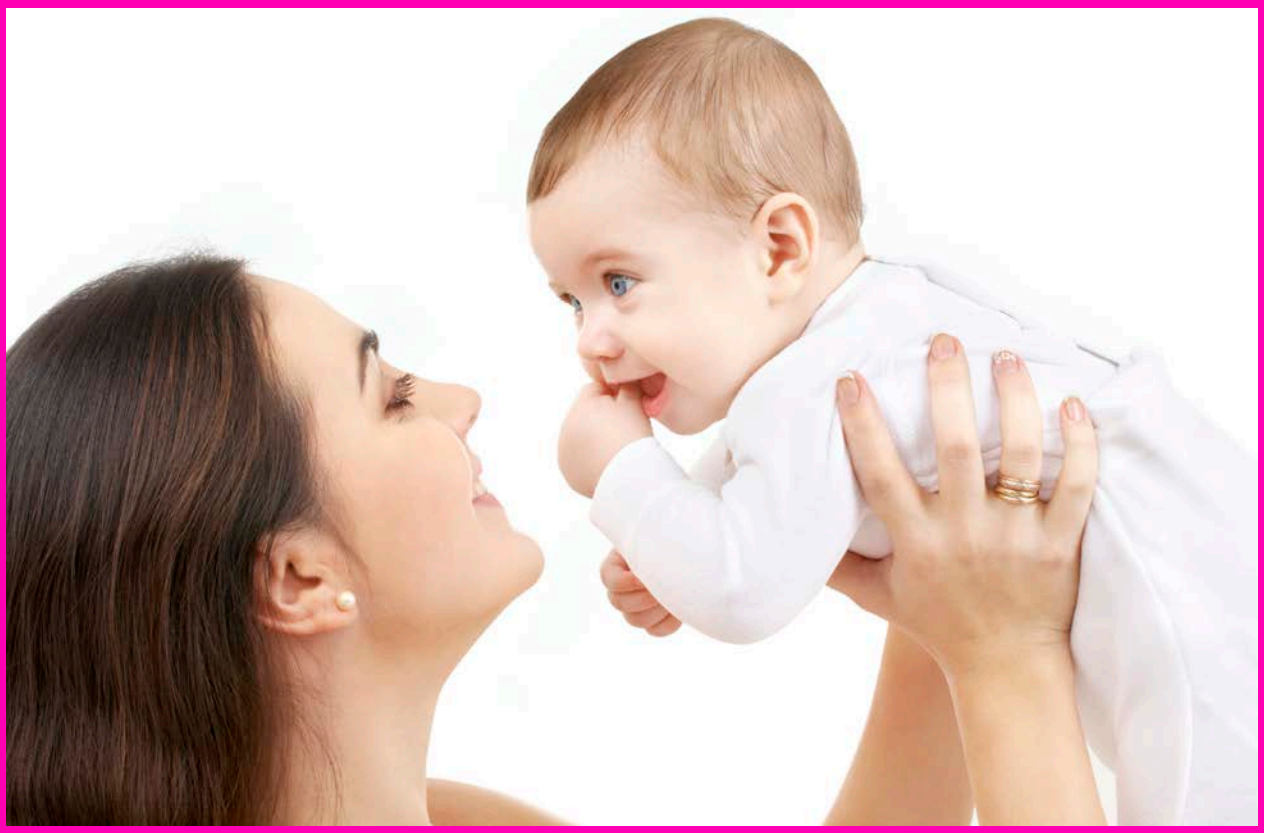
PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS



