

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	C06/S/a
<b>Service</b>	Specialised Perinatal Mental Health Services (In-Patient Mother and Baby Units and Linked Outreach Teams)
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

### 1. Population Needs

#### 1.1 National/local context and evidence base

##### 1.1.1 Introduction

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. 23% of women who died in the postnatal period (6 weeks – 12 months postpartum) had a mental disorder.<sup>1</sup>

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 care<sup>2</sup>.

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 inpatient services (Mother and Baby Units) which are commissioned by NHS England Specialised Commissioning team.

### **1.1.2. Specialised 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)<sup>3</sup>.

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 Health<sup>4</sup> and the maternity review report Better Births, Improving Outcomes of Maternity Services in England<sup>5</sup>.

Specialised perinatal mental health services encompass both community teams and

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<sup>1</sup> 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, December 2015

<sup>2</sup> <https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems>

<sup>3</sup> <https://www.nice.org.uk/guidance/CG192>

<sup>4</sup> <https://www.england.nhs.uk/mentalhealth/taskforce/>

<sup>5</sup> <https://www.england.nhs.uk/ourwork/futurenhs/mat-review/>

inpatient Mother and Baby Units (MBUs). It is the latter that is the focus of this specification as community teams would be commissioned on more of a locality basis by Clinical Commissioning Groups. Mother and Baby Units are highly specialised services focused on the treatment and recovery of women with the most severe and complex mental ill health.

**In-Patient Mother and Baby Units** enable the treatment and recovery of the mother whilst ensuring the developing relationship with the baby and its physical and emotional wellbeing. Units will have a **specialised Perinatal Outreach** function that provides assessments for women who would otherwise be admitted to the MBU, facilitates early discharge, the prevention of relapses and re-admission of discharged in-patients and of high risk (and admission vulnerable) women. In some areas this function may be provided by a community team commissioned by CCGs.

MBUs are staffed by clinicians with additional knowledge and skills in the impact of childbirth on maternal psychiatric disorder and the effects of maternal psychiatric disorder and its treatment on the infant both in-utero and after birth.

Both MBUs and community perinatal mental health teams (commissioned by CCGs) should work in close collaboration with maternity and obstetric services and health visitors, respond rapidly to presentations within the maternity context and address the additional risks to both mother and infant of serious perinatal mental health.

### 1.1.3. Incidence

#### 1.1.3.1. 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 Mother and Baby Units. 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.

#### 1.1.3.2. Disorders in Pregnancy

The incidence overall of mental disorders in pregnancy is up to 20%<sup>6</sup>. 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 2 admissions per 1000 live births annually and the number of live

<sup>6</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

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 admissions per year nationally.

It is estimated that 0.25 In-Patient Mother and Baby beds per 1000 live births will be required (if Specialised Perinatal Community Mental Health Teams are available) or 0.5 per 1000 if no Specialised Teams are provided. Currently there are 115 beds provided by 15 In-Patient Mother and Baby Units.

It is estimated that approximately 3-5% of pregnant women will be referred to Psychiatric Services and 1% of women in the perinatal period will meet the referral criteria for prescribed specialised care and treatment (Mother and Baby Units and Outreach). 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 the prescribed Perinatal Mental Health Service.

### 1.1.4. National Policy Initiatives and Evidence Base

The following evidence based national policy initiatives recommend that all women with serious mental illness in late pregnancy and the postpartum period should receive specialist perinatal psychiatric care. If they require admission, these women should be admitted with their babies to a Specialised In-Patient Mother and Baby Unit. They also recommend treatment and management guidelines for perinatal conditions and women of reproductive potential. Their aim is to reduce morbidity and mortality in mother and infants and to improve quality of life and patient satisfaction.

