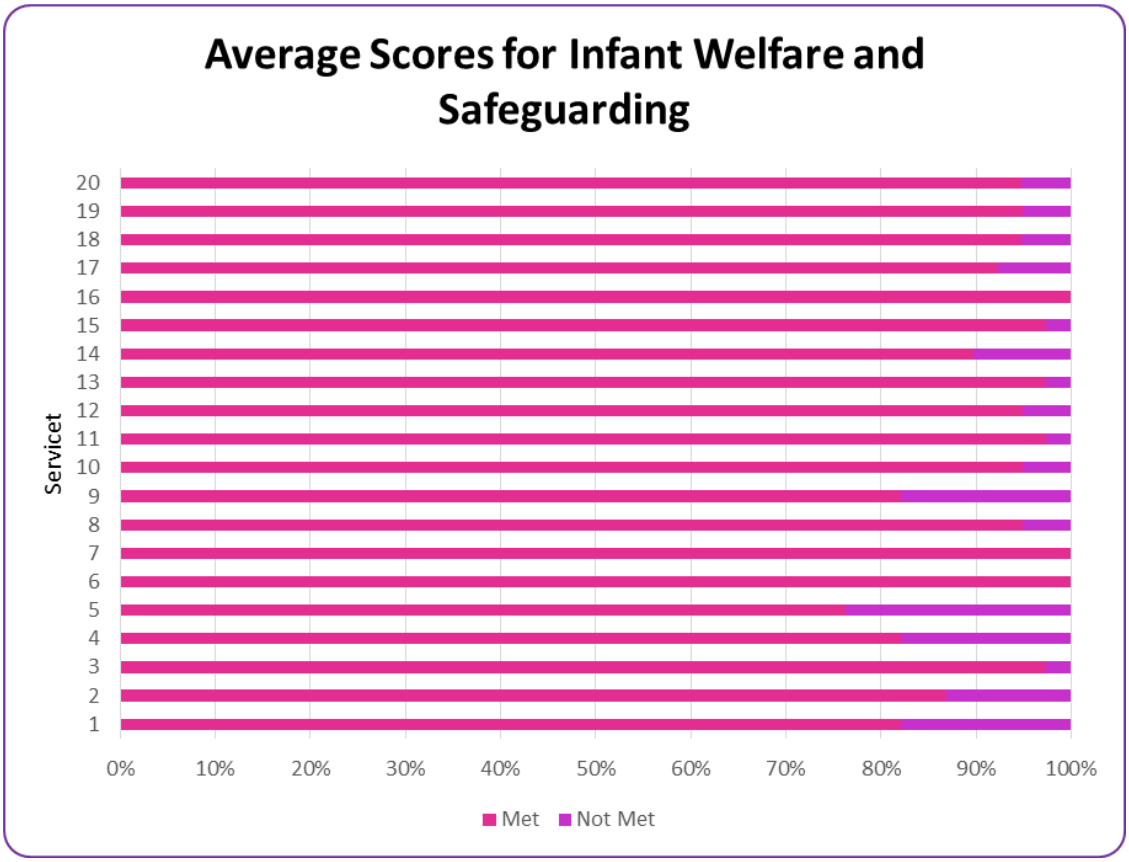
"I haven't had information about a carer's assessment"

"I wasn't given any written information about perinatal mental health"

Infant Welfare and Safeguarding

Key Findings

- Number of criteria in Infant Welfare and Safeguarding: 39
- Average percentage of criteria met by services: 93%
- Number of criteria in Infant Welfare and Safeguarding in Cycle 2: 39
- Average Percentage of criteria met by services in Cycle 2: 91%
- Range of percentages met in Infant Welfare and Safeguarding: 76%-100%



Areas of Achievement

- During the initial assessment process, 95% of services included: Parental responsibility for the infant, all the mother's children and all children in her household. This was a significant improvement from the 74% of services that were meeting this standard in cycle 2 (5.1b, Type 1).
- 100% of services in cycle 3 ensured that the child or unborn child is the subject of a Child Project Plan or Care Proceedings during the assessment in comparison to 95% in cycle 2 (5.1d, Type 1).
- The standard: 'The team should inform the local Social Care Information Management Team if any other child in the family has been subject to a care order or been on the Child Protection Risk Register' has improved from only 74% of services meeting this standard in cycle 2 compared to 89% in cycle 3 (5.22, Type 1).

'What I liked'

From Patients:

"Staff have spoken to me about how I am managing the relationship with my baby when I attended baby yoga as this was a big bonding exercise"

"I feel that staff have encouraged me to be involved in my daughter's care"

"Staff spoke to me about how I was managing the relationship with my baby and they arranged joint meetings with CAMHS"

"Any side effects of medication and breastfeeding were discussed with me as well as my choice of medication"

From Partners/ Family Members:

"I felt very included in my partner and baby's care"

"It's very much been a family process"

"Staff have encouraged me to be involved"

Areas for Improvement

- The lowest scoring standard overall across all areas was 'If a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility, the waiting area is exclusively for the use of the perinatal service during that session and equipped with age appropriate toys'. Only 28% of services met this standard in Cycle 2 and 31% in Cycle 3 (5.14, Type 3).
- The number of services conducting mother-infant assessments every 3 months, or more frequently should the patient's state change, dropped this cycle to 65% compared to 74% in cycle 2 (5.4, Type 2).
- There was an increase in the number of services using a risk assessment tool specifically designed and standardised for use by perinatal psychiatric services. This rose from 47% in Cycle 2 to 55% in Cycle 3. Although this shows an improvement it is still a very low met standard particularly considering that it is a Type 1.