Service Standards: Second Edition

Perinatal Community Mental Health Services

Editors: Peter Thompson and Hannah Rodell

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Introduction

Background

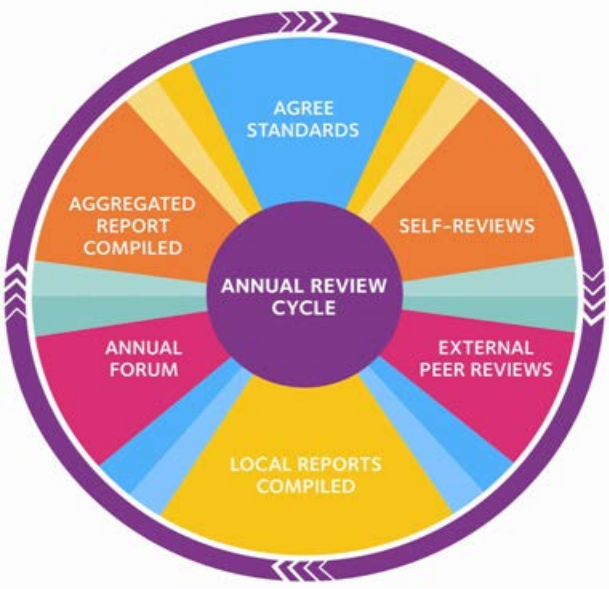
Following the inquiry into the deaths of Daksha and Freya Emson in October 2003 and the publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004, the Royal College of Psychiatrists made a commitment to promote perinatal mental health.

Initial funding was provided for the College Centre for Quality Improvement (CCQI) to complete a national survey of Specialist Perinatal Mental Health Services and to set up a network.

The Quality Network for Perinatal Mental Health Services was launched in June 2007, as part of this commitment, to develop and maintain standards for mother and baby units. The network engages with frontline staff and applies a clinical audit method within a peer-support network. Since 2007, over 80% of mother and baby units in the UK have participated in the process. In 2012, the network developed standards for community perinatal mental health services.

The Review Process

The standards represent just one part of the cycle: the real benefit for services is in taking part in the process of reviews. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see figure below).



Updating the standards

This second edition of the Perinatal community standards has been informed by a standards workshop which was held on 3rd March 2014, to which all members of the network were invited, to gain expert opinion and consensus. A good range of services were represented at the workshop. A wide range of disciplines were also represented alongside a patient representative.

Once additions and changes had been proposed there was a wider consultation with all members of the network via a consultation document which was sent out to over 200 members via the Perinatal-Chat email discussion group. The document listed suggested criteria additions, changes and removals. We accepted criteria where there was clear consensus; otherwise a decision was negotiated within the project team with the clinical lead for the network.

Important Note

Data collection tools adapted from these standards will be provided with guidance notes to members before reviews take place. This document is provided for reference and not for data collection.

These are best practice statements and consequently we would not expect services to meet every standard. While there are some statements that are based upon legal requirements, this document is not intended to act as a legal guide in any way. This is not intended to be a guide to any reviews conducted by regulatory bodies.

If you have any questions about these standards please contact Peter Thompson on 020 3701 2662 or email pthompson@rcpsych.ac.uk.

Standard Number	Standard	Standard Type
1	**Access and Referral**	
1.1	*The service provides information (in written and electronic form) for patients and professionals on:*	
1.1a	A description of the service	2
1.1b	Clear referral criteria	1
1.1c	Clear clinical pathways describing access and discharge	1
1.1d	How to make a referral	1
1.1e	Contact details, including emergency and out of hours details	1
1.2	*The service is provided for the following groups in a defined catchment area:*	
1.2a	Women following discharge from an inpatient stay	1
1.2b	Women suffering from bipolar illness / puerperal psychosis, other psychoses and serious affective disorder, who can be safely managed in the community	1
1.2c	Women with other serious non-psychotic conditions	1
1.2d	Women identified in pregnancy who are at risk of a recurrence / relapse of a psychotic or serious / complex non-psychotic condition	1
1.2e	Women requiring pre-conception counselling	1
1.3	The service only works with women who cannot be effectively managed by primary care services	2
1.4	The service only works with women with alcohol/substance misuse problems if there is also (or suspected) moderate to severe mental illness	2
1.5	Patients under age 18 can be referred if perinatal psychiatric disorder dominates the clinical picture	1
1.6	The perinatal service works with the local CAMHS service to provide care to patients under the age of 18	1
1.7	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP is informed.	2
1.8	Referrals from Children's Social Services can only be accepted if they meet the usual clinical criteria	2
1.9	The referral criteria ensure that personality disorder is not a barrier to appropriate service response	1
1.10	Referrals can be made directly to the service during working hours	1
1.11	The service responds to requests for telephone advice from other professionals within one working day	1
1.12	A clinical member of the team is available to discuss emergency referrals during working hours	1
1.13	When the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this	1
1.14	There is a procedure agreed with out of hours teams to ensure patients requiring Perinatal specialist care are referred the next working day	1
1.15	Where services accept referrals through a single point of access, these are passed to the Perinatal team within one working day	2
1.16	The team responds to non-urgent referrals within 6 weeks	2