- [NICE, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance \(2014\) and Quality Standard \(2016\)](#)
- [Mental Health Task Force, Five Year Forward View for Mental Health for the NHS in England \(2016\)](#)
- [National Maternity Review, Better Births, Improving Outcomes of Maternity Services in England \(2016\)](#)
- [The British Psychological Society \(BP8 2016\), Perinatal Service provision: The Role of Perinatal Clinical Psychology](#)
- [Falling through the gaps: perinatal mental health and general practice, Centre for Mental Health \(2015\)](#)
- [The Royal College of Psychiatrists – Perinatal Mental Health Services College Report CR197 \(2015\)](#)
- [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 \(2015\)](#)
- [Department of Health Chief Medical Officer annual report 2014: women's health \(2015\)](#)
- [Public Health England 0-19 service specification](#)
- [National Institute for Health and Care Excellence – The Management of Bipolar Disorder: Assessment and Management \(2014\)](#)
- [Department of Health Publication: Closing the gap: priorities for essential change in mental health \(2014\)](#)

- [The costs of perinatal mental health problems: LSE and Centre for Mental Health \(2014\)](#)
- [1001 Critical Days: The Importance of Conception to Age Two Period. Cross Party Manifesto \(2013\)](#)
- [Prevention in mind: All Babies Count; Spotlight on Perinatal Mental Health. NSPCC \(2013\)](#)
- [Maternal Mental Health Alliance, NSPCC and Royal College of Midwives \(2012\) Specialist Mental Health Midwives – what they do and why they matter](#)
- [The Scottish Intercollegiate Guidelines Network – Management of Perinatal Mood Disorders: A National Clinical Guideline \(2012\)](#)
- [Joint Commissioning Panel – Guidelines for the Commissioning of Perinatal Mental Health Services \(Royal College of Psychiatrists \(RCPsych\) 2012\)](#)
- [Centre for Maternal and Child Enquiries – Saving Mothers' Lives: Reviewing Maternal Deaths to make Motherhood Safer 2006-2008 \(2011\)](#)
- [Royal College of Psychiatrists' College Centre for Quality Improvement - Quality Network for Perinatal Mental Health Services - Standards for Mother and Baby In-Patient Units \(2014\)](#)
- [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](#)
- [The British Association of Psychopharmacology – Evidence-Based Guidelines for Treating Bipolar Disorder \(2016\)](#)
- [Healthy Child Programme – Pregnancy and the First Five Years of Life \(2009\)](#)
- [New Horizons – A Shared Vision for Mental Health \(2009\)](#)
- [Maternity Matters – Choice, Access and Continuity of Care in a Safe Service \(2007\)](#)
- [The National Service Framework for Children, Young People and Maternity Services - Maternity standard 11 \(2004\)](#)

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	

2.1.1. The following are key service outcomes which will be delivered through the commissioning of Specialised Perinatal Mental Health Services:

- All women in late pregnancy or following delivery requiring an emergency psychiatric admission will be admitted directly to an In-Patient Mother and Baby Unit or transferred within 24 hours of admission from an Adult Mental Health Admission Unit.
- All women requiring psychiatric admission are admitted with their infant to an In-Patient Mother and Baby Unit unless there are exceptional reasons not to do so.
- All mothers on an In-Patient Mother and Baby Unit will receive a daily assessment of their need for supervision, support and assistance to ensure that the emotional and physical needs of both mothers and their infants are safely met.
- There will be an improvement in the patient's quality of life as the result of admission to a Specialised In-Patient Mother and Baby Unit and/or referral to a Specialised Perinatal Community Mental Health Team.
- There should be a reduction in the numbers of admissions to a Specialised In-Patient Mother and Baby Unit of women with relapse or a recurrence of a pre-existing condition.
- A reduction in the number of in-patient readmissions within 1 month of discharge from the In-Patient Mother and Baby Unit.
- A reduction in delayed discharges from an In-Patient Mother and Baby Unit.
- A reduction in the mean length of stay on an In-Patient Mother and Baby Unit.
- A reduction in the use of the Mental Health Act
- To reflect experiential outcomes and measures for women (and their partners/families where appropriate) who have been admitted to an In-Patient Mother and Baby Unit, including the Friends & 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.

See section 5.3.3 for quality indicators.

