

IMPLEMENTING ROUTINE OUTCOME MONITORING

IN SPECIALIST PERINATAL MENTAL HEALTH SERVICES

Routine outcome monitoring is an important element of patient centred care and, when used fully and consistently, enables effective treatment and high-quality services development. This manual provides tools, tips and information to help Specialist Perinatal Mental Health Services (SPMHS) work through key elements of implementation.

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Child Outcomes Research Consortium (CORC)

CORC is the UK's leading membership organisation that collects and uses evidence to enable more effective child-centred support, services and systems to improve children and young people's mental health and wellbeing. CORC has over 15 years' experience in bringing together theoretical knowledge on outcome measurement and relating this to the insights and expertise developed by practitioners working with children and young people on the ground.



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FOREWORD

For the mother, the family and the baby, the impact of untreated perinatal mental illnesses are beyond doubt. Successive confidential enquiries into maternal deaths have shown that suicide and perinatal mental illnesses are amongst the leading causes of maternal death in the UK. Untreated perinatal mental illnesses may not only result in increased mortality but also in huge morbidity, affecting the whole family. We also know that this can be avoidable, as robust, evidence-based treatments are available for these conditions. However, less than five years ago, work by the Maternal Mental Health Alliance suggested only 15% of the country had access to comprehensive, specialised community perinatal mental health teams; and where women were most acutely unwell and required admission to specialist inpatient care, they could be travelling over 100km to access a bed where they could stay with their baby.

Following the publication of The Five Year Forward View for Mental Health in 2016, NHS England committed to increasing access to specialised perinatal mental health services across all of England, enabling 30,000 additional women each year to receive evidence-based care and treatment. This programme has been immensely successful – just three years later all areas of England have access to specialised perinatal community teams and the number of inpatient Mother and Baby Units has increased from 15 to 19. This huge achievement is the result of a lot of hard work between multiple professionals, organisations and experts with lived experience. However, there is still further work to do to ensure that all women who can benefit from a specialist perinatal mental health service can access it. This is recognised in the [NHS Long Term Plan](#) published in July 2019, in which NHS England commits to further increasing access so that by 2023/24 a total of 66,000 women per year will be accessing specialist perinatal mental health services.

As areas have started to make this transformation a reality, there has been a great deal of supporting work to provide services with evidence on what works in perinatal mental health. NHS England has produced [Perinatal Mental Health Care Pathways](#) which represent a commitment to ensuring that perinatal mental health care is delivered in a person centred, compassionate and supportive way as well as including which measures exist to monitor and measure outcomes and case studies of positive practice. [The National Collaborating Centre for Mental Health](#) and [Royal College of Psychiatrists' Perinatal Faculty](#) have produced a range of useful information that may also support local areas with implementation.

Most recently, the College has developed the [Framework for Routine Outcome Measures in Perinatal Psychiatry College Report](#) through a collaborative set of workshops involving representatives from across the perinatal multi-disciplinary team, experts with lived experience and academics. This shows the range of clinical outcome measures that are available to perinatal mental health teams.

Clearly-defined outcomes that are routinely collected and monitored are an essential part of understanding service effectiveness and quality improvement as they can measure whether the service being offered is contributing to genuine clinical improvement which is meaningful to mothers and families. They allow clinicians to re-adjust treatment plans and engage in different treatment strategies if progress is not being made, whilst offering additional reassurance to mothers and families when progress is in the right direction. On a bigger scale, collecting all of the data together helps teams and services to measure their own rate of success and their impact.

This practical guide is another important piece of the jigsaw in the development of perinatal mental health services. The existence of services everywhere is just the start. The next phase is embedding these services into the local health system, alongside targeted work to ensure health inequalities are identified and addressed in line with the ambitions of the NHS Long Term Plan. The routine collection of clinical outcome measures will help to show the whole system the efficacy and impact of specialist perinatal mental health services, as well as showing mothers and families how much individual progress has been made.