Standard Number	Standard	Standard Type
1.17	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	2
1.18	The acknowledgement letter is copied to the referrer and the patient's GP	2
1.19	If a referral is not accepted, the team advise the referrer on alternative options	1

2	Assessment	
2.1	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)	1
2.2	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	1
2.3	Women are offered a choice of where they would like their assessment to take place, taking into consideration clinical need	3
2.4	The service is able to conduct assessments in a variety of settings, which have been appropriately risk assessed	1
2.5.1	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.	1
2.5.2	Women referred with new onset conditions after 28 weeks of pregnancy and within 6 weeks of delivery should be offered an assessment appointment that takes place within the 2 weeks after the referral	2
2.6	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.	1
2.7	Women referred before 28 weeks of pregnancy, should be seen no later than this point in their pregnancy or within 2 weeks.	2
2.8.1	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*	1
2.8.2	Pregnant women receiving mood stabiliser medication should be offered an appointment that is within the two weeks after referral.	1
2.9	Women currently in the care of psychiatric services should be assessed and given advice/ treated in collaboration with their usual psychiatric care team	1
2.10	All women have a comprehensive assessment of their health and social care needs taking into consideration the needs of their children and family	1
2.11	*Practioners gather additional information reflecting the perinatal context, including:*	
2.11a	Current and past obstetric history	1
2.11b	Mode of infant feeding	1
2.11c	Contraception	1
2.11d	Contact details of relevant professionals	1
2.12	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	1
2.13	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	1

2.14	Care plans are reviewed at least every 3 months	1
2.15	The care plan is developed collaboratively with the patient	1
2.16	The views of the patient's partner, family and carers is incorporated into the care plan as appropriate	1
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	Nature of the risk and condition	1
2.17b	Details of current medication and any intended changes in late pregnancy and the early postpartum	1
2.17c	Consideration of whether the mother intends to breastfeed	1
2.17d	Those involved and frequency of contact	1
2.17e	Emergency contact details	1
2.17f	Admission to a mother and baby unit if necessary	1
2.17g	Plans for a maternity admission, including notifying the perinatal team once the patient has delivered	1
2.18	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	2

3	Discharge	
3.1	Women requiring continued psychiatric care are handed over to the appropriate team at the final review	1
3.2	*The discharge summary includes reference to:*	
3.2a	Assessment of the patient's mental state	1
3.2b	Risk assessment (mother and child)	1
3.2c	Advice regarding further pregnancies (including risk and benefits of medication)	2
3.2d	Contraception advice	2
3.2e	Mother-infant interaction	1
3.2f	Any remaining concerns / needs for intervention and support in relation to mother-infant care or older children	2
3.5	Any safeguarding concerns are referred to children's social services	1

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	Medication	1
4.1b	Psychological interventions *Guidance: This includes problem solving, stress management, brief supportive counselling and relapse prevention, CBT, interpersonal psychotherapy*	1
4.1c	Mother and baby interventions	2
4.1d	Family and couples interventions	3
4.1e	Creative therapies	3
4.2	Staff promote patients accessing social and recreational activities in their own community	3
4.3	*The clinical members of the team are able to advise (working with other professionals) the patient, partner and family on:*	
4.3a	Early mother-infant care and attachment	1
4.3b	Infant development	2
4.3c	Promoting involvement of partner / family members	1
4.4	Partners and designated family members are involved in decisions about care, where the patient consents	2
4.5	Carers are advised how to obtain a carers' assessment	2
4.6	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	2
4.7	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*	2
4.8	Age appropriate perinatal mental health information is available to older children in the patient's family	3
4.9	The team have established relationships with local mother and baby units	1
4.10.1	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*	1
4.10.2	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	1
4.10.3	Written and verbal information is given to the woman, her partner and family about the mother and baby unit	2
4.10.4	Patients and their carers are given the opportunity to visit the mother and baby unit if admission is being considered	2
4.11.1	As soon as possible after admission to a mother and baby unit a perinatal community psychiatric nurse should be allocated to the patient	1

