Hampshire Perinatal Mental Health Service: Integrated community and inpatient care

Annual Report 2013

UK Mental Health Team of the Year 2013
- nine years after winning Team of the Year in 2004
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2013 has been a year of consolidation and recognition by others, as well as facing local challenges and contributing to external opportunities. This follows the 5 year process of reorganisations and changes in jobs, locations and even inpatient services that preceded it, and led to the creation of the Hampshire-wide integrated community and inpatient specialist perinatal service. That process was led by the service itself with the aim of ensuring equitable, high quality specialist perinatal mental health care across the whole of Hampshire and Southampton City.

This year we set ourselves objectives of assuring the quality perinatal health care we offer, engaging with the individuals and population we serve, and working with others to try to meet the needs of the whole population of mentally ill mothers and their infants. Every member of the team has actively contributed to our collective efforts. This report provides a summary of this work, and looks forward to 2014 as a year of innovations and further quality enhancement to meet emerging challenges and opportunities.

1. OUR SERVICE
(for more detail request ‘What we do’, our plain English Operational Policy)

1.1 Our Values

- To be flexible, patient and child centred, needs led, evidence based and innovative in our approach to the care of patients and their families, providing and supporting high quality care across the whole antenatal and postnatal mental health pathway.

- To reject rigidity, traditional approaches which cannot be justified, defensive attitudes and practices, and activities which have no impact, whether directly or indirectly, on patient care.

- To work together collaboratively with high levels of mutual respect and trust for each other’s skills, knowledge and work.

- To support each other in enhancing the quality of what we do, to enhance our sense of empowerment, enthusiasm and motivation and to support each other’s individual professional needs and development.

1.2 What we do

The Perinatal Mental Health Service provides a specialist service for the assessment and treatment of women with severe mental health problems in pregnancy and postnatally, at home or in hospital.
Our aims are to improve the health and wellbeing of women who have, or are at risk of, severe mental health problems antenatally and postnatally and to improve outcomes for them, their infants and their families.

The service is for:

- women who are severely mentally ill during pregnancy or within one year of childbirth and are likely to require inpatient mother and baby care
- pregnant women with a past history of severe mental illness for preventative work
- women with less severe or disabling antenatal and postnatal illnesses: we provide advice and limited shared care according to patient need
- professionals, who are encouraged to telephone us for advice: we try to respond to calls within a day of a message being left

Awareness of the service is generated through the distribution of leaflets, our website and meeting with the various groups to discuss what the service provides and to share information on perinatal mental health issues. We provide regular programmes of training to primary care, maternity, child and mental health professionals and to third sector organisations.

1.3 Catchment area

The service is for women and their babies in the whole of Hampshire and Southampton (but excluding Portsmouth), covering over 15,000 births/year. Women can be seen in their homes, in maternity units or other health settings within this area. The Mother and Baby Unit are for women from across the south of England and the Channel Islands.

1.4 Referrals

We welcome referrals from any professional in primary or secondary care but request that referrers liaise with the patient’s GP prior to the referral being made.

1.5 How we work

1.5.1 Direct patient care

- Most of our community work is domiciliary. Home visits have multiple advantages: seeing women in their own environment facilitates contact with the family and reduces stigma; they eliminate the difficulty of travelling to appointments for women with significant mental health problems and the care of a baby/other children.
• The MBU provides advice and admission 24 hours a day throughout the year. There, we provide a full package of high quality, expert and individualised care to women experiencing the most severe and high-risk periods of illness, after 24 weeks of pregnancy or in the first year postnatally.

• In the community, we are not resourced to provide the full range of services that patients with complex needs require (eg. out of hours community care, crisis response, individual psychological therapies). Therefore, our Operational Policy specifies that we only provide services in conjunction with the local Community Mental Health Team. This also ensures better continuity of care for patients with long-term mental health problems who are only temporarily cared for by us. However, we have found that in many cases this is inefficient and unnecessary for standard level needs. We therefore share care on all highly complex cases but can provide standard care within the service where appropriate.

• In a continuing effort to enhance productivity, so that we can meet the needs of women from a much larger area, we have increased our use of telephone consultations. We are increasingly doing this not only for patients who are allocated at referral to telephone assessment but for triage, review and follow up of patients who are also receiving face-to-face care.

