Cynulliad Cenedlaethol Cymru / National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Iechyd Meddwl Amenedigol | Perinatal Mental Health
PMH 12
Ymateb gan: Bwrdd Iechyd Prifysgol Cwm Taf
Response from: Cwm Taf University Health Board

1. The Welsh Government's approach to perinatal mental health, with a specific focus on accountability and the funding of perinatal mental health services covering prevention, detection and management of perinatal mental health problems. This will include whether resources are used to the best effect. Cwm Taf context

Poor mental health is both a cause and a consequence of social, economic and environmental inequalities; mental health problems both reflect deprivation and contribute to it. Mental ill-health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical he
alth and adverse life events. Cwm Taf has the highest levels of mental illness and poor well-being in Wales (as measured by the Welsh health survey). In addition, austerity measures and welfare reforms have impacted severely on our area and this may lead to increased inequalities (Beatty and Fothergill 2014). The strongest negative impact of economic downturn is on mental health.

Adult mental health indicators

Indicator	Merthyr Tydfil	Rhondda Cynon Taf	Cwm Taf	Wales	What this means
Adults who reported consuming alcohol above guidelines	37%	41%	40%	40%	More than half of people with substance misuse problems are simultaneously diagnosed with a mental health disorder at some point in their lives, with alcohol being the most commonly reported substance misused
Adults who reported binge drinking	24%	26%	26%	24%	
Mental Component Summary Score (measure of well-being)	47.0	48.4	48.2	49.4	Cwm Taf has the lowest score for well-being in Wales
Adults who reported being treated for a mental illness	18%	15%	16%	14%	Cwm Taf is the highest in Wales
Admissions to mental health facilities (2015/16)			1225		
Suicide rate/100,000 population (2014)			14.1		Cwm Taf is the highest in Wales (Other health board areas range from 10.7 -13.6)

Sources: Welsh Health Survey/ Welsh Government Data Unit/ NCISHP report

The Well-being Assessment published by Cwm Taf Public Service Board acknowledges that having a good start in life is important to the wellbeing of future generations. Some children go through physical, emotional, or sexual abuse or live in families where there is parental separation, substance misuse, domestic violence, or mental illness. These are called Adverse Childhood Experiences (ACEs) and 47% of adults in Wales have experienced at least one ACE during childhood. These experiences cause long lasting health harms which continue into adulthood and older age. Evidence shows that we can have the greatest impact if we focus our efforts in preventing and/or protecting against the impact of ACEs for both parents and children during the first 1000 days of life from conception to age two; looking after women's health before, during and after pregnancy is fundamental to the prevention of ACEs.

In Cwm Taf, figures show that 719 (18%) of women who gave birth in 2016 had experienced a mental health problem. Of these 77 had a severe mental health diagnosis with the vast majority of others being anxiety, and depression

Together for Mental Health (October 2012), a strategy for mental health and well being in Wales and The Strategic Vision for Maternity Services (September 2011) have provided standards and key performance measures for Perinatal Mental Health in Wales.

In 2015 the Minister for Health and Social Services announced that Welsh Government had made available £1.5m of recurrent funding to develop community services for women with perinatal illnesses, their babies and families. The funding was to reflect the numbers of births in each locality, CTUHB was allocated £149,188. Before any monies were released, we were required to submit a concise plan for approval, setting out how the health board intended to utilise the additional funding.

With the funding we established a dedicated multi-professional community based team who work directly with women and their families by promoting their emotional health and well-being and ensuring that those who require specialist Perinatal care have effective integrated care pathways and

management plans in place. The team also provide enhanced support to all the relevant staff who works within our Obstetrics, Gynaecology and Sexual Health, and Mental Health Directorates.

The team consists of a Specialist Perinatal Mental Health Practioner and Specialist Perinatal Mental Health Midwife. Whose posts form the nucleus of our new service and are complimented with dedicated sessions from a Consultant Psychiatrist, a Clinical Psychologist and a staff grade Doctor (Mental Health).

The Cwm Taf Perinatal Mental Health service is based within our Mental Health Directorate's Primary Care Mental Health Support Service (PCMHSS) and has a well established Peri-natal Mental Health Steering Group.

Terms of Reference

- Work collaboratively across the UHB to set up the new peri-natal mental health service
- To develop robust systems and processes to ensure good governance across the service
- To identify appropriate training and induction for staff employed to work within the new service
- To link with the newly established All Wales Steering Group and consider the recommendations from that forum to inform the establishment of the service within Cwm Taf UHB

The team are part of the All Wales Perinatal Mental Health Community of Practice.