'What could be better'

From Patients:

"There weren't any toys or games for my older child to play with in the waiting room"

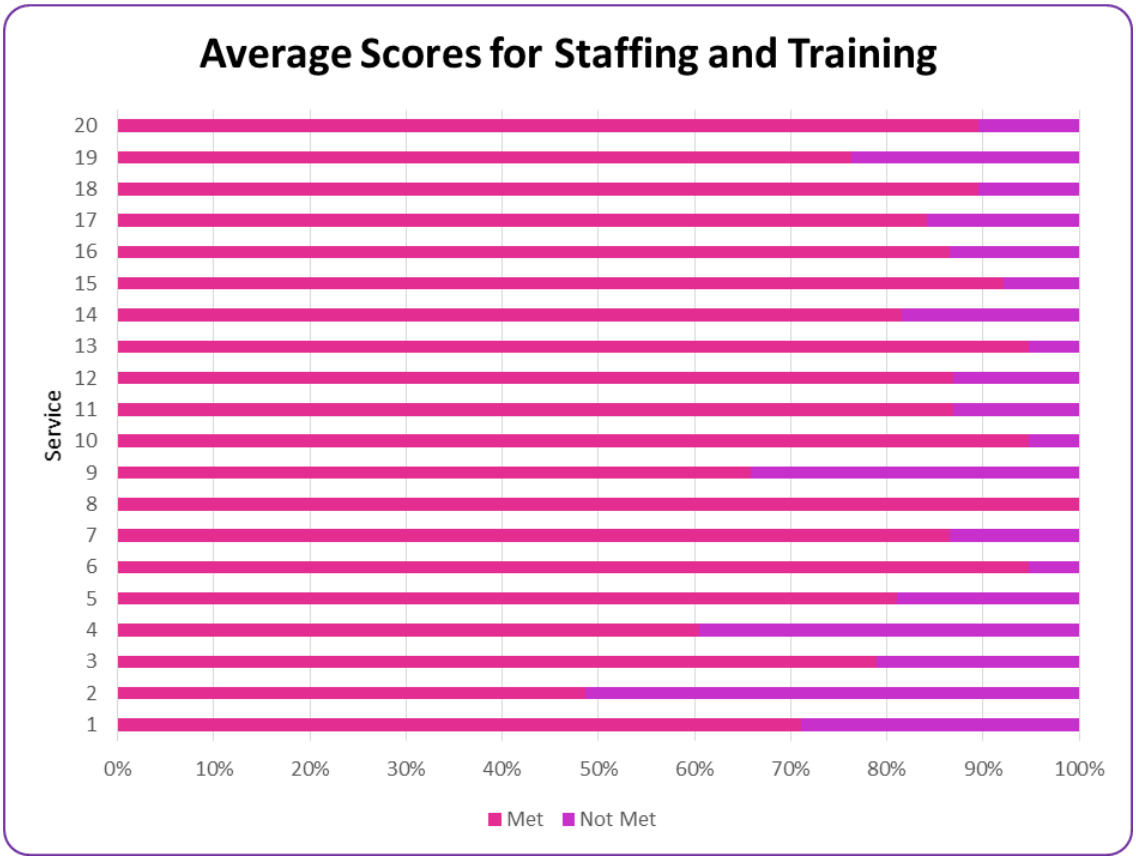
"Staff haven't talked to me about breastfeeding and medication yet"

"Staff did not talk to me about how I am managing the relationship with my baby in the anxiety management group – it was all about me and my anxiety, there were no questions about my baby and motherhood"

Staffing and Training

Key Findings

- Number of criteria in Staffing and Training: 38
- Average percentage of criteria met by services: 83%
- Number of criteria in Staffing and Training in Cycle 2: 37
- Average percentage of criteria met by services in Cycle 2: 80%
- Range of percentages met in Staffing and Training: 49%-100%



Areas of Achievement

- 90% of services are providing staff with training in basic infant development, which is an increase of 16% from Cycle 2 (6.2c, Type 1).
- 80% of services meet the standard for providing training for common physical disorders in pregnancy, compared to 68% in Cycle 2 (6.2j, Type 1).
- In Cycle 3, 85% of staff had been trained in alcohol, smoking and substance misuse in comparison to 68% in Cycle 2 (6.2o, Type 1).