• We are unable to provide out of hours services or emergency responses in the community. However, we try to work as flexibly as possible and we often respond very rapidly (even within a few hours) when required and if possible.

• All our clinical correspondence in the MBU and in the community is addressed to patients and copied to all professionals involved in that patient’s care.

• All copies sent to professionals have a ‘footer’, reminding them to refer patients who are pregnant who have a diagnosis of a major mental disorder, “Don’t forget: Please refer any pregnant women with current or past psychosis (schizophrenia, bipolar/manic depressive) to the Perinatal Service”

• With the agreement of the patient, partners and/or others supporting her are included in the care plan and given information, advice and support.

1.5.2 Indirect care

Important aspects of clinical care, which we support through our activities include:
• Our telephone advisory service, responding to requests for clinical advice from other professionals. Over half of the calls are about prescribing issues.

- We have developed a wide range of printed information for patients, families and other professionals on illnesses, risks and treatments in relation to mothers and babies.

• Regular training programmes for: midwives and student midwives; obstetricians and obstetric trainees; health visitors; GPs and GP trainees; mental health professionals and trainees; medical, nursing, OT and psychology students; and third sector organisations such as Homestart.

• We encourage and support the development of antenatal and postnatal depression groups provided by other services such as children's centres, health visitors, IAPT services and voluntary organisations.

• Our popular, free, multi-agency/multidisciplinary service Open Day provides:
  - information for other professionals about our work
  - an educational event for updating others
  - with others on clinical and training needs in this field
  - an opportunity for us to meet new staff joining local services

2. WHO WE ARE

2.1 Staff

Staff bring to the team a wide range of knowledge, experience and skills, with backgrounds in administration, management, mental health and nursery nursing, psychology, psychiatry, occupational therapy and social work.
2.2 Team functioning

- We work in a highly collaborative fashion with high levels of mutual respect and trust for each other’s skills, knowledge and work.

- We aspire to be flexible, patient-centred, needs led, evidence based and innovative in our approach to patient care.

- We reject rigidity, traditional approaches that cannot be justified, defensive attitudes and practices and activities that have no impact, whether directly or indirectly, on patient care.

- The morale amongst staff in the team is high, although we acknowledge that there are challenges, which we work to address.

- We place considerable importance on peer support within the team: for our clinical work in clinical team meetings; to enhance the quality of what we do through our quality improvement and reflective practice sessions; to enhance our collaborative attitudes and trust through all our joint activities including regular team social activities; to enhance our sense of empowerment, enthusiasm and motivation through team business and development meetings, and away-days; to enhance our professional development through educational meetings, external educational events and team supervision sessions (in addition to the high priority placed on individual supervision and development).
o Quality improvement processes

Processes for improving quality of care are well established in the team. They include:

- An Annual Team Awayday, focused on developing the annual objectives and strategy for the team in the coming year.

- Quality improvement sessions (1hr monthly):
  - attended by all
  - agenda set in response to patient and referrer feedback and proposals from team
  - actions reviewed on a six monthly basis
  - notes/action plans posted in team base (for an example see Appendix 2)

- Education sessions (1hr monthly) with internal and external contributors

- Business meetings (1-2hrs monthly) to deal with any issues affecting the team as they arise and implementation of operational/service changes

- Peer supervision and reflective practice sessions (1hr weekly) were introduced this year, rotating between mother-infant video, CBT, general reflective practice (all facilitated by Hannah Wilson, psychologist) and safeguarding supervision (facilitated by Kim Garner, social worker).

3. ACHIEVEMENTS IN THE PAST YEAR

3.1 Quality improvement

- The service won the 2013 UK Mental Health Team of the Year Award, nine years after winning this in 2004. Members of the team attended the award ceremony at the Royal Society of Medicine, which was a grand and spectacular affair, with 3 winners from the Perinatal field in different categories. We received several letters of support for our nomination from a range of people and agencies we work with and support (see appendix).

- At our Awayday in 2012, the team set its Quality Objectives for 2013, which have all seen major progress through the joint efforts of all staff:
  - Participate in first national peer review for community teams.
    - Achieved
• Meet all the MBU quality standards set by the National Perinatal Quality Network.
  ✔  Achieved

• Improving care for women with Personality disorder/complex-PTSD
  ✔  See 3.1.1 below

• Improve maternity liaison
  ✔  Achieved so far:
    o network of link midwives in every maternity service, 3 meetings held this year
    o monthly training days held on MBU for maternity (and other professionals): 80 participants this year
    o established link with Dorset Perinatal Service to share regional training to others: so far we have trained midwives in Hants and Surrey; they have covered Dorset and Wilts.
    o First multiagency meeting held in Southampton (IAPT, maternity, Health Visiting, Adult Mental Health, and us): we will replicate across Hants during 2014.