England has led the way in the development of perinatal mental health services internationally. Nowhere else in the world is able to offer this level of care to women in the perinatal period. It is important to build upon this great achievement. Collecting objective data around the impact of these services will contribute to the international evidence base for these services. This implementation guide therefore has the potential to not only help those families using our services now in England, but future women and families in this country and around the world.

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ROUTINE OUTCOME MONITORING IMPLEMENTATION MANUAL

OVERVIEW

Specialist Perinatal Mental Health Services (SPMHS) provide support to service users with moderate to severe mental health difficulties in the antenatal and postnatal period. This manual offers tools, tips and information to help in implementing routine outcome measurement (ROM) in SPMHS. It has been funded by NHS England and developed by the Child Outcomes Research Consortium with support from colleagues at the Child Attachment and Psychological Therapies Research Unit (ChAPTRe).

Research suggests that the implementation of systems to monitor outcomes and feed them back to service users can improve engagement in treatment and may significantly improve outcomes for the service user (De Jong et al., 2014; Lambert et al., 2002; 2003).

This manual outlines general guidance and tips about three different types of measures:

- Clinician Rated Outcome Measures (CROMs) ([Section 3](#))
- Patient Reported Outcomes Measures (PROMs) ([Section 4](#))
- Patient Reported Experience Measures (PREMS) ([Section 5](#))

The development of this guidance has been informed by consultation with staff from across SPMHS and with women with lived experience of SPMHS. They shared some great examples of best practice and tips for using outcome and experience measures, as well as what they have learnt from tackling some of the common challenges. The sections below explore the benefits of each type of measure, and shares feedback from service users and practitioners about how best to introduce them into the provision of care.

OVERARCHING BEST PRACTICE RECOMMENDATIONS:

- Being transparent and building trust: getting service users onboard by explaining clearly what measures will be used, when and why, and the value and relevance of the measures to their care.
- Using the measurement questionnaires as part of a collaborative conversation: the measures can open-up conversations that might not spontaneously happen, or help service users to express difficult feelings. Space needs to be given to review and discuss the responses together and explore what they mean to the individual.
- Acting on the feedback: either at the individual level or overall as a service - both service users and practitioners need to see feedback being reviewed and used in a meaningful way for routine outcome monitoring to successfully take root in a service.

There is an expectation that services will flow outcomes data to the Mental Health Services Data Set (MHSDS) and details on how this can be done are provided in [Section 8](#).

Effectively introducing routine outcome measurement involves commitment and change at all levels of an organisation. Embedding new approaches can take time, and nearly always involves some challenges. However there is a wealth of research and experience for services to draw on: [Section 2](#) provides information on best practice in implementing routine outcome measurement which can support services to overcome barriers and identify an approach that best works for them.

There are some particular considerations that emerged from consultations with a wide range of stakeholders, specifically in the implementation of measures focused on relapse prevention. Tips on best practice in these cases are provided in [Section 6](#).

The manual also provides details of other types of measures that could be useful in SPMHS, such as those assessing the parent-infant relationship, service user goals and measures specific to Occupational Therapy. These are described in [Section 7](#).

The aim of this manual is to provide a helpful framework and useful suggestions for services in how to implement measures. Each service is unique and decisions around how best to implement measures should be made locally, while still being informed by best practice.

We are grateful to service users and staff across SPMHS for their generous contributions to the development of this manual. This document, along with general information and resources about implementing routine outcome monitoring, is available online on the Child Outcomes Research Consortium website, www.corc.uk.net.

TERMS USED IN THIS MANUAL

OUTCOME MEASURE

Tools (generally questionnaires) that can be used to measure a variety of aspects of an individual's mental health and wellbeing, from specific symptoms and diagnoses through to general functioning. These can be assessed subjectively by service users themselves (patient-reported) or objectively by the clinician (clinician-rated).

EXPERIENCE MEASURE

Tools (generally questionnaires) that collect information from service users about how they found the support they received, sometimes referred to as feedback measures.

WHAT IS THE MENTAL HEALTH SERVICES DATA SET (MHSDS)?

The MHSDS is the mechanism used by NHS Digital to capture person-level data and information, for children, young people and adults who are in contact with Mental Health Services.