2. The pattern of inpatient care for mothers with severe mental illness who require admission to hospital across both specialist mother and baby units (designated mother and baby units in England) and other inpatient settings in Wales. (Since 2013, there has not been a mother and baby unit in Wales).

Since the Mother and Baby Unit (MBU) closed in Cardiff in 2013 there have be no MBU available in Wales. The only available inpatient facilities are in England with the closest being Bristol. However, due to limited availability mothers have been required to travel further and in one case a mother had

to travel to Bournemouth. This has had an impact on the use of valuable staff time to locate available beds with the pressure of having to secure an appropriate bed quickly given the urgency of such cases. Given the distances involved this has an impact on families to provide emotional and practical support to the new mother which can have a negative affect on their emotional health.

In situations where there are no appropriate beds available, 5 women have been admitted to the Royal Glamorgan Hospital Mental Health Unit in the last year. As such, women have been separated from their babies which poses many challenges especially with regards to mother and baby attachment, establishing breast feeding and midwifery care. This can not only have a negative psychological impact on the mother but also on the family whose time can be spilt between caring for the mother and baby in two separate locations.

3. The level of specialist community perinatal mental health provision that exists in each Health Board in Wales and whether services meet national standards.

The table below shows the level of Specialist Community Mental Health provision within Cwm Taf UHB (£149,188) which was accepted by Welsh Government based on our Perinatal Service Plan.

Pay Costs			**£**
Post	**Band**	**WTE**	**Gross Cost p.a.**
Specialist Mental Health Nurse	7	1	50,212
Specialist Midwife	7	1	50,212
Clinical Psychologist (1 session)	8b	0.1	7,084
Consultant Psychiatrist (1	N/A	0.1	11,902

session)			
Middle Grade Dr 1 session	N/A	0.1	9,800
Admin Support	3	0.5	11,683
Total Pay Costs			**140,893**
Non Pay Costs			
Set Up Costs			2,795
Training			2,750
Travel			2,750
Total Non Pay Costs			**8,295**
Grand Total			**149,188**
Balance Remaining			**0**

Assumptions

All costs are provided at top of scale & assume no shift enhancements.

Please see attached Perinatal Quality Network For Perinatal Mental Health Services CCQI Service Standards.

4. The current clinical care pathway and whether current primary care services respond in a timely manner to meet the emotional well-being and mental health needs? Of mothers, fathers and the wider family during pregnancy and the first year of a baby's life.

Referrals are accepted from any health professional working with women in the perinatal period (during pregnancy and up to one month postnatal). Six months after the introduction of the service the referral criteria post-natally was reviewed and changed from one year due to the volume of referrals and capacity of the Perinatal Service.

Referral Criteria

- Women identified during pregnancy who have severe mental illness, bipolar affective disorder, psychosis, psychotic depression, schizophrenia, suicidal ideation
- Women with a severe form of depression, anxiety, obsessional compulsive disorder, phobias, post traumatic stress disorder, personality disorder, pregnancy related mental health problems
- Women identified during pregnancy who are at risk of a serious mental illness (family history of bipolar disorder or severe child birth related mental illness i.e. puerperal psychosis
- Women with alcohol/substance misuse problems if there is an identified moderate to sever mental illness
- The team will work jointly with the local CAMHS services to provide care to patients under the age of 18 years

Within maternity services all pregnant women are booked by a community midwife usually between 8 and 10 weeks of pregnancy and during the booking appointment women will be asked a series of questions related to their mental health and family history (All Wales Maternity Records). If women respond positively to any of the questions this will be discussed by a telephone consultation in the first instance with the Perinatal Mental Health Team.

If a referral is accepted by the team it will be discussed in the referral meeting which is held weekly. Referrals will be discussed and allocated to

one of the team and an appointment will then be offered to the woman within 4-5 weeks.

All women under the care of the Perinatal Mental Health Team will have a mental health and well being birth plan in place. These plans have proved valuable to both women, maternity and mental health staff.

The Perinatal Services have established pathways with all stakeholders within Primary Care based on open and frequent communication channels and clear referral and care pathways. The role of the Consultant Psychiatrist within the Service provides expert advice and support to the team and colleagues as well as offering timely out-patient appointments.

5. Consideration of how well perinatal mental healthcare is integrated, covering antenatal education and preconception advice, training for health professionals, equitable and timely access to psychological help for mild to moderate depression and anxiety disorders, and access to third sector and bereavement support.

The role of the Specialist Perinatal Midwife and Clinical Nurse Specialist (Mental Health) have been invaluable in embedding effective integration of the maternity and mental health services. This close partnership working within the Perinatal Service has enabled joint working with other health professionals which has increased their knowledge and skills. The Service has been identified as providing specialist advice and support at a single point of contact.