### 3. Applicable Service Standards

#### 3.1 Aims and objectives of service

##### 3.1.1 Aims and objectives of a Perinatal Psychiatric Service (Prescribed Specialised Component)

The prescribed component of Specialised Perinatal Mental Health Services provides In-Patient Mother and Baby Units and Outreach function. The aim is to:

- Provide timely access to quality care and treatment to women in late pregnancy and the postpartum year who have severe and/or complex mental ill health, to ensure that the special needs and additional risks to mothers and infants will be met. This will reduce morbidity and mortality in both, over the short and longer term. The developing relationship between mother and infant will be promoted with short and long term benefits for the infant's mental health and the mother's quality

of life.

- Prevent avoidable recurrences and relapses and therefore admission in high risk women, to facilitate discharge and prevent relapses and readmissions, promoting and enabling recovery.

### **3.1.2 Objectives of the Service**

The Service will ensure that the following objectives are met:

- To ensure that women and their families have timely access to the right level of recovery focused care.
- If admission is required, to ensure that this will be to a Specialised In-Patient Mother and Baby Unit without delay so that no woman is unnecessarily separated from her baby.
- To safely and effectively meet the special needs and requirements, both emotional and physical, of mothers and infants.
- To provide specialist medical, nursing, psychological and statutory social care for mother and infant.
- To provide supervision, support, assistance and guidance in the care (both physical and emotional) of the infant whilst the mother is ill.
- To respond in a timely manner to emergency requests for assessment and advice.
- To ensure the integration in a seamless fashion of all components of care through access to discharge from the Service.
- To achieve the earliest resolution of the maternal mental illness whilst promoting the care and developing relationship with the infant.
- To assess and proactively manage high risk women with a prior history of serious mental illness to prevent avoidable recurrences in pregnancy and the postpartum period.
- To ensure that women, partners/significant others and families are able to make informed decisions about care and treatment, where they are able, including through provision of appropriate information and signposting to other relevant support.

## **3.2 Service description/care pathway**

### **3.2.1. In-Patient Mother and Baby Units**

In-Patient Mother and Baby Units undertake the assessment, care and treatment of women in late pregnancy and the postpartum period with serious mental illness that cannot be safely managed by Specialised Perinatal Community Mental Health Teams. The infant is admitted with the mother. They provide appropriate facilities, treatments and interventions to meet the special needs of mothers and their infants including both physical and psychological care. They provide support, assistance and supervision to the mother so that the physical and emotional needs of the infant are met and promote the developing mother-infant relationship.

In-Patient Mother and Baby Units provide care for **emergency admissions** 24 hours a day, 7 days a week (these are the majority of admissions). They are able to care for acute conditions including those detained under the Mental Health Act, without transferring mothers to other in-patient facilities (except in exceptional circumstances). They also accept planned admissions for less urgent but complex cases which cannot be managed in the community or by Adult Mental Health Services.

In order to ensure a safe environment for the care of both mother and infant, In- Patient Mother and Baby Units are separate from other acute admission units, have controlled access and facilities that are not shared by other acute psychiatric admission units. In-Patient Mother and Baby Units will meet these and other Standards of the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) for In-Patient Mother and Baby Units which are necessary for accreditation. These standards can be accessed at the following link:

The most recent [CCQI service standards \(fourth edition\) for Mother and Baby Inpatient Units](#): Compliance with these standards is the basis for accreditation and commissioning.

Mother and infants should have access to the same professionals and resources that they would have in the community, however there should be a link health visitor and a link midwife for every In-Patient Mother and Baby Unit to provide advice and assistance to both the mothers and staff. This is because many mothers will be admitted from a distance from their usual community services. (e.g. midwifery, health visiting, physiotherapy, immunisation etc).

In-Patient Mother and Baby Units will have a Specialised Outreach function to provide assessments for women who would otherwise be admitted to the unit, to facilitate early discharge and ensure proper follow-up, support and treatment in the community once the mother has been discharged from in-patient care. In some areas this function may be provided by a community team commissioned by CCGs.