'What I liked'

From Patients:

"I wouldn't be where I am now without them. I feel so much better and know that I can pick up the phone and there is always someone to talk to"

"The staff liaised with the gateway midwives and I was able to keep the same midwife throughout my care which was really important to me. They went above and beyond"

"The staff have been fantastic – they are so supportive"

"I think the staff are fabulous. They picked me up and brought me back to life"

From Partners/ Family Members:

"They all seem well trained"

"The team have been outstanding"

"I think the staff are brilliant. I know it's not always the easiest job but they're absolutely superb. If they weren't I don't think we'd have had another child"

Areas for Improvement

- Only 55% of services have non-consultant medical input compared to 84% in the previous cycle (6.8b, Type 2).
- There was a 10% decline in services having timely access to advice and support from a specialist perinatal psychiatrist during working hours with 90% of services meeting this standard (6.9, Type 1).
- In both Cycle 3 and Cycle 2, there was a low percentage of services who had access to a nursery nurse (35% in Cycle 3 and 26% in Cycle 2) and the services having dedicated OT sessions (40% in Cycle 3 and 21% in Cycle 2). Both of these areas have marginally improved but there is still a lot of room for development (6.8f, Type 2; 6.8g, Type 2).

'What could be better'

From Patients:

"I had a bit of an issue due to the number of different nurses that worked in the service, many of which I saw once and never saw again"

"There was no follow on from post-natal care and I didn't see them again. I wish I had seen them once or twice to manage the transition a bit better"

"There was an issue with appointment letters which were slow in arriving but this seems to be improving"

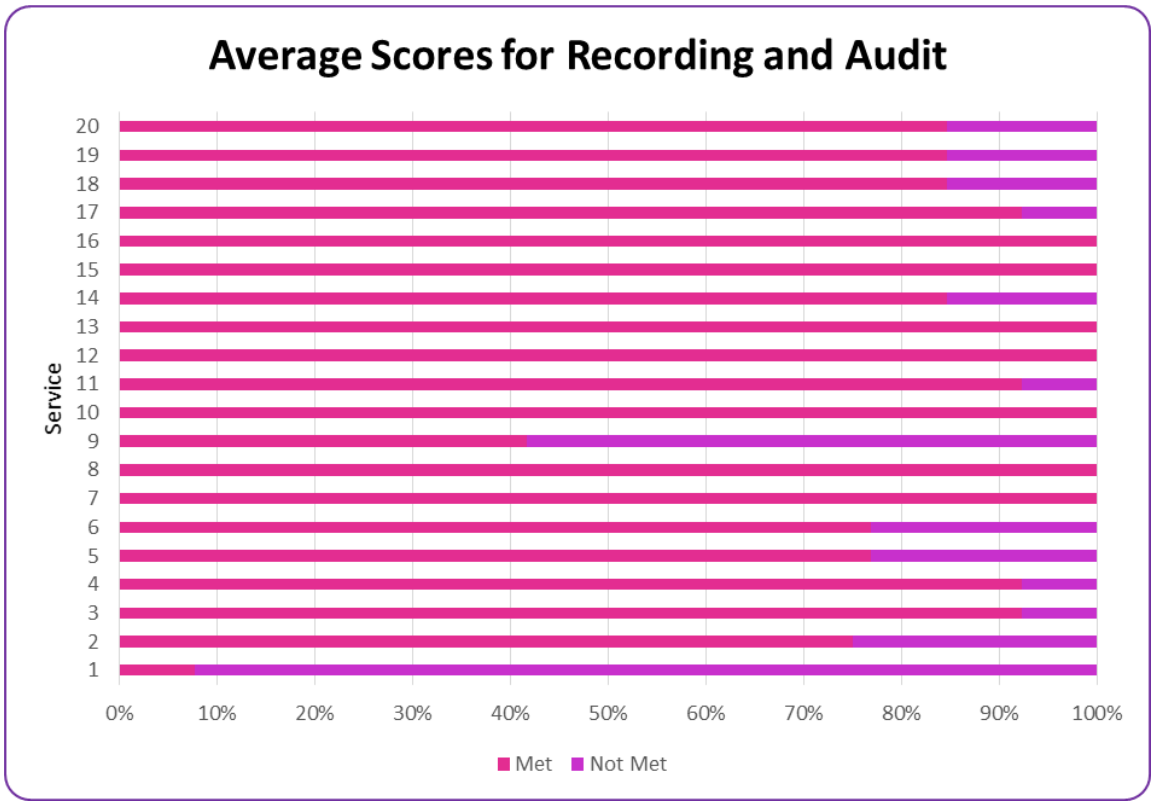
From Partners/ Family Members:

"I don't think there are enough staff of different professional groups"

Recording and Audit

Key Findings

- Number of criteria in Recording and Audit: 13
- Average percentage of criteria met by services: 85%
- Number of criteria in Recording and Audit in Cycle 2: 13
- Average Percentage of criteria met by services in Cycle 2: 75%
- Range of percentages met in Recording and Audit: 8%-100%



Areas of Achievement

- There has been a significant improvement from Cycle 2 (68%) to Cycle 3 (85%) in services annually evaluating feedback from patients and carers (7.1a, Type 2).
- An increase of 39% has been noted of services annually evaluating feedback from referrers with this now being met by 65% of services (7.1b, Type 2).
- Half of services are now evaluating feedback from service staff compared to 37% last cycle (7.1c, Type 2)
- 70% of services in Cycle 3 compared to 58% in Cycle 2 are annually evaluating women involved in care proceedings/child safeguarding protection plans (7.1i, Type 1).