• Reaching the whole population
  ✔  Achieved so far:
    o Analysis of our patient population and comparison with local demographics to identify under- or over-represented groups. This highlighted the under-representation of the traveller community and we have developed a plan to reach out to them.
    o We have undertaken translation of many of our materials into the more commonly spoken languages in this area.
    o We were awarded a Bronze Equality and Diversity Award by the Trust in the first wave of these new awards. Jemima, who has led this project, was given a personal special commendation.

• Carry out audit of preventable admissions.
  ✔  Spanish doctor on sabbatical with us has completed this – results see appendix

• Audit our innovative letters to patients.
  ✔  Audit completed, currently being written up

• Lead development and piloting of national Patient rated Outcome and Experience Measure (POEM) for perinatal.
  ✔  Development completed, first pilot conducted and data collected by medical student. Currently being written up.

• In addition we have responded to challenges and opportunities which have emerged during the year by making plans and changes to improve the quality and outcomes of the care we provide:
To gauge mothers perceptions of our monitoring and safeguarding procedures for babies on the ward, we developed a questionnaire and are now collecting the views of women, which will be analysed and acted upon during 2014.

We have engaged with commissioners to develop video conferencing clinical consultations, using CQIN funds. Funding has been agreed and we will be developing this work during 2014.

3.1.1. Developing a pathway for women with personality disorder/ Complex-PTSD in the perinatal period – ongoing development work started in 2012:

MBU staff have received a 3-day training in Dialectical Behaviour Therapy, allowing them to run an 8 session Emotional Coping Skills Group for woman admitted to the unit. This group was evaluated showing excellent outcomes of reduced distress, symptoms and improved confidence and ability to deal more effectively with strong emotions.

Four members of the community team then attended the Trust Up to Speed DBT training. In 2013 we worked with a patient to develop and run a 14 session Emotional Coping Skills group for community patients that focused on teaching DBT skills and how to apply them living with a young family and/or being pregnant. Following this first, highly successful group, further groups are planned for 2014. These will be held in Southampton, where patients have no access to any such groups.

In the rest of Hampshire we have negotiated access to ECS groups available through Adult Mental Health Services.

We have developed an information leaflet about Complex-PTSD which has been very well received by patients and staff. This is part of a gradual transformation in our approach to women who would previously have been diagnosed with Borderline or Emotionally Unstable Personality Disorder, acknowledging the symptoms as an understandable (but unhelpful) response to developmental trauma.

3.2 Patient involvement

Our aim is to involve patients in all aspects of services development, review and also delivery of care. We have developed a questionnaire to send out to all patients using the service to gauge their interest in helping us improve and develop the service. It aims to establish what areas they are interested in and identify what specific experience or skills they can offer.
• We have developed plans to set up peer support within the perinatal services, a WRAP group co-facilitated with staff and ex-patients who have completed their own WRAPs, and a co-facilitated Emotional Coping Skills course.

• We are working with an ex-patient to create ‘digital stories’ that can be placed on the website for other mums and professionals to hear about experiences and recovery journeys from some of our mums, to inspire, offer hope and be used as an educational/training tool.

• Ex-patients have helped us write, and translate into several languages, a series of information leaflets on topics selected by patients.

3.3 Training Received

As a sub-speciality tertiary service, the team places great emphasis on ensuring that all staff are up to date with their knowledge, understanding and skills. A high priority is therefore placed on training and links with other similar services across the UK. Thus, in addition to general mandatory training for all staff, this year the team has been involved in a wide range of valuable specialist training:

• In-house training programme to meet identified team training needs – one hour monthly throughout the year, for all staff.