### **3.2.2. Outreach Function**

In-Patient Mother and Baby Units will have an outreach function to provide place based assessments for women who would otherwise be admitted to the unit, to facilitate discharge and prevent avoidable relapses and re-admission. In some areas this function may be provided by a community team commissioned by CCGs.

They also undertake the assessment and treatment of pregnant and postpartum women who have a serious mental illness or who are at high risk of developing such an illness, thereby preventing avoidable relapses and admission.

They provide pre-conception counselling for women with a history of serious mental illness who are considering a pregnancy.

They advise Maternity, Obstetric and Adult Psychiatric Services on the detection, proactive management and prevention of women at high risk of postpartum illness and undertake emergency assessments of women referred for admission.



CR197 and CCQI community standards provide guidance on staffing of Outreach functions and community teams. There are CCQI standards

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 the Royal College of Psychiatrists 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.*

### **3.3 Population covered**

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.

#### **3.3.1 Access and Referral**

##### **3.3.1.1. In-Patient Mother and Baby Units**

Referrals will be considered in line with the relevant admission protocol from:

- Adult Mental Health Teams, CAMHS and other mental health services
- Internally from Specialised Perinatal Community Mental Health Teams
- GPs (if included in local admission protocols)
- Maternity Services and Obstetricians

##### **3.3.1.2. Emergency Admissions.**

These are the majority of admission. The patient will be acutely ill and usually within 12 weeks of childbirth. The patient will be assessed and accepted by a senior clinical member of the services either by telephone or by face to face assessment by members of MBU and/or Outreach function. Admissions can be accepted 24 hours a day, 7 days a week. This process is necessary to avoid delay in admission and the intermediate use of an admission to a General Psychiatric Unit without their baby.

##### **3.3.1.3. Planned admissions**

These are the minority of admissions. Non-urgent, serious/complex conditions will be assessed by one or more senior clinical member(s) of the In-Patient Mother and Baby

Unit or the Outreach function at a site most suited to the woman's needs. The potential admission will be discussed with the multidisciplinary team and referrer. Planned admissions also include those at high risk of an early postpartum relapse or recurrence of a pre-existing condition. The planned admission will be part of the patient's perinatal care plan drawn up by the Specialised Perinatal Mental Health Service.

### **3.3.2. Discharge and Exit**

#### **3.3.2.1. In-Patient Mother and Baby Units**

Women admitted to In-Patient Mother and Baby Units will remain in the care of the Specialised Service until their discharge from In-Patient care. Only in exceptional circumstances (such as a decision to remove their baby from their care or if a woman requires PICU care) will women be transferred from an In-Patient Mother and Baby Unit to a General Psychiatric Admission Unit.

Following discharge from an In-Patient Mother and Baby Unit stay, women will receive care and support from the Outreach function for a variable period of time, typically not less than 3 months (see below).

#### **3.3.2.2. Outreach Function**

Recently discharged in-patients will remain in the care of the Outreach function associated with the MBU until they no longer require intensive home support, their condition has stabilised and the risk of recurrence and readmission has passed. They will then return to the care of the Specialised Perinatal Community Team/Community Team funded by the CCG(s) until they have recovered and no longer require specialist secondary psychiatric care. At this point, usually before the end of the first postpartum year, they will either be discharged into the care of their general practitioner or if necessary transferred to non-specialised mental health teams to meet their longer term mental health needs.

Women referred to the Outreach function who have a prior serious psychiatric history and are at high risk of a relapse or recurrence will be monitored and supported by the Outreach function for at least 3 months following delivery. Once the risk of recurrence and admission has passed, they will either be referred back to their general practitioner or in the case of longer mental health needs, to the appropriate Adult Mental Health Team.