Areas for Improvement

- Although there have been increases in the number of services annually evaluating feedback from patients/carers (up from 68% to 85%) referrers (26% to 65%) and service staff (37% to 50%), there is still room for further improvement (7.1a, b, , c, Type 2)
- Women involved in care proceedings/child safeguarding protection plans is still an area which needs improving with 58% of services meeting this standard in Cycle 2 and 70% in Cycle 3 (7.1i, Type 1).

Appendix 1: Aggregated Results of Reviews

The table below outlines the aggregated scores for the 20 services that received a review in Cycle 3. It highlights the percentage met for each standard. This is compared to the percentage met in Cycle 2.

The criteria are split into three types:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
- **Type 2:** standards that an accredited ward would be expected to meet.
- **Type 3:** standards that an excellent ward should meet or standards that are not the direct responsibility of the service.

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
1		**Access and Referral**		
1.1		*The service provides information (in written and electronic form) for patients and professionals on:*		
1.1a	2	A description of the service	100%	95%
1.1b	1	Clear referral criteria	100%	100%
1.1c	1	Clear clinical pathways describing access and discharge	90%	89%
1.1d	1	How to make a referral	100%	100%
1.1e	1	Contact details, including emergency and out of hours details	100%	95%
1.2		*The service is provided for the following groups in a defined catchment area:*		
1.2a	1	Women following discharge from an inpatient stay	100%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
1.2b	1	Women suffering from bipolar illness / puerperal psychosis, other psychoses and serious affective disorder, who can be safely managed in the community	100%	100%
1.2c	1	Women with other serious non-psychotic conditions	100%	100%
1.2d	1	Women identified in pregnancy who are at risk of a recurrence / relapse of a psychotic or serious / complex non-psychotic condition	100%	100%
1.2e	1	Women requiring pre-conception counselling	95%	100%
1.3	2	The service only works with women who cannot be effectively managed by primary care services	100%	100%
1.4	2	The service only works with women with alcohol/substance misuse problems if there is also (or suspected) moderate to severe mental illness	100%	100%
1.5	1	Patients under age 18 can be referred if perinatal psychiatric disorder dominates the clinical picture	90%	95%
1.6	1	The perinatal service works with the local CAMHS service to provide care to patients under the age of 18	95%	95%
1.7	2	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP is informed.	90%	95%
1.8	2	Referrals from Children's Social Services can only be accepted if they meet the usual clinical criteria	95%	100%
1.9	1	The referral criteria ensure that personality disorder is not a barrier to appropriate service response	100%	100%
1.10	1	Referrals can be made directly to the service during working hours	100%	95%
1.11	1	The service responds to requests for telephone advice from other professionals within one working day	95%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
1.12	1	A clinical member of the team is available to discuss emergency referrals during working hours	95%	89%
1.13	1	When the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this	90%	100%
1.14	1	There is a procedure agreed with out of hours teams to ensure patients requiring perinatal specialist care are referred the next working day	90%	100%
1.15	2	Where services accept referrals through a single point of access, these are passed to the perinatal team within one working day	85%	80%
1.17	2	A written acknowledgement is sent to all patients whose referral is accepted within two working weeks of receipt of the referral, giving details of proposed actions and information about the service	100%	89%
1.18	2	The acknowledgement letter is copied to the referrer and the patient's GP	95%	89%
1.19	1	If a referral is not accepted, the team advise the referrer on alternative options	100%	100%
2		**Assessment**		
2.1	1	Teams assess all women who are suffering from a new episode of serious or complex mental illness (in pregnancy and until 6 months postpartum with follow up to 12 months)	95%	95%
2.2	1	An integrated care pathway including screening questions is agreed with maternity services to detect those at risk of a recurrence of serious mental illness following delivery	95%	100%
2.3	3	Women are offered a choice of where they would like their assessment to take place, taking into consideration clinical need	95%	89%
2.4	1	The service is able to conduct assessments in a variety of settings, which have been appropriately risk assessed	100%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
2.5.1	1	Women referred with new onset conditions after 28 weeks of pregnancy and within 6 weeks of delivery should be discussed with the referrer within 5 working days and appropriate advice given.	85%	74%
2.6	1	Pregnant women referred with a past history of serious affective disorder / psychosis / severe panic disorder / obsessive compulsive disorder, even if currently well, should be offered an assessment to take place in their pregnancy.	95%	100%
2.7.1	1	All women who are referred with a known or suspected mental health problem are assessed for treatment within two weeks of referral	53%	n/a
2.7.2	1	All women who are referred with a known or suspected mental health problem are provided with psychological interventions within 1 month of the initial assessment	63%	n/a
2.8.1	1	Pregnant women receiving mood stabiliser medication should be discussed with the referrer and their usual psychiatrist within 2 working days and appropriate advice given. Guidance: When the Consultant Psychiatrist is not available another appropriate member of the team may have these discussions	85%	84%
2.9	1	Women currently in the care of psychiatric services should be assessed and given advice/ treated in collaboration with their usual psychiatric care team	100%	100%
2.10	1	All women have a comprehensive assessment of their health and social care needs taking into consideration the needs of their children and family	95%	100%
2.11		Practitioners gather additional information reflecting the perinatal context, including:		

