
Perinatal specialist community mental health team service specification template

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The services

Service specifications

Sections 1–4:

These are mandatory sections to include but the detail is for local determination and agreement.

Sections 5–6:

These are optional sections to include but, again, the detail is for local determination and agreement.

Ensure the specification states the following:

- Specialist perinatal community mental health team
- Commissioner Lead
- Local Clinical Commissioning Group
- Provider Lead
- Period
- Date of review

1. Population needs

1.1 National/local context and evidence base

This service specification draws on evidence from national targets laid down by the Department of Health, and regional and national guidelines and standards for the treatment and management of perinatal psychiatric disorders.

Policy at both regional and national level has focused on promoting closer working between Primary Care organisations, NHS Trusts (Acute and Mental Health), NHS Foundation Trusts and Local Authorities. The Department of Health has set out a framework which requires local health care providers and service commissioners to achieve specified core targets and improvements. Sustainability and Transformation Partnerships (STPs) are being developed by commissioners and providers working collaboratively to improve patient care across organisational boundaries.

1.1.1 Perinatal mental health

The perinatal period is defined here as pregnancy and the first 12 months following childbirth. Perinatal mental health problems include both conditions with their onset at this time and pre-existing conditions that may relapse or recur in pregnancy or the postpartum year.

Up to 20% of women experience a mental health problem in the perinatal period. They range from mild to extremely severe, requiring different pathways, management and care. They include antenatal and postnatal depression, anxiety disorders including obsessive compulsive disorder and panic disorder, eating disorders, post-traumatic stress disorder, relapse of known severe mental illnesses including schizophrenia, schizoaffective disorder and bipolar affective disorder and postpartum psychosis.

While treatment is also just as effective for women in the perinatal period as at other times, what is different is the heightened need for prompt and effective care. This is because a mental health problem during the perinatal period not only has the potential to adversely affect the mother, but also to have lasting consequences for her developing child. These may include emotional and behavioural problems, delayed physical development, reduced cognitive development, impaired mother-baby interactions and an increased risk of parental conflict and relationship breakdown. Linked to this, the separation of mother and infant can have serious effects on the mother-infant relationship and be difficult to reverse.

For women, inadequate or absent treatment can result in a range of adverse psychological, social and employment outcomes, including increased risk of relapse.

Although maternal deaths are generally low in the UK, perinatal mental illness is associated with maternal mortality: 10% of women who died in the perinatal period, died as a result of completed suicide, and 23% of women who died in the postnatal period (6 weeks – 12 months postpartum) had a mental disorder⁷.

Perinatal mental health problems that are not treated effectively are also associated with substantial economic and social costs to both the NHS and public services, and society as a whole. The 2014 London School of Economics/Centre for Mental Health report highlights a long-term cost to society of £8.1 billion for each birth cohort, with £1.2bn falling directly on health and social care¹².

Postpartum serious mental illness has a number of distinctive clinical features including acute onset in the early days and weeks following delivery, rapid deterioration and severe symptoms and behavioural disturbance.

The majority of perinatal mental health services are commissioned by CCGs with the exception of specialised perinatal mental health in-patient services (Mother and Baby Units) which are commissioned by NHS England Specialised Commissioning team.

1.1.2. Perinatal mental health services

Women who require specialist treatment for mental health problems in the perinatal period need different facilities and service response from those provided by general adult mental health services. This has been acknowledged and promoted in a range of evidence-based publications, particularly the NICE clinical management and service guidance on antenatal and postnatal mental health (2014) and associated quality standard (2016)¹.

Key recent national strategies have also outlined perinatal mental health as a priority where improvements in access and outcomes for women and families are required. These include NHS England's Five Year Forward View for Mental Health² and the maternity review report Better Births, Improving Outcomes of Maternity Services in England³.

Perinatal mental health services encompass both specialist community teams and in-patient Mother and Baby Units (MBUs). It is the former that is the focus of this specification as MBUs are commissioned by NHS England Specialised Commissioning. MBUs are highly specialised services focused on the treatment and recovery of women with the most severe and complex mental ill health. It is recognised in NICE guidance¹ that community teams and MBUs must function in an integrated manner.

For the purpose of planning and commissioning specialist perinatal mental health services in line with national guidelines and standards,

it is possible to estimate the number of women both nationally and regionally who will require specialist care and treatment. This can be measured in terms of the number of women who require a referral to a perinatal community mental health team and/or in-patient admission to an in-patient MBU, using established epidemiology and data on live births.