The Perinatal Service works closely with the DGH Psychiatric Liaison, CMHT, Primary Care Mental Health and Crisis Services which has resulted in more timely assessments and treatments.

The close links with the DGH Psychiatric Liaison Team has facilitated effective partnership working with the maternity unit being able to access advice and support much quicker with specialist input from the Perinatal Service. This is supported by the provision of the Mental Health and Well Being Birth Plan.

All women are asked about their mental wellbeing and family history at the booking interview and provided with Bump Baby and Beyond information book which includes information about emotional wellbeing in pregnancy and post birth. The fourth version of the All Wales Maternity Records due to

be introduced shortly includes the question at each consultation: 'Have you over the last two weeks been able to stop or control worrying?' This will facilitate inquiry of women's emotional health and wellbeing at each ante-natal contact.

With regards to ante-natal education there is a drive towards having information being delivered in a more uniform fashion. All midwives involved in Parentcraft attended Enjoy your Bump Training session, which covered mental health and wellbeing some of which could be incorporated into Parentcraft education.

Pre conception counselling is not available within our team at present but is something we hope to provide in the future.

The Perinatal Services have been supported within the Health Board and through the All Wales Community of Practice to attend relevant study days and events. The learning from these events has had a positive effect on developing our Services and improving the knowledge and skills of our colleagues.

Research has shown that mothers with low mood and anxiety can benefit from supportive and psychologically informed conversations about mental health issues with midwives and health visitors. This provides a non-stigmatising environment, usually within the woman's home and it reduces the demands placed upon secondary mental health services. Currently no systematised model specific training is provided for midwives and health visitors to give them skills and a level of confidence enabling them to have supportive useful conversations about a woman's mental health. The Perinatal Services are currently exploring suitable training opportunities to address this need. Promoting and protecting the well-being of all women in the perinatal period would further support the prevention of ACEs.

The Specialist Nurse and Midwife have a close working relationship with the midwife counsellor who they meet with on a regular basis. They also work closely with Mind, Two in Mind, HomeStart, Action for Children, CAB, and have contact with various other organisations.

The Service has access to one session per week of a clinical psychologist. Whilst this is an important part of our Service the restrictions in funding has limited the availability of psychological intervention, supervision of staff and training.

The team are able to refer and signpost to the following groups and support networks :

Blue Bells Group, Enjoy Your Baby, Enjoy Your Bump, Valley Steps,

Primary Care Mental Health Support Service, Cruse, SANDS, Miscarriage Association.

6. Whether services reflect the importance of supporting mothers to bond and develop healthy attachment with her baby during and after pregnancy, including breastfeeding support.

In line with The Strategic Vision for Maternity Services (September 2011) the Perinatal Service has been developed around the needs of the mother and baby. The Specialist Nurse and Midwife play a vital role in supporting mothers to bond and develop healthy attachments by working closely with their colleagues in Midwifery and Health Visiting Services.

This is achieved by 1:1 consultations/parenting education (usually in the client's home), promotion of breastfeeding and additional support within the post natal period. Close communications with Midwives and Health Visitors facilitates continuity of information and advice with additional support of the infant feeding co-ordinator when required.

On occasions where women have had to be admitted to our Mental Health In-Patient Services the Specialist Perinatal Nurse and Midwife have worked closely with the mental health and obstetric services to minimise the negative impact on bonding/attachment and breastfeeding whilst the mother and baby are separated.

7. The extent to which health inequalities can be addressed in developing future services.

The Perinatal Steering Group provides the governance framework for monitoring standards within the service and health inequalities/service developments.

Six months after the introduction of the service the high volume of referrals led to a review of the referral criteria. This review led to the introduction of a telephone triage to assess the appropriateness of the referral and reduction in post natal time from a year to one month.

Whilst the reduction to one month was a difficult decision for the team to make they did not have the capacity to meet the referral demands.

Although we acknowledge the funding of Welsh Government was based on the number of births and didn't take into account what Perinatal Services each Health Board had in place the funding allocated to Cwm Taf UHB where no previous perinatal service existed has limited the service we can provide currently by a small team. With Cwm Taf having the highest levels of mental illness and poor well-being in Wales due to the levels of health inequalities and social depravation we would welcome a review of Welsh Government funding in order to further develop our Perinatal Service in line with other Health Boards in Wales.