### **3.3.3 Outreach Service (the prescribed component of Specialised Perinatal Mental Health Services)**

They provide assessment and care of women in pregnancy and the postpartum year who meet the following criteria:

- Women discharged from Specialist In-Patient Mother and Baby Units
- Women with the following conditions who are at high risk of admission to an In-Patient Mother and Baby Unit (admission vulnerable):
  - Postpartum psychosis; bipolar affective disorder; schizo-affective disorder and other psychoses; serious depressive illness, severe anxiety

disorder

- Women with a history of serious mental illness after childbirth or at other time
- Women who require a high intensity of specialist input because of serious/complex disorder on a weekly or more frequent basis
- Women with a history of serious mental illness who are considering a pregnancy (pre-conception counselling).

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **3.4.1. Acceptance Criteria**

##### **3.4.1.1. In-Patient Mother and Baby Unit**

###### **3.4.1.1.1 Emergency Admissions**

Women in the last trimester of pregnancy or the first 9 months following delivery who are suffering from an acute episode of serious mental illness including:

- Postpartum Psychosis.
- Bipolar Affective Disorder.
- Schizo-affective Disorder and other psychoses.
- Severe Depressive Illness.
- Other serious/complex conditions.
- Mothers with these conditions under the age of 18, if there is significant perinatal mental illness and they are likely to be the infant's principal carer. In-Patient Mother and Baby Units are suitable for the admission of a young mother but the admission will be managed in collaboration with Child and Adolescent Mental Health Services (CAMHS) and Social Services.
- In-Patient Mother and Baby Units should be adequately resourced to manage acutely ill women. In the rare occasion when the mother poses such a risk to herself or others, that it is necessary to access a PICU then the mother and baby unit should maintain regular contact with the PICU to ensure that, as soon as PICU care is no longer required, transfer to an In-Patient Mother and Baby Unit is arranged promptly.

Mother and Baby Units as an emergency but this will be on a case-by-case basis, taking into account the best interests of the infant.

###### **3.4.1.1.2 Planned admissions**

Women with a prior history of serious mental illness and a high risk of postpartum relapse in the first few days following delivery can be admitted following a prior multidisciplinary assessment shortly before or immediately after delivery until the period of risk has passed.

Other cases of serious/complex disorder posing management problems in Adult Mental Health Services that cannot be safely managed in the community and require specialist perinatal assessment and care.

Admissions can be accepted in a planned fashion after a multidisciplinary assessment and discussion with the referrer.

- Wherever possible, mothers will be admitted to the nearest in-patient mother and baby unit. If that is full, then referrers should be informed of likely future availability and availability in other mother and baby units, ensuring that an appropriate plan is made for the woman's immediate care, which has involved the woman and her family. If the woman is not admitted to an alternative In-Patient Mother and Baby Unit, the nearest In-Patient Mother and Baby Unit should make daily contact with the referrer to update plans for her care, until either she is admitted to an In-Patient Mother and Baby Unit or her need for admission has passed.

### 3.4.2 Exclusion criteria

Women will not be admitted to an **In-Patient Mother and Baby Unit** under the following circumstances:

- For the sole purpose of a parenting assessment unless they are also suffering from, or there is a suspected/potential, serious or complex mental illness.
- Women with severe personality disorder, learning disability or substance misuse unless they are also suffering from, or there is suspected, serious mental illness.
- If there is evidence that the mother will not be capable of independent functioning in caring for her infant in the community even with reasonable support?
- If there is evidence of serious violence/aggressive behaviour that might pose a risk of harm or injury to her own or other babies on the In-Patient Mother and Baby Unit.

Women will not be under the care of the prescribed **outreach** component of Specialised Perinatal Mental Health Service if:

- They are not admission vulnerable
- They have a condition of mild to moderate severity that does not require the Specialised Perinatal Mental Health services and/or can be managed effectively in Primary Care
- They have a severe personality disorder, learning disability or substance misuse unless they are also suffering from serious or complex mental illness.

## 3.5 Interdependencies with other services/providers

### 3.5.1 Co-located Services

Specialised In-Patient Mother and Baby Units will be located on the same site as an Adult Psychiatric Admission Unit to allow for clinical cover and assistance in emergencies.