1.1.3 Incidence

Postpartum disorders

The epidemiology of postpartum psychiatric disorders and their service uptake is well established (Kendal et al 1987; Oates 1997; Kumar and Robson, 1984; Munk-Olsen, 2009, 2011). 2 per 1000 women delivered will suffer from a postpartum psychosis and are admitted to a Psychiatric Unit. A further 2 per 1000 delivered women will be admitted suffering from other serious/complex disorders. All of these require Specialised MBUs and subsequent follow-up by a specialist perinatal community team. 3% of women in the perinatal period will be referred to secondary psychiatric services; 10 to 15% of all delivered women will suffer from mild to moderate postnatal depression, the majority of whom will be cared for in Primary Care.

Disorders in pregnancy

The incidence overall of mental disorders in pregnancy is up to 20%⁸. The rate of new onset serious mental illness in pregnancy is reduced. However, women with a previous history of serious illness, even if recovered, are at high risk of recurrence or relapse in pregnancy and after delivery. Proactive, preventative assessment and management will reduce morbidity and the need for admission. There is little national data on the prevalence of these high-risk women but it is thought to be approximately 4 per 1000 of women in the perinatal period.

Based on a minimum of two admissions per 1000 live births annually and the number of live births for the population of England (ONS number of births in England in 2014 (most recent figures), stood at 662,000). It is anticipated that there will be at least 1300 women requiring admission and subsequent specialist community follow-up per year nationally.

It is estimated that approximately 3–5% of pregnant women will be referred to psychiatric services. Based on this and the number of live births for the population of England, each year there will be approximately 6,600 women with serious mental illness who require a specialist perinatal mental health service.

Evidence shows that the treatment of serious mental illness in pregnancy and following childbirth by specialised perinatal mental health

services (in-patient MBUs and/or perinatal community mental health teams) results in improved mental health outcomes for women, their children and wider family, compared to standard psychiatric care. These benefits are well recognised in the short, medium and long-term. The economic cost to the public sector and society as a whole of failing to provide services to support women with perinatal mental illness is significant.

For perinatal mental health, the focus is on improving the treatment and management of pregnant and postpartum mentally ill women by maternity, psychiatric and primary care services, as set out in the following guidelines:

- 1 NICE, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (2014) and Quality Standard (2016)
- 2 Mental Health Task Force, Five Year Forward View for Mental Health for the NHS in England (2016)
- 3 National Maternity Review, Better Births, Improving Outcomes of Maternity Services in England (2016)
- 4 The British Psychological Society (BP8 2016), Perinatal Service provision: The Role of Perinatal Clinical Psychology
- 5 Falling through the gaps: perinatal mental health and general practice, Centre for Mental Health (2015)
- 6 The Royal College of Psychiatrists – Perinatal Mental Health Services College Report CR197 (2015)
- 7 Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011–13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13 (2015)
- 8 Department of Health Chief Medical Officer annual report 2014: women's health (2015)
- 9 Public Health England 0–19 service specification
- 10 National Institute for Health and Care Excellence – The Management of Bipolar Disorder: Assessment and Management (2014)
- 11 Department of Health Publication: Closing the gap: priorities for essential change in mental health (2014)

- 12 The costs of perinatal mental health problems: LSE and Centre for Mental Health (2014)
- 13 1001 Critical Days: The Importance of Conception to Age Two Period. Cross Party Manifesto (2013)
- 14 Prevention in mind: All Babies Count; Spotlight on Perinatal Mental Health. NSPCC (2013)
- 15 Maternal Mental Health Alliance, NSPCC and Royal College of Midwives (2012) Specialist Mental Health Midwives – what they do and why they matter
- 16 The Scottish Intercollegiate Guidelines Network – Management of Perinatal Mood Disorders: A National Clinical Guideline (2012)
- 17 Joint Commissioning Panel – Guidelines for the Commissioning of Perinatal Mental Health Services (Royal College of Psychiatrists (RCPsych) 2012)
- 18 Centre for Maternal and Child Enquiries – Saving Mothers’ Lives: Reviewing Maternal Deaths to make Motherhood Safer 2006-2008 (2011)
- 19 Royal College of Psychiatrists’ College Centre for Quality Improvement – Quality Network for Perinatal Mental Health Services - Standards for Mother and Baby In-Patient Units (2014)
- 20 Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines on Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (Good Practice No 14) 2011
- 21 The British Association of Psychopharmacology – Evidence-Based Guidelines for Treating Bipolar Disorder (2016)
- 22 Healthy Child Programme – Pregnancy and the First Five Years of Life (2009)
- 23 New Horizons – A Shared Vision for Mental Health (2009)