PERINATAL QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

CCQI SERVICE STANDARDS

Informal review of where Cwm Taf UHB Perinatal Mental Health Team are within relation to the standards

Cwm Taf UHB Perinatal Mental Health Team:

Dr Vaidya Consultant Psychiatrist 2 sessions per week

Dr Kele Psychiatrist 1 session per week

Lynn Rodgerson Clinical Nurse Specialist wte

Lisa Nickels Specialist Midwife wte

Stella Swift Clinical Psychologist 1 session per week

Kimberley Jones Administrator 18.5 hours per week

The team covers the whole of Cwm Taf UHB

	Type	Standard	
1		Access and Referral	
1.1		*The service provides information (in written and electronic form) for patients and professionals on:*	
1.1a	2	A description of the service	YES
1.1b	1	Clear referral criteria	YES
1.1c	1	Clear clinical pathways describing access and discharge	NO
1.1d	1	How to make a referral	YES
1.1e	1	Contact details, including emergency and out of hours details	YES
1.2		*The service is provided for the following groups in a defined catchment area:*	
1.2a	1	Women following discharge from an inpatient stay	YES

1.2b	1	Women suffering from bipolar illness / puerperal psychosis, other psychoses and serious affective disorder, who can be safely managed in the community	**YES**
1.2c	1	Women with other serious non-psychotic conditions	**YES**
1.2d	1	Women identified in pregnancy who are at risk of a recurrence / relapse of a psychotic or serious / complex non-psychotic condition	**YES**
1.2e	1	Women requiring pre-conception counselling	**NO**
1.3	2	The service only works with women who cannot be effectively managed by primary care services *Guidance: This includes women who are currently unwell and those who are at risk of becoming unwell*	**YES**
1.4	2	The service only works with women with alcohol/substance misuse problems if there is also (or suspected) moderate to severe mental illness	**YES**
1.5	1	Patients under age 18 can be referred if perinatal psychiatric disorder dominates the clinical picture	**NO**
1.6	1	The perinatal service works with the local CAMHS service to provide care to patients under the age of 18	**NO**
1.7	2	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP is informed.	**YES**
1.8	2	Referrals from Children's Social Services can only be accepted if they meet the usual clinical criteria	**YES**
1.9	1	The referral criteria ensure that personality disorder is not a barrier to appropriate service response	**YES**
1.10	1	Referrals can be made directly to the service during working hours *Guidance: Services may have a single point of access system in addition to this*	**YES**

1.11	1	The service responds to requests for telephone advice from other professionals within one working day	YES
1.12	1	A clinical member of the team is available to discuss emergency referrals during working hours	NO
1.13	1	When the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this	YES
1.14	1	There is a procedure agreed with out of hours teams to ensure patients requiring Perinatal specialist care are referred the next working day	NO
1.15	2	Where services accept referrals through a single point of access, these are passed to the Perinatal team within one working day	NO
1.16	2	A written acknowledgement is sent to all patients whose referral is accepted within two working weeks of receipt of the referral, giving details of proposed actions and information about the service	NO
1.17	2	The acknowledgement letter is copied to the referrer and the patient's GP	YES
1.18	1	If a referral is not accepted, the team advise the referrer on alternative options	YES

	Type	Standard	
2		**Assessment**	
2.1	1	Teams assess all women who are suffering from a new episode of serious or complex mental illness (in pregnancy and until 6 months postpartum with follow up to 12 months)	NO
2.2	1	An integrated care pathway including screening questions is agreed with maternity services to detect those at risk of a serious mental illness following delivery	YES
2.3	3	Women are offered a choice of where they would like their assessment to take place, taking into consideration clinical	NO

		need	
2.4	1	The service is able to conduct assessments in a variety of settings, which have been appropriately risk assessed	YES
2.5	1	New onset condition arising after 28 weeks and before 6 weeks postpartum have the potential to be serious. Discussion with the referrer should take place within 2 working days. *Guidance: When the Consultant Psychiatrist is not available another appropriate member of the team may have these discussions*	NO
2.6	1	Pregnant women referred with a past history of serious affective disorder / psychosis / severe panic disorder / obsessive compulsive disorder, even if currently well, should be offered an assessment to take place in their pregnancy.	YES
2.7.1	1	All women who are referred with a known or suspected mental health problem are assessed for treatment within two weeks of referral	YES
2.7.2	1	All women who are referred with a known or suspected mental health problem are provided with psychological interventions within 1 month of the initial assessment	NO
2.8.1	1	Pregnant women receiving mood stabiliser medication should be discussed with the referrer and their usual psychiatrist within 2 working days and appropriate advice given. *Guidance: When the Consultant Psychiatrist is not available another appropriate member of the team may have these discussions*	NO
2.9	1	Women currently in the care of psychiatric services should be assessed and given advice/ treated in collaboration with their usual psychiatric care team	YES
2.10	1	All women have a comprehensive assessment of their health and social care needs taking into consideration the needs of	YES