4.11.2	The allocated perinatal psychiatric team member attends the patient's multidisciplinary ward rounds as appropriate	2
4.11.3	A member of the perinatal psychiatric team member attends the patient's pre-discharge meeting	1
4.12	Following discharge from an inpatient stay, the patient is seen in the community by a member of the perinatal team within 7 days	1

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:*	
5.1a	The baby's age and date of birth or due date	1
5.1b	Parental responsibility for the infant, all the mother's children and all children in her household	1
5.1c	Name and contact numbers of GP, health visitor, midwife, obstetrician, any social worker or paediatrician involved and any other relevant professionals or agencies	1
5.1d	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	1
5.1e	Mode of delivery and obstetric complications during gestation	1
5.1f	Current or planned mode of feeding and any previous problems with feeding	1
5.1g	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*	1
5.2	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	2
5.4	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	2
5.5	All mother-infant assessments are fed back to and discussed with the patient with particular reference to progress and problem areas	2
	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	Disclosures of harmful or potentially harmful acts	1
5.6b	Any delusions / overvalued ideas or hallucinations involving the unborn baby, infant or other children	1
5.6c	Any thoughts, plans or intentions of harming the unborn baby, infant or other children	1
5.6d	Hostility and / or irritability towards the unborn baby, infant or other children	1
5.6e	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*	1
5.6f	Any concern about any other person who may pose a risk to the unborn baby, child or other children	1
5.7	The risk assessment tool is specifically designed and standardised for use by perinatal psychiatric services	1

5.8	The risk assessment is updated a minimum of every 3 months or as appropriate	1
5.9	Risk assessments are completed prior to discharge and a summary is sent to all relevant agencies involved in care	1
5.10	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)	1
	Care and Treatment of the Infant	
5.11	*Case notes include:*	
5.11a	Any maternal concerns in relation to the unborn baby/ infant	1
5.11b	Her care of the unborn baby/ infant	1
5.11c	Her enjoyment of the unborn baby/ infant	1
5.11d	If the infant is absent from the contact the reason why is recorded	1
5.12	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*	2
5.13	*Women who choose to breastfeed are supported and encouraged by the following:*	
5.13a	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	1
5.13c	Women and all clinicians have access to up to date and expert information about medication in relation to breastfeeding	1
5.14	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	3
	Safeguarding of the Infant	
5.15	Local safeguarding and child protection guidance is available and accessible to all staff members	1
5.16	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details	1
5.17	A member of the perinatal psychiatric team is a member of the local safeguarding or child protection group	3
5.18	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)	1
5.19	*When the following factors are identified a referral to Children and Family Services should be made:*	
5.19a	Concern from risk assessment about the immediate safety of the infant from its mother, partner or any other person	1
5.19b	An assessment identifies that the child is at ongoing risk of harm	1
5.19c	Current domestic violence	1
5.19d	Evidence that harm has already occurred	1
5.20	Any safeguarding referral is made in accordance with local NHS Trust (or equivalent body) and county council procedures	1

5.21	Protocols and procedures are in place to ensure perinatal and children's social services work collaboratively	3
5.22	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	1

6	Staffing and Training	
6.1	All staff receive a service specific induction when they first join the service	1
6.2	*Training has been provided in the following:*	
6.2a	The range of perinatal disorders	1
6.2b	Risk assessment	1
6.2c	Basic infant development including the main development milestones	1
6.2d	Cultural differences in infant feeding care / interaction and family relationships	1
6.2e	Prescribing in pregnancy and breastfeeding	1
6.2f	Understanding and promoting mother-infant interaction and attachment	1
6.2g	Safeguarding children (Level 2 minimum including the Common Assessment Framework or national equivalent)	1
6.2h	Infant mental health training (e.g. Solihull, Watch Wait Wonder or Mellow Babies)	2
6.2i	Normal emotional changes in pregnancy and after birth	1
6.2j	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist)	1
6.2k	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (updated annually)	1
6.2l	A range of therapeutic interventions for staff to use with patients, for example, cognitive and behavioural techniques, brief psychotherapy techniques, family interventions and counselling	1
6.2m	Contraception and sexual health	2
6.2n	The Mental Health Act	1
6.2o	Alcohol, smoking and substance misuse	1
6.2p	Management of self-harm	1
6.2q	Infant feeding (including breastfeeding)	3
6.2r	Domestic abuse	1
6.3	Specialised training needs are informed annually through staff appraisal, individual development plans and supervision	1
6.4	All clinical staff attend a specialist perinatal training day at a minimum of once every two years	2
6.5	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	2
6.6	All staff receive regular individual clinical supervision totalling at least one hour every month from a person with appropriate experience GUIDANCE: *This includes clinical and managerial issues*	1
6.7	All staff receive annual appraisals and personal development plans	2