• Team or individual attendance at the following meetings:
  • Royal College of Psychiatrists Perinatal Section Annual Meeting
  • Royal College of Psychiatrists Annual Meeting
  • Perinatal Network Annual Forum
  • Marcé Society Annual Conference and Scientific Meeting
  • National Annual Two Day Perinatal Mental Health Course
  • Association of Infant mental Health Annual Meeting
  • Infant mental health course at Anna Freud Centre
  • Various therapy training courses described elsewhere

3.2 Training Delivered

• We aim to make at least one presentation about an element of our work to a national conference every year. This year, our nursery nurses presented at the National Perinatal Mental Health Nursery Nurses Annual Conference, hosted by the RCPsych Quality Network.

• We offer a full time Specialist Registrar training post, one of only a handful of Perinatal training posts in the UK, which is a popular and highly rated placement.
The range and quality of clinical experience available are particularly valued, including: assessment, in a variety of settings, of maternal mental illness, maternal-infant relationship, parenting and family dynamics; supervised individual and family based interventions; specialist inpatient and domiciliary work. A rich experience is also gained in liaising with professionals in other areas including GPs, health visitors, midwives, obstetricians, general adult mental health, child health, child mental health and child social care. All senior trainees get management or service development experience by leading a project within the team, the Trust or in links with local and national commissioning and quality assurance bodies. We also provided a session of special interest training for an additional Specialist Registrar.

- We provide highly rated training to students: nursing, midwifery, social work, psychology, occupational therapy and medical.

- We have established a successful and popular specialist placement for medical students, with the highest feedback scores of all specialist placements.

- Regular multidisciplinary training to primary care, mental health, maternity and social care professionals.

- We regularly offer training to third sector organisations. For example we provide an annual session for Homestart focussing on basic information about illnesses, their impact on mothers and families and what the third sector can do to minimise suffering and disability, and help recovery.

3.4 Audit

- Audit, currently being analysed, of letters written to patients.

- Continuous ongoing audit of patient and referrer satisfaction.

- Participate in Trust Annual Audit Programmes, which includes safeguarding children, case note audits, safeguarding adults.

- Following this year’s visit by the National Perinatal Quality Network, we were awarded re-accreditation.

- We participated in the first wave of the national quality network for perinatal community teams.

3.6 Collaboration with others

*With patients*
• All patients receive a summary letter written to them about their assessment, with a clear care plan and another letter summarising care and further recommendations when they are discharged from the service. Patients take an active part in developing their care plan. An audit of this has showed high satisfaction from patients and referrers and was repeated in 2013 (data being analysed).

• We send all patients a list of information sheets and leaflets covering a wide range of topics. They can tick the ones they want, return the form to us and we send them the leaflets.

• We provide up to date, patient friendly advice sheets. (Available on request)

*With professionals*

• In addition to delivering training and the support to the new link worker network (see above), we hold a popular open day for all professionals, providing information and education. This year over 60 professionals attended, with excellent feedback.

• **Link worker network** During 2013 we have continued to work with other services (health visiting, maternity and children’s social care) to establish a network of named link professionals. We will have regular meetings with the newly established network to enhance communication and quality across the APMH (Antenatal and Postnatal Mental Health) Pathway (see appendix 1).

*External links*

• In addition to networking through attendance at national meetings and through the peer review process, we have hosted visits from other services working on the development of perinatal teams and shared our good practice and materials.

• Alain Gregoire keeps the team up to date with relevant national and international news and policy through his external leadership roles, for which the team gives him a great deal of support. These include:
  • Member of NICE Guideline Development Group for Antenatal and Postnatal Mental Health (2007 and 2012 review)
  • Chair of RCPsych regional perinatal leads
  • Member of National Commissioning Board Expert Reference Group
  • Chair of Maternal Mental Health Alliance

4. CLINICAL ACTIVITY

4.1 Referrals (community)
Data is currently available for the calendar year 2012: a total of 688 referrals were received by the service, compared to 425 and 484 in 2011 and 2010 respectively. This increase reflects the substantial growth in the population we serve and we anticipate further substantial growth in future years as we continue to raise awareness and expectations amongst professionals and women themselves. Sources of referrals are shown in the table below.

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4.2 Admissions to the MBU

Occupied bed days (OBDs) across Hampshire have begun to reduce, as we hoped following the introduction of the prevention pathway, from 98/1000 births in 2011 to 75/1000. Mean length of stay has changed little at 30 days. Total OBDs for areas not covered by community teams was 1152 (by birth rate not calculable as there is no defined catchment area). In Southampton where we have unchanged prevention services the OBDs were particularly low at 28/1000 (71.2 in 2011), but this appears to be largely due to 3 protracted admissions of women, who would otherwise have come to the MBU, to the Psychiatric Intensive Care Unit.