		their children and family	

	Type	Standard	
2.11		*Practioners gather additional information reflecting the perinatal context, including:*	
2.11a	1	Current and past obstetric history	YES
2.11b	1	Mode of infant feeding	YES
2.11c	1	Contraception	NO
2.11d	1	Contact details of relevant professionals	YES
2.12	1	All women have a named mental healthcare professional. They are told how and who to contact if this person is not available and in an emergency	YES
2.13	1	There is a written care plan for every patient, reflecting their individual needs *GUIDANCE: Care plans should record any medication advice given well as any psychological / social interventions advised / carried out*	YES
2.14	1	Care plans are reviewed at least every 3 months *Guidance: For patients with complex needs on CPA (or local equivalent) this should be a formal review involving members of the multi-disciplinary team and other relevant professionals. For patients not on a CPA (or local equivalent) the review may be conducted by the professional(s) from the service directly involved with the patient's care.*	NO
2.15	1	The care plan is developed collaboratively with the patient	YES

2.16	1	The views of the patient's partner, family and carers is incorporated into the care plan as appropriate	YES
2.17		*For women seen in pregnancy, there is a peripartum management plan formulated and recorded in the handheld records by 32 weeks of pregnancy shared with the woman, her family (where appropriate), GP, Midwife, Health Visitor, obstetrician and any other relevant professionals or organisations. This includes:*	
2.17a	1	Nature of the risk and condition	YES
2.17b	1	Details of current medication and any intended changes in late pregnancy and the early postpartum.	YES
2.17c	1	Consideration of whether the mother intends to breastfeed.	YES
2.17d	1	Those involved and frequency of contact.	YES
2.17e	1	Emergency contact details.	YES
2.17f	1	Admission to a mother and baby unit if necessary	NO
2.17g	1	Plans for a maternity admission, including notifying the perinatal team once the patient has delivered	YES
2.18	2	Women referred in pregnancy who are at high risk of serious illness are seen by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed	YES

	Type	Standard	
3		**Discharge**	
3.1	1	For women requiring continued psychiatric care the appropriate team are invited to the final review	YES
3.2		*The discharge summary includes reference to:*	
3.2a	1	Assessment of the patient's mental state	NO
3.2b	1	Risk assessment (mother and child)	NO

3.2c	2	Advice regarding further pregnancies (including risk and benefits of medication)	NO
3.2d	2	Contraception advice	NO
3.2e	1	Mother-infant interaction	NO
3.2f	2	Any remaining concerns / needs for intervention and support in relation to mother-infant care or older children	NO
3.5	1	Any safeguarding concerns are referred to children's social services	NO

4	Type	Standard Care and Treatment	
4.1		*All teams have access to a range of therapeutic interventions focusing on mother, baby, and family including:*	
4.1a	1	Medication	YES
4.1b	1	Psychological interventions *Guidance: This includes problem solving, stress management, brief supportive counselling and relapse prevention, CBT, interpersonal psychotherapy*	NO
4.1c	2	Mother and baby interventions	NO
4.1d	3	Family and couples interventions	NO
4.1e	3	Creative therapies	NO
4.2	3	Staff promote patients accessing social and recreational activities in their own community	YES
4.3		*The clinical members of the team are able to advise (working with other professionals) the patient, partner and family on:*	
4.3a	1	Early mother-infant care and attachment	YES
4.3b	2	Infant development	YES
4.3c	1	Promoting involvement of partner / family members	YES

4.4	2	Partners and designated family members are involved in decisions about care, where the patient consents	**YES**
4.5	2	Carers are advised how to obtain a carers' assessment	**YES**
4.6	2	Carers are given a pack with information on perinatal mental health problems, what they can do to help, their rights as carers and information about local services they can access	**NO**
4.7	2	The service ensures that older children and other dependents are supported appropriately *Guidance: This may be done via other services, e.g. social services, health visitor*	**YES**
4.8	3	Age appropriate perinatal mental health information is available to older children in the patient's family	**NO**
4.9	1	The team have established relationships with local mother and baby units	**NO**
4.10.1	1	The team informs a 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*	**NO**
4.10.2	1	The potential for admission is communicated verbally to the woman and her family and recorded in the written care plan and communicated to her GP, midwife and health visitor if appropriate	**YES**
4.10.3	2	Written and verbal information is given to the woman, her partner and family about the mother and baby unit	**NO**
4.10.4	2	Patients and their carers are given the opportunity to visit the mother and baby unit if admission is being considered	**NO**
4.11.1	1	As soon as possible after admission to a mother and baby unit a perinatal community psychiatric nurse should be allocated to the patient	**YES**