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
2.11a	1	Current and past obstetric history	95%	95%
2.11b	1	Mode of infant feeding	95%	95%
2.11c	1	Contraception	95%	68%
2.11d	1	Contact details of relevant professionals	95%	100%
2.12	1	All women have a named mental healthcare professional. They are told how and who to contact if this person is not available and in an emergency	100%	100%
2.13	1	There is a written care plan for every patient, reflecting their individual needs GUIDANCE: Care plans should record any medication advice given well as any psychological / social interventions advised / carried out	95%	100%
2.14	1	Care plans are reviewed at least every 3 months	85%	89%
2.15	1	The care plan is developed collaboratively with the patient	95%	95%
2.16	1	The views of the patient's partner, family and carers is incorporated into the care plan as appropriate	90%	95%
2.17		For women seen in pregnancy, there is a peripartum management plan formulated and recorded in the handheld records by 32 weeks of pregnancy shared with the woman, her family (where appropriate), GP, Midwife, Health Visitor, obstetrician and any other relevant professionals or organisations. This includes:		
2.17a	1	Nature of the risk and condition	95%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
2.17b	1	Details of current medication and any intended changes in late pregnancy and the early postpartum	95%	95%
2.17c	1	Consideration of whether the mother intends to breastfeed	95%	95%
2.17d	1	Those involved and frequency of contact	95%	89%
2.17e	1	Emergency contact details	95%	89%
2.17f	1	Admission to a mother and baby unit if necessary	95%	95%
2.17g	1	Plans for a maternity admission, including notifying the perinatal team once the patient has delivered	95%	95%
2.18	2	Women referred in pregnancy who are at high risk of serious illness are seen by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed	100%	100%
3		**Discharge**		
3.1	1	Women requiring continued psychiatric care are handed over to the appropriate team at the final review	100%	100%
3.2		The discharge summary includes reference to:		
3.2a	1	Assessment of the patient's mental state	90%	95%
3.2b	1	Risk assessment (mother and child)	85%	95%
3.2c	2	Advice regarding further pregnancies (including risk and benefits of medication)	85%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
3.2d	2	Contraception advice	65%	79%
3.2e	1	Mother-infant interaction	85%	84%
3.2f	2	Any remaining concerns / needs for intervention and support in relation to mother-infant care or older children	90%	95%
3.5	1	Any safeguarding concerns are referred to children's social services	100%	95%
4		**Care and Treatment**		
4.1		All teams have access to a range of therapeutic interventions focusing on mother, baby, and family including:		
4.1a	1	Medication	100%	100%
4.1b	1	Psychological interventions Guidance: This includes problem solving, stress management, brief supportive counselling and relapse prevention, CBT, interpersonal psychotherapy	95%	79%
4.1c	2	Mother and baby interventions	95%	95%
4.1d	3	Family and couples interventions	70%	68%
4.1e	3	Creative therapies	50%	47%
4.2	3	Staff promote patients accessing social and recreational activities in their own community	100%	100%
4.3		The clinical members of the team are able to advise (working with other professionals) the patient, partner and family on:		

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
4.3a	1	Early mother-infant care and attachment	100%	95%
4.3b	2	Infant development	100%	100%
4.3c	1	Promoting involvement of partner / family members	100%	100%
4.4	2	Partners and designated family members are involved in decisions about care, where the patient consents	100%	100%
4.5	2	Carers are advised how to obtain a carers' assessment	90%	84%
4.6	2	Carers are given a pack with information on perinatal mental health problems, what they can do to help, their rights as carers and information about local services they can access	40%	32%
4.7	2	The service ensures that older children and other dependents are supported appropriately Guidance: This may be done via other services, e.g. social services, health visitor	95%	89%
4.8	3	Age appropriate perinatal mental health information is available to older children in the patient's family	25%	21%
4.9	1	The team have established relationships with local mother and baby units	95%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
4.10.1	1	The team informs the mother and baby unit of all women at risk of potential admission Guidance: This includes women with a past history of puerperal psychosis / bipolar disorder / serious affective disorder and women with serious illness currently managed in the community	95%	83%
4.10.2	1	The potential for admission is communicated verbally to the woman and her family and recorded in the written care plan and communicated to her GP, midwife and health visitor if appropriate	95%	100%
4.10.3	2	Written and verbal information is given to the woman, her partner and family about the mother and baby unit	100%	100%
4.10.4	2	Patients and their carers are given the opportunity to visit the mother and baby unit if admission is being considered	100%	100%
4.11.1	1	As soon as possible after admission to a mother and baby unit a perinatal community psychiatric nurse should be allocated to the patient	95%	100%
4.11.2	2	The allocated perinatal psychiatric team member attends the patient's multidisciplinary ward rounds as appropriate	95%	100%
4.11.3	1	A member of the perinatal psychiatric team member attends the patient's pre-discharge meeting	90%	100%
4.12	1	Following discharge from an inpatient stay, the patient is seen in the community by a member of the perinatal team within 7 days	95%	100%
5		**Infant Welfare and Safeguarding**		
5.1		During the initial assessment process for the patient, the infant's care needs will be assessed. This assessment will include:		