### 3.5.2 Interdependent Services

There will be easy access to the following Acute Trust Services preferably co-located with but if not within a short travelling distance:

- A Maternity Unit to allow for the joint care and speedy transfer of pregnant and recently delivered women, Neonatal and Paediatric Services, including Paediatric A&E.
- Perinatal Outreach Services are co-located and/or integrated with Perinatal Community Teams or with mother and baby units.

### **3.5.3 Related Services.**

Close working relationships will be provided between Specialised Perinatal Mental Health Services and:

- Adult Mental Health Services including Crisis and Home Treatment Teams and Out of Hours Services
- Extended Primary Care Services including Health Visiting.
- Improving Access to Psychological Therapies (IAPT) Services.
- CAMHS Services
- Perinatal Community Mental Health Teams (commissioned by CCGs)

### **3.5.4 Perinatal Mental Health Clinical Networks**

Specialised Perinatal Mental Health providers will be members of the appropriate Perinatal Mental Health Clinical Network alongside other commissioners, including CCGs, and people with lived experience to ensure a holistic pathway covering community as well as inpatient services.

## **4. Applicable Service Standards**

### **4.1 Applicable national standards e.g. NICE**

#### **National Institute for Health and Care Excellence (NICE) Guidelines for Antenatal and Postnatal Mental Health (2014)**

NICE recommend the provision of Specialised In-Patient Mother and Baby Units and Specialised Perinatal Community Mental Health Teams for all women requiring secondary psychiatric care in pregnancy or the postpartum year. Women should not be admitted to an Adult Psychiatric Admission Unit without their baby unless there are specific reasons to do so. They also recommend treatment and management guidelines for pregnant and postpartum women and recommendations for service design.

## **4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

### **4.2.1 The Royal College of Psychiatrists CCQI Standards for In-Patient Mother and Baby Units.**

These are nationally accepted consensus, appraisal and accreditation standards for Specialised Perinatal In-Patient Mother and Baby Units. These set down the minimum requirements for the treatment and management of women with serious postnatal psychiatric disorder who are admitted to Specialised Perinatal In-Patient Mother and Baby Units, the resources and facilities and staffing of In-Patient Mother and Baby Units and the interventions and resources available. For accreditation purposes these are divided into Level 1, 2 and 3. For accreditation, the Unit must meet 100% of Level 1 Standards and 80% of Level 2. Specialised In-Patient Mother and Baby Units will be members of the RCPsych CCQI and be accredited by them.

### **4.2.2 The Royal College of Psychiatrists CCQI Standards for Specialised Perinatal Community Mental Health Teams**

These are consensus standards for the staffing and function of Specialised Perinatal Community Mental Health Teams and the care and treatment provided by these Teams. It is an appraisal network. Specialised Perinatal Community Mental Health Teams will be members of the relevant RCPsych CCQI and undertake annual appraisals. These standards can be accessed using the following link:

The most recent CCQI service standards (fourth edition) for Perinatal Community Services:

- [Service standards perinatal community health](#)

### **4.2.3 Royal College of Psychiatrists College Report 197**

These are standards devised by the Perinatal Facility of the Royal College of Psychiatrists. They stipulate the design of perinatal mental health inpatients and community services.

## **4.3 Equity of Access, Equality and Non-Discrimination**

All providers are required to comply with the service conditions of the NHS standard contract section “SC13 Equity of Access, Equality and Non-Discrimination” and “SC14 Pastoral, Spiritual and Cultural Care”.

## **5. Applicable quality requirements and CQUIN goals**

### **5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**

### **5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

CQUIN to be established once the 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

- With reference to items identified in **Section 2.1.1**
- Service response (implementation) to RCPsych CCQI annual appraisal.
- As indicated in schedule 4 part C (NHS England standard contract) Local Quality requirements.

#### 5.3.2 Clinical outcome measures

- Clinician Reported Outcome Measures (CROM) e.g. HoNOS, BPRS, Crittenden Care Index for changes in mother infant dyadic relationship
- Patient Reported Outcome Measures (PROM) e.g. POEM, CORE
- Patient Reported Experience Measure (PREM)e.g. POEM

#### 5.3.3 Quality Indicators

Quality indicators for this service are detailed below.