4.11.2	2	The allocated perinatal psychiatric team member attends the patient's multidisciplinary ward rounds as appropriate *Guidance: If they are unable to attend in person they should participate by phone*	**YES**
4.11.3	1	A member of the perinatal psychiatric team member attends the patient's pre-discharge meeting *Guidance: If they are unable to attend in person they should participate by phone*	**YES**
4.12	1	Following discharge from an inpatient stay, the patient is seen in the community by a member of the perinatal team within 7 days	**YES**

5	**Type**	**Standard** **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	1	The baby's age and date of birth or due date	**YES**
5.1b	1	Parental responsibility for the infant, all the mother's children and all children in her household	**YES**
5.1c	1	Name and contact numbers of GP, health visitor, midwife, obstetrician, any social worker or paediatrician involved and any other relevant professionals or agencies	**YES**
5.1d	1	If the child or unborn child is the subject of a Child Protection Plan (formerly known as the Child Protection Register or At Risk Register) or Care Proceedings	**YES**
5.1e	1	Mode of delivery and obstetric complications during gestation	**YES**
5.1f	1	Current or planned mode of feeding and any previous problems with feeding	**YES**

5.1g	1	A brief assessment of mother-infant interaction, care and attachment *Guidance: This should be based on the care needs of the infant and should be followed up by a more thorough assessment where appropriate*	**YES**
5.2	2	If areas of concern are highlighted then the care co-ordinator ensures a full assessment is completed using an instrument that is relevant to the concern, working collaboratively with the health visitor, psychologist or social worker if involved	**NO**
5.4	2	Mother-infant relationship and care should be observed and recorded in the patients notes every 3 months or more frequently should the patient's mental state and behaviour change	**YES**
5.5	2	All observations of mother-infant relationship and care are fed back to and discussed with the patient with particular reference to progress and problem areas	**YES**
		Risk Assessment of the Infant	
5.6		*A risk assessment of mother and infant must be undertaken during the initial assessment process by the service. This should include:*	
5.6a	1	Disclosures of harmful or potentially harmful acts	**YES**
5.6b	1	Any delusions / overvalued ideas or hallucinations involving the unborn	**YES**

	Type	Standard	
		baby, infant or other children	
5.6c	1	Any thoughts, plans or intentions of harming the unborn baby, infant or other children	**YES**
5.6d	1	Hostility and / or irritability towards the unborn baby, infant or other children	**YES**

5.6e	1	Any involvement with Children's Social Care *Guidance: e.g. unborn baby, infant or older children subject to child protection plan or child care proceedings*	YES
5.6f	1	Any concern about any other person who may pose a risk to the unborn baby, child or other children	YES
5.7	1	The risk assessment tool is specifically designed for use by perinatal psychiatric services *Guidance: This could include a measure adapted or developed by the service or an existing measure such as Perinatal FACE (http://www.face.eu.com/solutions/assessment-tools/perinatal-psychiatry)*	NO
5.8	1	The risk assessment is updated a minimum of every 3 months or as appropriate	NO
5.9	1	Risk assessments are completed prior to discharge and a summary is sent to all relevant agencies involved in care	NO
5.10	1	At each stage of Care and Risk Assessment consideration is given as to whether it is appropriate to initiate a CAF (or local equivalent) to better assess any additional needs the baby or older children of the family may have (www.ecm.gov.uk/caf)	YES
5.11		Care and Treatment of the Infant *Case notes include:*	
5.11a	1	Any maternal concerns in relation to the unborn baby/ infant	YES
5.11b	1	Her care of the unborn baby/ infant	YES
5.11c	1	Her enjoyment of the unborn baby/ infant	YES
5.11d	1	If the infant is absent from the contact the reason why is recorded	NO