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
5.1a	1	The baby's age and date of birth or due date	100%	100%
5.1b	1	Parental responsibility for the infant, all the mother's children and all children in her household	95%	74%
5.1c	1	Name and contact numbers of GP, health visitor, midwife, obstetrician, any social worker or paediatrician involved and any other relevant professionals or agencies	100%	100%
5.1d	1	If the child or unborn child is the subject of a Child Protection Plan (formerly known as the Child Protection Register or At Risk Register) or Care Proceedings	100%	95%
5.1e	1	Mode of delivery and obstetric complications during gestation	100%	100%
5.1f	1	Current or planned mode of feeding and any previous problems with feeding	100%	100%
5.1g	1	A brief assessment of mother-infant interaction, care and attachment Guidance: This should be based on the care needs of the infant and should be followed up by a more thorough assessment where appropriate	95%	95%
5.2	2	If areas of concern are highlighted then the care co-ordinator ensures a full assessment is completed using an instrument that is relevant to the concern, working collaboratively with the health visitor, psychologist or social worker if involved	80%	79%
5.4	2	Mother-infant assessments are conducted every 3 months or more frequently should the patient's mental state and behaviour change. This should include liaison with the health visitor	65%	74%
5.5	2	All mother-infant assessments are fed back to and discussed with the patient with particular reference to progress and problem areas	75%	74%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
		Risk Assessment of the Infant		
5.6		A risk assessment of mother and infant must be undertaken during the initial assessment process by the service. This should include:		
5.6a	1	Disclosures of harmful or potentially harmful acts	100%	100%
5.6b	1	Any delusions / overvalued ideas or hallucinations involving the unborn baby, infant or other children	100%	100%
5.6c	1	Any thoughts, plans or intentions of harming the unborn baby, infant or other children	100%	100%
5.6d	1	Hostility and / or irritability towards the unborn baby, infant or other children	100%	100%
5.6e	1	Any involvement with Children's Social Care Guidance: e.g. unborn baby, infant or older children subject to child protection plan or child care proceedings	100%	100%
5.6f	1	Any concern about any other person who may pose a risk to the unborn baby, child or other children	100%	100%
5.7	1	The risk assessment tool is specifically designed and standardised for use by perinatal psychiatric services	55%	47%
5.8	1	The risk assessment is updated a minimum of every 3 months or as appropriate	80%	79%
5.9	1	Risk assessments are completed prior to discharge and a summary is sent to all relevant agencies involved in care	85%	84%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
5.10	1	At each stage of Care and Risk Assessment consideration is given as to whether it is appropriate to initiate a CAF (or local equivalent) to better assess any additional needs the baby or older children of the family may have (www.ecm.gov.uk/caf)	100%	95%
		Care and Treatment of the Infant		
5.11		Case notes include:		
5.11a	1	Any maternal concerns in relation to the unborn baby/ infant	100%	100%
5.11b	1	Her care of the unborn baby/ infant	100%	100%
5.11c	1	Her enjoyment of the unborn baby/ infant	100%	100%
5.11d	1	If the infant is absent from the contact the reason why is recorded	95%	84%
5.12	2	Staff encourage the involvement of partners and/or other significant family members in the care of the mother and her infant, unless detrimental to the mother or infant. Guidance: Record of this should be included in the care plan	100%	95%
5.13		Women who choose to breastfeed are supported and encouraged by the following:		
5.13a	1	Where the service is prescribing psychotropic medication for breastfeeding mothers it is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration	100%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
5.13c	1	Women and all clinicians have access to up to date and expert information about medication in relation to breastfeeding	100%	100%
5.14	3	If a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility, the waiting area is exclusively for the use of the perinatal service during that session and equipped with age appropriate toys	31%	28%
		Safeguarding of the Infant		
5.15	1	Local safeguarding and child protection guidance is available and accessible to all staff members	100%	100%
5.16	1	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details	95%	100%
5.17	3	A member of the perinatal psychiatric team is a member of the local safeguarding or child protection group	80%	83%
5.18	1	Referral to Children and Family Services should be made on the basis of a risk assessment and should not be "routine" (i.e. only because the mother is mentally ill)	100%	100%