4.2 Waiting Times (community)

We try to ensure that all referrals are seen as soon as is clinically required and we do not operate a waiting list. If it is felt the referrals do not fit the criteria for the service but still require some specialist advice (eg: pregnant woman with moderate depression needing medication advice), we usually allocate to our Telephone Clinic. Clinicians from the team then telephone the client to assess and advise. A letter is sent summarising the telephone call, which is copied to all professionals involved.
4.3 Telephone Service

Results of a previous audit are shown below.

Fig. 1 below shows the number of calls needed to meet needs patients allocated to telephone clinic. This audit found that 18% of women were re-referred to the service after discharge from the telephone clinic.

Fig. 2 below shows the type of service to which they were then allocated.

5. STAKEHOLDERS (PATIENTS, FAMILY, REFERRERS)

5.1 Involvement in team activities and development

We involve patients very closely in every aspect of their own care and we seek feedback and suggestions about our services from every patient at discharge. User or carer input into our ongoing activities or developments. This presents a considerable challenge as all our users are extremely busy due to their circumstances, are in many cases only temporarily involved with the services and usually want to put their experiences behind them and get on with their lives. We have been fortunate in having a past service user as a member of our inpatient team who has contributed to all our business, educational and team development activities in the past year. We are continuing to explore ways of involving users and carers more.
Despite the major changes that occurred in the service during 2012, feedback from patients and referrers remained generally positive, and has probably not changed significantly overall in either direction. There may have been a pattern of a drop in referrer satisfaction with issues relating to communication. We are aware that there were problems relating to our relocation, including delays and failures in the telecoms and IT systems as well as obvious changes in phone numbers and addresses. In
addition we were starting up a new service in many parts our new area, so some of the low scores may reflect professionals having no knowledge of our service. In response we will focus efforts on communication and information during the coming year and monitor feedback on this issue.

6. ASPIRATIONS

6.1 Objectives for 2014 were developed by the whole team at our Awayday:

- Enhance therapeutic interventions in community and use creatively any opportunities which may arise internally or externally (primary care/IAPT and CTTS) to enhance and prioritise access for our population to psychological therapies.
- Increase the profile of the baby and mother-infant relationship in our work.
- Improve the efficiency of administrative processes and the recording of clinical and quality monitoring information.
- Improve the systems for delivering advice and information to patients, public and professionals.

6.2 Beyond 2014 - long term aspirations

- Women across the south of England will know about the service, where to get help and how to self care. (set in 2011)
- There will be access across the whole perinatal pathway for all women in Hampshire. (set in 2011)
- We will try to become the best perinatal service in the world. (set in 2011)
- We will work with other bodies, services and professionals nationally to establish consistent and equitable services throughout the UK. (set in 2011)
- We will work with other agencies to extend high quality parental mental health care to families with children under 5. (set in 2014)

Achieved in 2013:
- We will try to achieve and demonstrate excellence in the care we deliver, and have this recognised by an external assessment. Set in 2011, Team of the Year Awarded this year.
Direct and Indirect Care Supported by the Perinatal Mental Health Service

**Preconception**
- Education to other professionals
- Advice to other professionals (telephone; written; advice sheets)
- Assessment and Advice to women with psychotic illness

**Pregnancy**
- Education to other professionals
- Advice to other professionals (tel.; written; advice sheets)
- Raising awareness with pregnant women and their families
- Screening for previous psychotic illness
- Home based assessment of high risk and currently ill women
- Integrated care pathway for high risk and SMI women

**Postnatal**
- Health visitor screening programme
- PND groups development and support programme
- Partner information and support
- Assessment of parenting
- Specialist home based Assessment Monitoring Support
- Early post natal ward contact
- Close communication with woman, family and professionals
- Coordinated multiagency care
- Mother and baby inpatient care
- Intensive home based care

**Parenthood**
- SMI parents group
- Raising awareness of needs
- Better start for mother and child
APPENDIX 1 CARE PATHWAYS DEVELOPED BY THE SERVICE (ADOPTED REGIONALLY)

Emotional wellbeing in pregnancy care pathway

Mental health care

History of mental illness and current mental health assessed at first contact and booking

Support from GP, HV and MW, plan continued close monitoring in the early postnatal period. Obtain specialist advice as necessary.