	Type	Standard	

5.12	2	Staff encourage the involvement of partners and/or other significant family members in the care of the mother and her infant, unless detrimental to the mother or infant. *Guidance: Record of this should be included in the care plan*	YES
5.13		*Women who choose to breastfeed are supported and encouraged by the following:*	
5.13a	1	Where the service is prescribing psychotropic medication for breastfeeding mothers it is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration	YES
5.13c	1	Women and all clinicians have access to up to date and expert information about medication in relation to breastfeeding	YES
5.14	3	If a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility, the waiting area is exclusively for the use of the perinatal and/or maternity services during that session	NO
		Safeguarding of the Infant	
5.15	1	Local safeguarding and child protection guidance is available and accessible to all staff members	YES
5.16	1	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details	NO
5.17	3	A member of the perinatal psychiatric team is a member of the local safeguarding or child protection group	NO
5.18	1	Referral to Children and Family Services should be made on the basis of a risk assessment and should not be "routine" (i.e. only because the mother is mentally ill)	YES
5.19		*When the following factors are identified a referral to Children and Family Services should be made:*	
5.19a	1	Concern from risk assessment about the immediate safety of the infant from its mother, partner or any other person	YES
5.19b	1	An assessment identifies that the child is at ongoing risk of harm	YES

5.19d	1	Current domestic violence	YES
5.19e	1	Evidence that harm has already occurred	YES
5.20	1	Any safeguarding referral is made in accordance with local NHS Trust (or equivalent body) and county council procedures	YES
5.21	3	Protocols and procedures are in place to ensure perinatal and children's social services work collaboratively	NO
5.22	1	The team should inform the relevant local social care team if any other child in the family has been subject to a care order or been on the Child Protection Risk Register *Guidance: This should not automatically be a formal 'referral'*	YES

6	Type	Standard Staffing and Training	
6.1	1	All staff receive a service specific induction when they first join the service	NO
6.2		*Training has been provided in the following:*	
6.2a	1	The range of perinatal disorders	YES
6.2b	1	Risk assessment	NO
6.2c	1	Basic infant development including the main development milestones	NO
6.2d	1	Cultural differences in infant feeding care / interaction and family relationships	NO
6.2e	1	Prescribing in pregnancy and breastfeeding	YES
6.2f	1	Understanding and promoting mother-infant interaction and attachment	YES
6.2g	1	Safeguarding children (Level 2 minimum including the Common Assessment Framework or national equivalent)	YES
6.2h	2	Infant mental health training (e.g. Solihull, Watch Wait Wonder or Mellow	NO

		Babies)	
6.2i	1	Normal emotional changes in pregnancy and after birth	YES
6.2j	1	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist)	NO
6.2k	1	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (updated annually)	YES
6.2l	1	A range of therapeutic interventions for staff to use with patients, for example, cognitive and behavioural techniques, brief psychotherapy techniques, family interventions and counselling	YES
6.2m	2	Contraception and sexual health	NO
6.2n	1	The Mental Health Act	NO
6.2o	1	Alcohol, smoking and substance misuse	NO
6.2p	1	Management of self-harm	NO
6.2q	3	Infant feeding (including breastfeeding)	NO
6.2r	1	Domestic abuse	YES
6.3	1	Specialised training needs are informed annually through staff appraisal, individual development plans and supervision	YES
6.4	2	All clinical staff attend a specialist perinatal training day at a minimum of once every two years	YES
6.5	2	The team provide an annual training plan or strategy about perinatal mental health and its services which is appropriate for and accessible to midwives, health visitors, GPs, obstetricians, social workers and mental health workers	NO
6.6.1	1	All staff receive regular individual clinical supervision totalling at least one hour every month from a person with appropriate experience	YES
6.6.2	1	All staff receive regular individual managerial supervision totalling at least one hour every two months	NO

6.7	2	All staff receive annual appraisals and personal development plans	**YES**
6.8		*The service consists of:*	
6.8a	1	Sessions from a dedicated specialised consultant perinatal psychiatrist	**YES**
6.8b	2	Non-consultant medical input	**YES**
6.8c	1	Dedicated perinatal community psychiatric nurses	**YES**
6.8d	2	Dedicated sessions of a social worker	**NO**
6.8e	2	Dedicated clinical psychologist sessions	**YES**
6.8f	2	Dedicated nursery nurse sessions	**NO**
6.8g	2	Dedicated OT sessions	**NO**
6.8h	2	Dedicated administrative and data entry support	**YES**
6.9	1	Members of the team have timely access to advice and support from a specialist perinatal psychiatrist during working hours	**YES**
6.10	1	The service has access to interpreters within working hours	**YES**
6.11	1	The team has a base and office accommodation	**YES**
6.12	2	Staff working in teams covering a large geographical area can hot desk at other locations	**NO**
6.13	2	All staff access performance and quality data on both their own patients and the team as a whole, including the regular reviewing of outcome measures to inform patient care and team development	**NO**

7	**Type**	**Standard** **Recording and Audit**	
7.1		*The service evaluates annually:*	
7.1a	2	Feedback from patients and carers	**NO**
7.1b	2	Feedback from referrers	**NO**