5.19		When the following factors are identified a referral to Children and Family Services should be made:		
5.19a	1	Concern from risk assessment about the immediate safety of the infant from its mother, partner or any other person	100%	100%
5.19b	1	An assessment identifies that the child is at ongoing risk of harm	100%	100%
5.19c	1	Current domestic violence	100%	100%
5.19d	1	Evidence that harm has already occurred	100%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
5.20	1	Any safeguarding referral is made in accordance with local NHS Trust (or equivalent body) and county council procedures	100%	100%
5.21	3	Protocols and procedures are in place to ensure perinatal and children's social services work collaboratively	75%	89%
5.22	1	The team should inform the local Social Care Information Management Team if any other child in the family has been subject to a care order or been on the Child Protection Risk Register	89%	74%
6		**Staffing and Training**		
6.1	1	All staff receive a service specific induction when they first join the service		
6.2		Training has been provided in the following:		
6.2a	1	The range of perinatal disorders	85%	84%
6.2b	1	Risk assessment	100%	95%
6.2c	1	Basic infant development including the main development milestones	90%	74%
6.2d	1	Cultural differences in infant feeding care / interaction and family relationships	60%	47%
6.2e	1	Prescribing in pregnancy and breastfeeding	100%	95%
6.2f	1	Understanding and promoting mother-infant interaction and attachment	95%	89%
6.2g	1	Safeguarding children (Level 2 minimum including the Common Assessment Framework or national equivalent)	100%	100%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
6.2h	2	Infant mental health training (e.g. Solihull, Watch Wait Wonder or Mellow Babies)	70%	58%
6.2i	1	Normal emotional changes in pregnancy and after birth	95%	79%
6.2j	1	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist)	80%	68%
6.2k	1	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (updated annually)	95%	89%
6.2l	1	A range of therapeutic interventions for staff to use with patients, for example, cognitive and behavioural techniques, brief psychotherapy techniques, family interventions and counselling	95%	95%
6.2m	2	Contraception and sexual health	50%	53%
6.2n	1	The Mental Health Act	100%	89%
6.2o	1	Alcohol, smoking and substance misuse	85%	68%
6.2p	1	Management of self-harm	80%	89%
6.2q	3	Infant feeding (including breastfeeding)	70%	68%
6.2r	1	Domestic abuse	100%	95%
6.3	1	Specialised training needs are informed annually through staff appraisal, individual development plans and supervision	95%	89%
6.4	2	All clinical staff attend a specialist perinatal training day at a minimum of once every two years	90%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
6.5	2	The team provide an annual training plan or strategy about perinatal mental health and its services which is appropriate for and accessible to midwives, health visitors, GPs, obstetricians, social workers and mental health workers	60%	79%
6.6.1	1	All staff receive regular individual clinical supervision totalling at least one hour every month from a person with appropriate experience	85%	89%
6.6.2	1	All staff receive regular individual managerial supervision totalling at least one hour every two months	95%	n/a
6.7	2	All staff receive annual appraisals and personal development plans	95%	95%
6.8		*The service consists of:*		
6.8a	1	Sessions from a dedicated specialised consultant perinatal psychiatrist	90%	100%
6.8b	2	Non-consultant medical input	55%	84%
6.8c	1	Dedicated perinatal community psychiatric nurses	100%	100%
6.8d	2	Dedicated sessions of a social worker	40%	42%
6.8e	2	Dedicated clinical psychologist sessions	65%	58%
6.8f	2	Dedicated nursery nurse sessions	35%	26%
6.8g	2	Dedicated OT sessions	40%	21%
6.8h	2	Dedicated administrative and data entry support	90%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
6.9	1	Members of the team have timely access to advice and support from a specialist perinatal psychiatrist during working hours	90%	100%
6.10	1	The service has access to interpreters within working hours	100%	100%
6.11	1	The team has a base and office accommodation	95%	100%
6.12	2	Staff working in teams covering a large geographical area can hot desk at other locations	94%	82%
6.13	2	All staff access performance and quality data on both their own patients and the team as a whole, including the regular reviewing of outcome measures to inform patient care and team development	80%	79%
7		**Recording and Audit**		
7.1		The service evaluates annually:		
7.1a	2	Feedback from patients and carers	85%	68%
7.1b	2	Feedback from referrers	65%	26%
7.1c	2	Feedback from service staff	50%	37%
7.1d	2	Accident and incident records GUIDANCE: The service should provide the quality network with information of any SUIs, investigations or complaints in the past 12 months	95%	84%
7.1e	2	Analysis of complaints	90%	89%