- 24 Maternity Matters – Choice, Access and Continuity of Care in a Safe Service (2007)
- 25 The National Service Framework for Children, Young People and Maternity Services - Maternity standard 11 (2004)

2. Outcomes

2.1 NHS outcomes framework domains and indicators

Domain 1

Preventing people from dying prematurely

Domain 2

Enhancing quality of life for people with long-term conditions

Domain 3

Helping people to recover from episodes of ill-health or following injury

Domain 4

Ensuring people have a positive experience of care

Domain 5

Treating and caring for people in safe environment and protecting them from avoidable harm

2.2 Local defined outcomes

- To ensure that all women of reproductive age with a current or previous serious mental illness have access to pre-conceptual advice and information on the risks of pregnancy and childbirth on their mental health and the health of the foetus/infant, including the risks and benefits of psychotropic medication.
- To deliver a timely service (in line with national recommendations) to meet the requirements of mothers and infants in a community setting without undue delay, maintaining and promoting good mental health throughout their pregnancy and postpartum year.
- All women requiring psychiatric admission in pregnancy or following delivery will have follow-up by a specialist community team.
- There will be an improvement (or maintenance were already well) in the patient's quality of life as the result of referral to a specialised perinatal community mental health team.

- There should be a reduction in the numbers of admissions to a specialised in-patient MBU of women with relapse or a recurrence of a pre-existing condition.
- A reduction in the number of in-patient readmissions within one month of discharge from the in-patient MBU.
- A reduction in delayed discharges from an in-patient MBU.
- A reduction in the mean length of stay on an in-patient MBU.
- To reflect experiential outcomes and measures for women (and their partners/families where appropriate) who have been referred to a specialised perinatal community mental health team, including the Friends and Family Test
- An expectation for the provider to collect, monitor and measure on all of these outcome areas as a means of demonstrating impact and as a tool for continuous improvement.
- Direct involvement in training for other services and agencies.

See section 5.3.3 for quality indicators.

3. Scope

3.1 Aims and objectives of service

Specialised perinatal community mental health teams provide assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services.

They also assist in the detection and proactive management of women who are at risk of developing a serious perinatal postnatal mental illness and provide advice and assistance to primary care, maternity and psychiatric services on the treatment and management of serious perinatal mental illness. This includes appropriate training.

The core principle of specialised perinatal community mental health teams is to safely and effectively meet the special needs and requirements of mothers and infants in a community setting. This should be underpinned by the provision of care and treatment which is:

- Inclusive – for all women living in the designated catchment area.
- Comprehensive – providing medical, nursing, psychological and social care in a community-based setting.

- Integrated – all components of care including access and discharge are integrated in a seamless fashion.
- Appropriate and flexible – ensuring that women have timely access to the right level of care.
- Ensures speedy resolution of the maternal mental illness whilst promoting the care and developing relationship with the infant.
- The teams should be staffed by professionals who have the requisite knowledge, skills, experience and competencies to offer expert advice, treatment and care (as outlined in Royal College of Psychiatrists. Quality Network for Perinatal Mental Health Services (2016) Perinatal Community Standards).

These teams work in conjunction with specialised in-patient MBUs to provide appropriate alternatives to admission and to provide treatment and support for women following discharge after an in-patient stay.

Specialised perinatal community mental health teams undertake the assessment, care and treatment of women who develop:

- a serious and/or complex illness during pregnancy and the first postpartum year
- women with a pre-existing serious/complex illness who become pregnant
- and women who are well but at risk of developing a serious mental illness following delivery
- can be safely managed in a community setting.

These teams should also provide:

- a liaison service to maternity, primary care and psychiatric services
- expert advice to non-specialist health professionals
- pre-conception advice to women with a diagnosis or vulnerability to develop a psychiatric illness considering a pregnancy
- assessment and care of pregnant women who are well but at risk of developing a serious mental illness following delivery.

Specialist perinatal mental health services should not be commissioned in isolation but as part of a comprehensive pathway of care including the extended primary care team, maternity services health visiting, and perinatal IAPT, with practitioners who have knowledge and competence to treat perinatal mental health.