History of possible severe mental illness or current severe illness, identified by any service

Communicate for information

Talking therapies

Other services

Support from GP, HV and MW

If persists or worsens

Specialised perinatal care pathways

Schizophrenia

Depression

Anxiety

OCD

Perinatal specialist infant care (mother and baby unit)

Perinatal MH services

MBU ELEMENT OF CARE PATHWAY

Care of baby and mother infant relationship

Care of mother

Within 24 hours

Welcome and introduction to unit by nurse in charge

Within 7 days

Initial assessment by nurse of immediate needs and risks and initial plan

Baseline care and interaction assessment (Louis Macro + video, with feedback)

Multidisciplinary assessment of needs and risks. Diagnosis, goals for admission and joint care plan agreed.

Assessment of needs, risks and joint care plan

Specialised perinatal care pathways:

Bipolar disorder; Schizophrenia; Depression; Emotional instability; Anxiety; OCD

Assessment of post discharge needs, risks and joint care plan made

Discharge planning meeting: pre and post discharge needs, risks, blocks identified. Plan and preliminary timetable agreed.

Pre discharge assessment of care and interaction

Final post discharge plans agreed

Communicate post discharge plans in letter to patient cc to all involved (within 3 days)

Discharge medication issued. Feedback forms/online survey completed and collected

Weekly MDT summary to referrer and patient

Weekly summary of relevant (NB Caldicott) information to commissioner from MDT

Weekly summary of information to referrer from GP and others

Summarised in letter to patient cc to referrer, GP and others

Summarised in letter to patient cc to referrer, GP and others

Send discharge summary form A to GP within 24 hrs and form B within 7 days

Weekly summary of

Care of mother

Specialised perinatal care pathways:

Bipolar disorder; Schizophrenia; Depression; Emotional instability; Anxiety; OCD

Specialised perinatal care pathways:

Bipolar disorder; Schizophrenia; Depression; Emotional instability; Anxiety; OCD

Specialised perinatal care pathways:

Bipolar disorder; Schizophrenia; Depression; Emotional instability; Anxiety; OCD

Specialised perinatal care pathways:

Bipolar disorder; Schizophrenia; Depression; Emotional instability; Anxiety; OCD
**Winchester Perinatal POEM Patient rated Outcome and Experience Measure**

We are always trying to improve the quality of the service we provide. To help us do this we would be grateful if you could give us your views regarding the service you have received from us. If you have a partner, or someone who has been closely involved in supporting you, who would also like to express their views on the care we offered you, we have enclosed another form for them to fill in. If you would prefer to complete this online please visit [http://goo.gl/dJqAox](http://goo.gl/dJqAox)

- I am a patient
- I am a partner/other (when answering questions, ‘me’ or ‘my’ means the mum/patient)

### 1. Please rate your view of the service based on your own experiences. Please try to tick one answer for each of the questions:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>Staff did not communicate with others involved in my care</td>
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<td>Staff gave me the right amount of support</td>
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<td>I did not get help quickly enough after referral</td>
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<td>Staff listened to me and understood my problems</td>
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<td>Staff did not treat me with respect and dignity</td>
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<td>The information I received from staff was useful and helpful</td>
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<td>Staff did not involve me enough in my care and treatment</td>
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<td>The service provided me with the information I needed</td>
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<td>Staff were not sensitive to my needs</td>
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<td>Staff helped me to understand my illness/difficulties</td>
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<td>Staff were not sensitive to the needs of my baby</td>
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<td>My partner was not well supported by the service</td>
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<td>The service definitely helped me to get better</td>
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<td>Staff helped me be more confident with caring for my baby</td>
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<td>The service involved other relevant people in a helpful way</td>
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<td>My discharge from the service was not well organised</td>
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<tr>
<td>I would recommend this service to others</td>
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Next page ➔
2. If you have been on the Mother and Baby Unit:

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<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know</th>
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<tr>
<td>The unit was clean and hygienic</td>
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<td>The unit did not provide a good place for me to recover in</td>
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<td>The unit did not provide helpful activities and therapies</td>
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<td>The unit provided a good place for my baby to be with me</td>
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<td>The unit supported me in my contact with family and friends</td>
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<td>The food provided was not acceptable to me</td>
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3. Please rate how your mental health has been