Standard Number	Standard Type	Standard	Cycle 3 % met	Cycle 2% met
7.1f	2	The findings of audits	95%	89%
7.1g	2	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data)	85%	84%
7.1h	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored	90%	84%
7.1i	1	Women involved in care proceedings / child safeguarding protection plans	70%	58%
7.2	3	There is a programme of audit including at least one perinatal specific audit a year	90%	89%
7.3	1	Any serious untoward incident including those involving a child and any emergency child protection order should be audited within 6 weeks and chaired by a suitably qualified clinician external to the service	100%	100%
7.4	1	The service keeps a record of any difficulties / undue delay in transferring the patient to another psychiatric service	90%	72%
7.5	2	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice	95%	89%

Appendix 2: Services Participating in Cycle 2

Birmingham and Solihull Perinatal Mental Health Services
Barberry Centre, 25 Vincent Drive, Edgbaston, Birmingham, B15 2FG
Giles Berrisford, Consultant Psychiatrist

0121 201 2180
giles.berrisford@bsmhft.nhs.uk

Cardiff Perinatal Community Service
Llewellyn Office, Whitchurch Hospital, Park Road, Whitchurch, Cardiff, CF14 7XB
Sue Smith, Consultant Psychiatrist

01446 420953
sue.smith5@wales.nhs.uk

City and Hackney Perinatal Outpatients Service
City and Hackney Centre for Mental Health, Homerton Row, London, E9 6SR
Sasha Singh, Modern Matron

0208 510 8151
sasha.singh@eastlondon.nhs.uk

Derbyshire Perinatal Community Mental Health Team
The Beeches, Radbourne Unit, Uttoxeter Road, Derby, DE22 3WQ
Cheryl Sticka, Service Manager

01332 623921
cheryl.sticka@derbyshcft.nhs.uk

Devon Perinatal Mental Health Service
Wonford House Hospital, Dryden Road, Exeter, EX2 5AF
Joanne Black, Perinatal Consultant Psychiatrist

01392 674964
j.black2@nhs.net

Dorset Perinatal Community Team
49 Alumhurst Road, Bournemouth, Dorset, BH4 8EP
Jagoda Banovic, Perinatal Service Manager
01202 584329
jagoda.banovic@dhuft.nhs.uk

Glasgow and Clyde Perinatal Mental Health Service
Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU
John Walker, Nurse Team Leader
0141 2116500
john.walker@ggc.scot.nhs.uk

Hampshire Perinatal Mental Health
Melbury Lodge, Romsey Road, Winchester, Hampshire, SO22 5DG
Jenny Walsh, Perinatal Service Leader
01962 897780
Jenny.Walsh@southernhealth.nhs.uk

Leeds Community Perinatal Mental Health Team
Leeds Perinatal Services, The Mount, 44 Hyde Terrace, Leeds, LS2 9LN
Gopi Narayan, Consultant Psychiatrist
0113 3055505
gopi.narayan@nhs.net

Lincoln Community Perinatal Mental Health Team
2 Carlton Boulevard, Outer Circle Road, Lincoln, LN2 4WJ
Steph Hodds, Clinical Manager
01522 526827
steph.hodds@lpft.nhs.uk

Livingston Perinatal Mental Health Team
St John's Hospital Livingston, Scotland, EH54 6PT
Anna Wroblewska, Consultant Psychiatrist
01506 524176
anna.wroblewska@nhslothian.scot.nhs

Newcastle and North Tyneside Community Mental Health Team
C/O Beadnell Ward, St George's Park, Morpeth, Northumberland, NE61 2NU
Jan Rigby, Team Manager

01670 501710
jan.rigby@ntw.nhs.uk

Newham Perinatal Team
Newham University Hospital, Glen Road, London, E13 8SL
Charles Musters, Consultant Psychiatrist

0207 363 8218
charles.musters@bartshealth.nhs.uk

North East London Perinatal Parent Infant Mental Health Service
Goodmayes Hospital, Barley Lane, Goodmayes, IG3 8XJ
Michelle Hayes, Deputy Manager

0300 555 119
Michelle.hayes@nelft.nhs.uk

Nottingham Community Perinatal Mental Health Team
Millfields Centre, Millbrook Mental Health Unit, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, NG17 4JT
Judith Ring, Perinatal Community Manager

0115 9560 844
judith.ring@nottshc.nhs.uk

Sheffield Perinatal Mental Health
Michael Carlisle Centre, 75 Osborne Road, Sheffield, S11 9BJ
Nusrat Mir, Consultant Psychiatrist

0114 2716069
Nusrat.mir@shsc.nhs.uk

South London and Maudsley Community Perinatal Services

1st Floor Psychological Medicine, King's College Hospital, Denmark Hill, London, SE5 9RS
Pamela Prescott, Perinatal Services Lead

020 3299 3234
Pamela.Prescott@slam.nhs.uk

Sussex Partnership Specialist Perinatal Service

East Brighton Community Mental health centre, Brighton General Hospital, Elm Grove, Brighton, BN2 3EW
Jenny Cooke, Consultant Psychiatrist

07795226048
Jennifer.cooke2@nhs.net

Tower Hamlets Perinatal Service

First Floor, Burdett House, Mile End Hospital, London, E1 4DG
Rebecca Moore, Consultant Psychiatrist

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rebecca.moore@eastlondon.nhs.uk

Worcestershire Community Perinatal Service

Studdert Kennedy House, Spring Gardens, Worcester, WR1 2AE
Linda Smith, Team Manager

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