At least 50% of pregnancies are unplanned (often 70% in mental health populations), general mental health services should be commissioned to discuss risks related to mental illness/medication and pregnancy routinely at reviews.

CR197 and the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) community standards provide guidance on staffing of specialist community teams. All clinical staff within these functions will receive education and training in perinatal mental health within three months of appointment and updated on a regular basis. They will be members of CCQI for specialised perinatal community mental health teams and adhere to these and other standards.

Perinatal clinicians will have a contract and job description which specifies their responsibilities to the service. During their contracted hours, they will not have responsibilities to other services. It is expected that the service will be staffed by contracted professionals and that other staff/bank or agency staff are used only in exceptional circumstances.

3.2 Service description/care pathway

Specialised perinatal community mental health teams provide assessment and care of childbearing women in the following circumstances or if they meet the following criteria:

- Following discharge from MBUs.

- New episodes of serious mental illness during pregnancy and the first postnatal year (where this is safe and appropriate), including:
 - Postpartum psychosis, bipolar affective disorder, serious affective disorder and/or other psychoses.
 - Severe depressive illness.
 - Severe anxiety-based disorders e.g. OCD and panic disorder.
 - Severe and/or complex mental illnesses including obsessive compulsive disorder.

Pre-existing serious mental illness in pregnancy will usually be under the care of adult mental health services. Specialised perinatal community mental health teams will either advise on management and treatment, take over the care of the woman temporarily or co-work with the psychiatric team, according to individual need and choice.

- Before conception or during early pregnancy, women who are well but at high risk of developing a serious postpartum illness, including a history of serious mental illness e.g. schizoaffective disorder, bipolar affective disorder or severe depressive illness (postnatally or at other times)
- Women with a family history of serious mental illness.
- Mothers under the age of 18 if significant perinatal mental illness dominates their presentation and they are likely to be the baby's principal carer. In these circumstances the assessment, treatment and management of a young mother should be undertaken in collaboration with CAMHS and social services.
- Mothers with significant mental health problems and mild learning disability who are likely to be the baby's principal carer.

The teams will do the following:

- Provide a range of medical, psychological and social interventions in the management of perinatal mental disorders.
- Monitor, support and provide care for mothers discharged from mother and baby units.
- Undertake routine, urgent clinical assessments of patients in a variety of locations including the patient's own home, maternity and psychiatric clinics/units.
- Monitor the mental health of patients who have been assessed as being at risk of developing a serious mental illness and assist in the development of proactive management plans. Pre-birth perinatal mental health plans should be developed with the pregnant women, partner and professionals involved in her care at 28–32 weeks' gestation.
- Undertake needs and risk assessment of women and their infants and develop individualised programmes of care.
- Together with the health visitor and extended primary care team, ensure the optimal physical emotional, cognitive and social development of the baby.
- Provide consultation, supervision and information to primary care, maternity and psychiatric services, offering advice on the management and treatment of perinatal psychiatric disorders.
- Offer advice on the use of medication during pregnancy and following childbirth and monitoring patients' progress on drug regimes.

During pregnancy and the postpartum period, women will be in routine contact with a variety of health professionals including GPs, health visitors and midwives and some women may also require additional input from obstetric services. Women who have pre-existing mental health disorders may also be under the care of a general adult mental health team.

Women who develop a first onset serious acute mental illness may be seen by adult mental health services. Women may also be in contact with social services, Child and adolescent mental health services and other services who are involved in their care or the care of their children.

In order to ensure that women with perinatal mental illness receive proper care and treatment in a timely manner, systems should be in place so that primary care, maternity and adult mental health services are able to obtain advice and information from specialised perinatal community mental health teams on when and how to refer women to the service.

This includes the following:

- A clinical pathway and priority pathway, together with guidelines for the management of new onset (acute) postnatal mental illness, criteria and guidance on how to make a referral, together with any associated documentation.
- A training and education programme for non-specialist health professionals (see Appendix 4).
- A perinatal psychiatric liaison consultation service to primary care, maternity, mental health and other involved services. The main function of this service is to advise and assist in the identification, assessment and treatment/management of pregnant and postpartum women with a current or previous serious mental illness and to promote early planning, intervention and treatment.

Referral processes

Specialised perinatal community mental health teams should accept referrals from primary care, adult mental health and maternity services and health visiting.

The service should provide telephone advice and guidance to potential referrers and others involved in the care of new mothers, such as social care.