	Indicator	Data Source	Outcome Framework Domain	CQC Key question
<b>Clinical Outcomes</b>				
101	Number of readmissions within one month of discharge	Monthly patient level data	1, 2, 3, 4, 5	safe, effective responsive caring
102	Number of admissions with a relapse or recurrent condition	Monthly patient level data	1, 2, 3, 4, 5	safe, effective responsive caring
103	Average delay to discharge	Specialised Services Quality Dashboard	3, 5	safe, effective responsive caring
104	Mean length of stay	Monthly patient level data	3, 5	safe, effective responsive caring
105	Number of times Mental Health Act used	Monthly patient level data	1, 2, 5	safe, effective responsive caring
106	% of patients where information sent to the receiving clinician and GP.	Specialised Services Quality Dashboard	2, 4	safe, effective responsive caring
107	Rate of complaints	Specialised Services Quality Dashboard	4	safe, effective responsive caring

108	Proportion of complaints received by Trust/organisation from service users	Specialised Services Quality Dashboard	4	safe, effective responsive caring
	<b>Indicator</b>	<b>Data Source</b>	<b>Outcome Framework Domain</b>	<b>CQC Key question</b>
109	Proportion of complaints received by Trust/organisation from carers	Specialised Services Quality Dashboard	4	safe, effective responsive caring
<b>Patient Experience</b>				
201	Patient feedback	Specialised Services Quality Dashboard	4	responsive, caring
202	PROM	Service Quality Performance Report	4	responsive, caring
<b>Structure and Process</b>				
301	Inpatient core staff	Self-declaration	1,2,3,5	safe, effective responsive caring
302	Adherence by In-Patient Mother and Baby Unit to all level 1 Standards of the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI).	Self-declaration	3,4	safe, effective responsive caring
303	There are agreed clinical protocols	self-declaration	1,2,3,5	safe, effective
304	Supervision and support	Self-declaration	1,2,3,5	safe, effective responsive caring
305	Clinical audit	Self-declaration	1, 2	safe, effective caring

**6. Location of Provider Premises**

**The Provider’s Premises are located at:**

- Northumberland, Tyne and Wear NHS FT: Beadnell Mother and Baby Unit, Morpeth, Northumberland
- Leeds Partnership NHS FT: Mother and Baby Unit, The Mount, Leeds
- Manchester Mental Health and Social Care Trust: The Anderson Ward, Wythenshawe Hospital, Manchester
- Nottinghamshire Healthcare NHS Trust: Margaret Oates Mother and Baby Unit, Queen's Medical Centre, Nottingham
- Derbyshire Mental Health Services NHS FT: The Beeches, Derby City General Hospital, Derby
- Leicestershire Partnership NHS Trust
- South Staffordshire and Shropshire Healthcare NHS FT: Brockington Mother and Baby Unit, St George's Hospital, Stafford
- Birmingham and Solihull Mental Health NHS FT: Mother and Baby Unit, The



Barberry, Birmingham

- Hertfordshire Partnership NHS FT: Thumbswood Mother and Baby Unit, SD
- North Essex Partnership NHS FT: Rainbow Mother and Baby Unit, The Linden Centre, Chelmsford, Essex
- East London NHS FT: East London Mother and Baby Unit, City and Hackney Centre for Mental Health, London
- Central and Northwest London NHS FT: Coombe Wood Perinatal Mental Health Unit, Coombe Wood, London
- South London and Maudsley NHS FT: Channi Kumar Mother and Baby Unit, Bethlem Royal Hospital, Kent
- Avon and Wiltshire Mental Health NHS FT: New Horizons Mother and Baby Centre, Southmead Hospital, Bristol
- Hampshire Partnership NHS FT: Winchester Mother and Baby Unit, Melbury Lodge, Winchester, Hampshire
- Dorset Healthcare University NHS FT: Florence House Mother and Baby Unit, Bournemouth