<table>
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<tr>
<th>Rating</th>
<th>Very well</th>
<th>Well</th>
<th>Unwell</th>
<th>Very unwell</th>
<th>Extremely unwell</th>
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<tr>
<td>When I first came into contact with the service, I was</td>
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<td>When I was discharged from the service, I was</td>
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<tr>
<td>When you first came into contact with the service, how many days out of the previous 30 had your mental health interfered with your usual activities?</td>
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<tr>
<td>When you were discharged from the service, how many days out of the previous 30 had your mental health interfered with your usual activities?</td>
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4. Please use this space for any other comments about the service and how we could improve it

5. This questionnaire was easy to fill in

<table>
<thead>
<tr>
<th>Rating</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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Please use the space below for any other comments about this questionnaire

Thank you for completing this questionnaire. If you wish to find out more about the Perinatal Feedback Questionnaire please contact the Perinatal Quality Network on 0207 977 6691

Would you be interested in contributing to the improvement of our service by participating in discussion/meetings?  No ☐ Yes ☐

OPTIONAL: If you want to be contacted about helping with our service improvement, please write your
name address/email below. If you prefer, you can tear off and send it to us separately.
APPENDIX 3

TEAM MEETINGS: clarity of purpose

We place considerable importance on peer group support within the service: for our clinical work in clinical team meetings; to enhance the quality of what we do through our quality improvement sessions; to enhance our collaborative attitudes and trust through all our joint activities including regular social activities; to enhance our sense of empowerment, enthusiasm and motivation through business and development meetings, and awaydays; to enhance our professional development through educational meetings (to which all contribute), attendance at external educational events and individual supervision for all team members.

The following meetings are coordinated by a named individual in the service and a programme circulated to all staff.

Inpatient and community clinical meetings:
- **Purpose**: to provide all clinical staff with an opportunity for peer supervision; to support multidisciplinary clinical care; to enhance shared understanding and knowledge; to support good clinical communication
- **Attended by**: all available staff
- **Duration & frequency**: COMMUNITY: two hours per week; INPATIENT: handover 1hr between shifts
- **Informed by**: current patient needs; referrals
- **Outputs**: staff awareness of current caseload; well supported staff; shared knowledge, approach and ethos; consistent and optimised patient care; PMHOTs: triage and allocation of referrals to team

Whole service meetings: (*written outputs in form of action plans detailing what, who and when)

- **Quality improvement sessions (QIS)**
  - **Purpose**: to involve all members of staff in continuous quality improvement and pride in their service
  - **Attended by**: all available staff (standard = min of 70% per team)
  - **Duration & frequency**: one hour a month
  - **Informed by**: patient and referrer feedback, awayday action plan*, proposals from team members
  - **Outputs**: action plans* from each QIS; progress reviewed on a six monthly basis; notes/action plans* posted in team base

- **Education sessions**
  - **Purpose**: to provide all staff with an opportunity to keep up to date with developments in knowledge of relevance to specialised perinatal MH care
  - **Attended by**: all available staff (standard = min of 70% per team)
  - **Duration & frequency**: one hour a month
  - **Informed by**: clinical training needs identified from service/team objectives; individual training analyses
  - **Outputs**: well trained staff; capacity to deliver top quality care

- **Business meetings**
  - **Purpose**: to deal with any issues affecting the team as they arise and implementation of operational/service changes
  - **Attended by**: all available staff
  - **Duration & frequency**: one-two hours per month
  - **Informed by**: current operational issues raised by anybody
  - **Outputs**: staff awareness of operational issues and clear action plans* if appropriate

- **Steering/development Group**
  - **Purpose**: strategic leadership
  - **Attended by**: Lead Clinician, Locality Manager, Team Managers, Matron, Consultants, other relevant senior staff. Patient representative
  - **Duration & frequency**: one hour per month
  - **Informed by**: local, SHA and national needs, policy and standards
  - **Outputs**: strategic direction and action plans*
• Annual Team Awayday
  o **Purpose:** To engage all staff in setting team aspirations and priorities for the coming year
  o **Attended by:** all available staff (standard = min 70% of staff)
  o **Duration & frequency:** one day per year
  o **Informed by:** local and national developments and priorities; feedback from patients and referrers; proposals from staff and other stakeholders
  o **Outputs:** annual strategy for the team in the coming year with clear action plans