Information about the philosophies and activities of the service, including referral criteria and care pathways/management guidelines should

be available for both professionals and the public in written and electronic form to facilitate timely and appropriate referral.

Referrals should only be accepted by a clinician in the service (refer to your local clinical pathways). If perinatal referrals are made to other adult psychiatric services, such as single point of access, crisis teams and community mental health services, they should be discussed with the specialised service as soon as possible and decisions made about their further care.

Response times and prioritisation

Referrals will be managed by the service in line with national guidance and according to the following criteria:

Emergencies

- A member of the clinical team should be available to discuss emergency referrals and plan a response during working hours.
- During working hours, the team undertakes an assessment within four hours of receiving the referral unless otherwise negotiated with the referrer or the patient.
- Out-of-hours emergencies will be assessed by the adult psychiatric emergency service (i.e. crisis teams) in line with the urgent and emergency care pathways; they will be discussed with the specialised team the next working day.
- Requests for emergency admissions to a mother and baby unit out of hours will be discussed with a senior clinician from the mother and baby unit.
- Women in late pregnancy or the postpartum year should not be separated from their babies or admitted to an adult psychiatric unit unless there are specified reasons to do so.

Urgent

- During working hours, the team responds to the referrer by telephone the same day and undertakes an assessment within two working days.

Non-urgent

- Within seven working days of the service receiving the referral, all accepted referrals are offered an appointment.

- The majority of accepted referrals will have a biopsychosocial assessment within two weeks of referral.
- It is recommended that women should have started evidence-based (NICE-recommended) psychological interventions within six weeks of referral.
- The majority of women referred for preconception advice will be seen within six weeks of referral.

Assessments should be conducted in the community, at hospital in scheduled or emergency out-patient clinics, or as required.

Discharge processes from specialised inpatient services

Specialised perinatal community mental health teams support women and their families in the transition and adjustment from an in-patient stay on a MABU to restored family life in the community.

Discharge planning together with the community team should begin as soon as possible after admission or after the initial assessment has been completed. This includes decisions about any continuing care needs that the woman and her family may have following discharge from in-patient care, and should meet the following criteria:

- Pre-discharge planning involves the community perinatal mental health team, health visitor, GP and if appropriate social services, as well as the care coordinator, patient and key family members.
- All key professionals receive copies of the discharge plan including details of when the patient will next be seen, who by and contact details in the case of an emergency.
- Following discharge from in-patient services, women are seen by a member of the perinatal service

3.3 Population covered

This should include the local context, e.g. population, birth rate, presence of any specialist services, other notable services along pathway, estimation of unmet need, i.e. gaps in service provision. (Examples can be provided on request.)

The service outlined in this specification is for patients ordinarily already resident in England or otherwise the commissioning responsibility of the NHS in England (as defined in *Who Pays?* establishing the

responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Specifically, this service is for women in pregnancy and the year postpartum with serious mental illness, together with their infants, who require specialist resources, service response and management as outlined in this specification.

3.4 Any acceptance and exclusion criteria and thresholds

Women with a substance misuse problem should not be referred to specialised perinatal community mental health teams unless they are also suffering from, or there is, a suspected/potential serious/complex mental illness. Personality disorder should not be a barrier to specialist care.

3.5 Interdependence with other services/providers

Services and the provision of care for women who develop mental health disorders during pregnancy and following childbirth should be organised in such a way that they are able to access the right level of care at the right time, proportional to the severity of the illness. Mild to moderate disorders should usually be managed by primary care services or IAPT. The intervention of specialist perinatal mental health services will be required for the more serious and/or complex illnesses or where there are significant risks.

In order to ensure the provision of effective care and treatment of women with serious mental illness in pregnancy and the postpartum period, systems should be in place to facilitate joint working and clinical integration between primary and secondary care services and non-specialist and specialist perinatal mental health services which will require co-working and cooperation across professional and organisational boundaries.

During pregnancy and the postpartum period, women will be in routine contact with a variety of health professionals including GPs, health visitors and midwives and some women may also require additional input from obstetric services. Women who have pre-existing mental health disorders may also be under the care of a general adult mental health team, and women who develop a first onset serious acute mental illness may be seen by adult mental health services. Women may also be in contact with social services, child and adolescent mental health services and other services who are involved in their care or the care of their children.

Effective local links should be developed with GP and adult mental health services (including crisis resolution teams, early intervention in

psychosis and community mental health teams), health visiting and midwifery teams; and obstetric services.