6.8	*The service consists of:*	
6.8a	Sessions from a dedicated specialised consultant perinatal psychiatrist	1
6.8b	Non-consultant medical input	2
6.8c	Dedicated perinatal community psychiatric nurses	1
6.8d	Dedicated sessions of a social worker	2
6.8e	Dedicated clinical psychologist sessions	2
6.8f	Dedicated nursery nurse sessions	2
6.8g	Dedicated OT sessions	2
6.8h	Dedicated administrative and data entry support	2
6.9	Members of the team have timely access to advice and support from a specialist perinatal psychiatrist during working hours	1
6.10	The service has access to interpreters within working hours	1
6.11	The team has a base and office accommodation	1
6.12	Staff working in teams covering a large geographical area can hot desk at other locations	2
6.13	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	2

7	Recording and Audit	
7.1	*The service evaluates annually:*	
7.1a	Feedback from patients and carers	2
7.1b	Feedback from referrers	2
7.1c	Feedback from service staff	2
7.1d	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	2
7.1e	Analysis of complaints	2
7.1f	The findings of audits	2
7.1g	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data)	2
7.1h	Action plans are developed based on the service evaluation and resulting quality improvement is monitored	2
7.1i	Women involved in care proceedings / child safeguarding protection plans	1
7.2	There is a programme of audit including at least one perinatal specific audit a year	3
7.3	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	1
7.4	The service keeps a record of any difficulties / undue delay in transferring the patient to another psychiatric service	1
7.5	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice	2

Members Consultation

Standards Revision Workshop Attendees- 3rd March 2014

Peter Thompson (Senior Programme Manager, CCQI)
Hannah Rodell (Project Worker, CCQI)
Keith Mahon (Project Worker, CCQI)
Julia Kennedy (Patient Representative, CCQI)
Elaine Clark (Nurse Consultant, Perinatal Mental Health Service- Glasgow and Clyde)
Jan Rigby (Community Practice Nurse, Perinatal Community Team Northumberland Tyne & Wear)
Andrew Cairns (Consultant Psychiatrist, Perinatal Community Team Northumberland Tyne & Wear)
Judith Ring (Team Leader, Nottingham Community Perinatal Psychiatric Service)
Linda Igwe (Ward Manager, Rainbow MBU)
Irene Mungate (Acting Charge Nurse, Rainbow MBU)
Laura Grainger (Nursery Nurse, Rainbow MBU)
Fay Gopie (Community Services Manager, Birmingham Perinatal Mental Health Service)
Emma Gasson (Deputy Community Services Manager, Birmingham Perinatal Mental Health Service)
Julie MacFarlane (Perinatal Community Nurse, Leeds Perinatal Service)
Darrel Mahabir (Clinical Specialist, Hackney Perinatal Service)
Pamela Prescott (Service Manager, South London and Maudsley Perinatal Service)
Mary Ofori (Team Manager, South London and Maudsley Perinatal Service)
Stephanie Usher (Highgate Mental Health Centre)
Jenny Walsh (Service Manager, Hampshire Perinatal Mental Health)
Clare Haughey (Clinical Nurse Manager, Perinatal Mental Health Service- Glasgow and Clyde)

Email comments

Andrew Cairns (Consultant Psychiatrist, Perinatal Community Team Northumberland Tyne & Wear)
Anne Oxley (Ward Manager, Perinatal Community Team Northumberland Tyne & Wear)
Neelam Sisodia (Senior Perinatal Consultant Psychiatrist, Nottingham Perinatal Psychiatric Service)
Margaret Oates (Consultant Psychiatrist, Clinical Lead, CCQI)
Nisha Shah (Consultant in Perinatal Psychiatry, Highgate Mental Health Centre)
Judith Ring (Team Leader, Nottingham Perinatal Psychiatric Service)

Project Team

Margaret Oates (Clinical Lead)
Peter Thompson (Senior Programme Manager)
Hannah Rodell (Project Worker)