7.1c	2	Feedback from service staff	NO
7.1d	2	Accident and incident records *GUIDANCE: The service should provide the quality network with information of any SUIs, investigations or complaints in the past 12 months*	YES
7.1e	2	Analysis of complaints	YES
7.1f	2	The findings of audits	YES
7.1g	2	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data)	YES
7.1h	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored	YES
7.1i	1	Women involved in care proceedings / child safeguarding protection plans	YES
7.2	3	There is a programme of audit including at least one perinatal specific audit a year	NO
7.3	1	Any serious untoward incident including those involving a child and any emergency child protection order should be audited within 6 weeks and chaired by a suitably qualified clinician external to the service	YES
7.4	1	The service keeps a record of any difficulties / undue delay in transferring the patient to another psychiatric service	NO
7.5	2	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice	YES

PERINATAL QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

CCQI SERVICE STANDARDS

Informal review of where Cwm Taf UHB Perinatal Mental Health Team are within relation to the standards

Cwm Taf UHB Perinatal Mental Health Team:

Dr Vaidya Consultant Psychiatrist 2 sessions per week

Dr Kele Psychiatrist 1 session per week

Lynn Rodgerson Clinical Nurse Specialist wte

Lisa Nickels Specialist Midwife wte

Stella Swift Clinical Psychologist 1 session per week

Kimberley Jones Administrator 18.5 hours per week

The team covers the whole of Cwm Taf UHB

STANDARD TYPES:

Type 1

Type 2

Type 3

STANDARDS:

1) ACCESS and REFERRAL:

The team are reaching standard type 1 on all parts except:

How to make a referral

Contact details

and for the two above we are reaching standard type 2

we are in the process of reviewing all the other parts of this standard due to the volume of referrals we have received since the team went live in June 2016

1.2) The service is provided for a number of groups of clients in a defined catchment area (Cwm Taf UHB)

The team are reaching standard type 2 on all parts of this apart from:

1.2e 1.5 1.6 1.12 1.13 1.14 1.15

all of the above are currently reaching standard type 1 but are being reviewed within the team

2) ASSESSMENT:

The team are reaching standard type 1 on all parts of this except:

2.2 There is an integrated pathway in place which appears to be working from maternity staff to the team

2.7.2 The team are unable to provide psychological interventions within one month of assessment

2.17 There is a plan in place for all women by 32 weeks with regard to their mental health and emotional well being

2.18 Women referred in pregnancy at high risk are being seen by a member of the team

The team are reaching standard type 2 for all the above except 2.7.2

3) DISCHARGE:

The team are reaching standard type 1 for all parts of 3 although we are reviewing and working towards standard type 2

4) CARE and TREATMENT:

The team is reaching standard type 1 on all parts of although we can refer to PCMHSS for some psychological interventions and we do have access to two infant attachment specialist health visitors within the UHB. We also involve client and carer in birth plan discussions.

We have no local mother and baby unit in Wales so it is very difficult to develop established links with the units in England because we will not know where a mother and baby might be admitted too. All of this part of 4 will continue to be reviewed.

5) INFANT WELFARE and SAFEGUARDING:

5.1 – 5.1g we are achieving standard type 2

5.2 – 5.5 we are achieving standard type 1

5.6 – 5.6f we are achieving standard 1

5.7 – 5.10 we are achieving standard type 1 but this needs to be reviewed in line with our new assessment documentation Care Partner (FACE)

5.11 – 5.13 we are achieving standard type 1

5.14 we do not have exclusive waiting areas for the children of parents we see in the team

5.15 – 5.22 we are achieving standard type 1 for all parts of this but we are developing links with our safe guarding teams across the UHB and are involved in safe guarding conference, child in need

6) STAFFING and TRAINING:

All staff if new to the team would be given an induction period and the two full time staff within the team both had a varied and informative induction

The team are probably achieving standard type 1 on most of the 6.1 – 6.3 although we will need to review on a regular basis but members of the team have attended conferences and training sessions both statutory and optional

6.4 this will need to be reviewed as the team develops and progresses

6.5 – 6.7 we are achieving standard type 1 for these and we are looking to provide training for colleagues within midwifery, mental health and health visiting

The team are achieving standard 1 on some of the parts 6.8 – 6.13 but do not have:

6.8d 6.8f 6.8g 6.12

6.13 needs to be reviewed

7) RECORDING and AUDIT:

7.1d 7.1e 7.1g 7.3 7.4 7.5 the team are achieving standard type 1 in these parts

The remaining parts of 7 need to be discussed and reviewed within the team

The team have work to do to progress to standard type 2 but considering how small the team is and how many referrals we have received the team are working well