National quality standards, care pathways and education and training programmes should be implemented by service commissioners and providers to support effective joint working across all levels of service provision. Standards of care at each level of the care pathway should be developed jointly by services.

In order to ensure that women with perinatal mental illness receive proper care and treatment in a timely manner, Specialised perinatal community mental health teams will provide advice and information on when and how to refer women to the service. These systems include the establishment of care pathways, education and training programmes and a liaison-consultation service. They will liaise with and co-ordinate input to other providers as determined by clinical need.

There should be an expectation that women with pre-existing mental health conditions requiring secondary care intervention will be transferred to or co-worked with specialist mental health services unless there is an exceptional reason not to do so. Specialist perinatal mental health services should be directly involved in the provision of specialist training to non-mental health professionals.

A perinatal mental health clinical network will be established and managed by a coordinating board of healthcare professionals, commissioners, managers and service users. The networks should promote equity of access, education and training programmes and quality care and quality assurance.

4. Applicable service standards

4.1 Applicable national standards (e.g. NICE)

Services should update to meet any relevant changes in the standards and deliver best practice. For example:

- NICE: Guidelines on Antenatal and Postnatal Mental Health 2007, 2014
- NHS England National Service Specification for Perinatal Mental Health Services 2013
- NHS England Perinatal Mental Healthcare Pathways (2018).

4.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. a Royal College)

Examples include:

- RCOG Guidelines on Management of Women with Mental Health Issues during pregnancy and the postnatal period (Good Practice No 14) 2011.
- RCPsych Perinatal Mental Health Services College Report CR88 2000 (2015 revision).
- The Royal College of Psychiatrists – Perinatal Mental Health Services College Report CR197 (2015)
- RCPsych Quality Network for Perinatal Mental Health Services Accreditation Standards Mother and Baby Units 2016.
- Royal College of Psychiatrists. Quality Network for Perinatal Mental Health Services (2016) Peer Appraisal Standards for Perinatal Community Standards.
- Joint Commissioning Panel Guidance for Commissioners of Perinatal Mental Health Services 2012.

Specialist perinatal mental health services provide appropriate facilities, treatments and interventions for meeting the special needs of mothers and their infants.

Nationally accepted appraisal and accreditation standards for specialist perinatal community mental health teams have been developed by the Royal College of Psychiatrists' CCQI. These set down the minimum requirements for the treatment and management of women with serious perinatal psychiatric illness.

All specialised perinatal teams should be members of the RCPsych CCQI Quality Network for perinatal mental health services and adhere to their standards. They should participate in annual appraisal of their own and other national services and provide evidence of responding to issues raised and demonstrate that they have achieved the minimum requirements of safety, quality and effectiveness as defined by the peer review/accreditation standards.

4.3 Applicable local standards

The service and its clinical staff should belong to the relevant perinatal mental health network and participate in quality improvement and reducing unwarranted variation in care.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements

Refer to Appendix 4 for training/education/audit activities.

5.2 Applicable CQUIN goals

CQUIN to be established once service is embedded.

Current services to have CQUIN to be developed and agreed with local commissioning group.

5.3 Quality measures

5.3.1. Quality performance measures

- As a minimum response times and activity levels
- Service response (implementation) to RCPsych CCQI annual appraisal.

5.3.2 Clinical outcome measures

- Clinician reported outcome measures (CROM), e.g. HoNOS, HoNOSCA, BPRS, Bethlem Mother–Infant Interaction Scale, Crittenden Care Index, Parent–Infant Interaction Scale (PIIOS) for changes in mother–infant dyadic relationship.
- Patient Reported Outcome Measures (PROM) e.g. CORE 10, CORE-OM for psychological therapies; Postpartum Bonding Questionnaire (PBQ) patient report of dyadic relationship.
- Patient Reported Experience Measure (PREM) e.g. POEM.

State where the provider’s premises are located.

6. Appendices

This section could include the following:

- 1 Population and expected referral data
- 2 2.1a Antenatal Care Pathway
2.1b Postnatal Care Pathway
2.1c Management Algorithm
2.2 Priority Care Pathway
- 3 Quality Network for Perinatal Mental Health Services – (CCQI)
Standards web link: <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/perinatal/perinatal-qualitynetwork.aspx>
- 4 Teaching and Audit
4.1 Training and Audit
4.2 Audit