It is unique in its coverage, because it covers not only services provided in hospitals, but also in outpatient clinics and in the community, where most people in contact with these services are treated. The data originates in services, where it is collected and stored locally, before being collated into a specified, digital format and sent to NHS Digital on a monthly basis.

Once at NHS Digital this data can then be extracted for:

- Commissioning
- Clinical audit
- Research
- Service planning
- Inspection and regulation
- Monitoring government policies and legislation
- Local and national performance management and benchmarking
- National reporting and analysis

The more that data is accurately collected and sent to NHS Digital, the more robust decisions can be made on all of the above.

1 INTRODUCTION TO ROUTINE OUTCOME MONITORING (ROM)

Routine outcome monitoring (ROM) is an important element of patient-centered care, and when used fully and consistently, ROM enables effective treatment and high-quality service development. There is a wide range of outcome and experience measures that may be suited to the work undertaken by SPMHS; they each offer different types of information, different perspectives, or may have been designed for particular purposes.

CHOOSING THE RIGHT MEASURE

[The Framework for Routine Outcome Measures in Perinatal Psychiatry](#) (Royal College of Psychiatrists, 2018) provides information about a number of measures most suitable for the perinatal period, including the three measures used as examples in this manual that SPMHS could adopt as a minimum standard where no existing suitable measures are already being routinely used in practice.

It is helpful to bear in mind that there is a balance to be struck in choosing which measures to use. For example longer, more specialised, measures can offer helpful specificity at practice level – for example to support an assessment. Shorter, more general, measures may be more practical for gathering evidence at a whole service or system level. Therefore, you need to think carefully about what you want to find out and choose the best measures to achieve this.

Some important considerations include:

- Your purpose in using the measure: what do you want to understand?
- How robust the measure is: does the research suggest it is a valid and reliable tool?
- Whether it is right for your client group: is the language suited to those who will need to fill it out? Does it match with the usual range of presenting problems of people who access your service?
- Whether it is right for the type of service you provide: does the measure match the aims of the interventions provided? Can the measure provide useful information for assessment and/or formulation?
- The cost and time of using it: is there any cost in using the measure or being trained to use it? How long does it take to complete? How easy it is to score and interpret?
- Whether others are using the measure: is there learning to be shared? Will there be potential to get contextual information or benchmarks from others?
- The perspectives you want: for example the perspective of the clinician, the service user, or other relevant individuals. Do you want just one perspective, or several?

KNOWING WHEN TO USE THE MEASURE

Each service will need to agree an approach that makes sense for their specific context (see [Section 6](#) below). It is important to balance the usefulness of receiving regular data against the value (or potential burden) for the practitioner or service user. Nevertheless, it is a good idea to use measures at the start, at defined review points, and at the end of the intervention, as demonstrated in [figure 1](#).





ASSESSMENT/ ADMISSION	<ul style="list-style-type: none"> • Clinician Rated Outcome Measure/s Time Point 1: What are the first observations from a clinical perspective? • Patient Reported Outcome Measure/s Time Point 1: How is the service user is feeling and what are the specific areas of difficulty to work on
CLINICALLY MEANINGFUL CHECK POINT	<ul style="list-style-type: none"> • Patient Reported Outcome Measure/s & Clinician Rated Outcome Measure/s Intermediate Time Point/s: How are things? Has anything changed?
REVIEW AND CLOSE	<ul style="list-style-type: none"> • Clinician Rated Outcome Measure Final Time Point: Follow up observations from a clinical perspective • Patient Reported Outcome Measure/s Final Time Point: Reflecting on the change • Patient Reported Experience Measure/s: How was the experience?

Fig. 1 Timetable for using measures over time

TIME POINT 1

In principle, the first time point for CROMs and PROMs should be as soon as clinically appropriate. Change can happen quickly and waiting too long until the first-time measures are used could mean that very early improvements or deteriorations are not picked up.

The first time point could be:

- At referral
- At the assessment appointment or shortly thereafter
- At the first session of a psychological intervention
- For Mother and Baby Units, at admission

INTERMEDIATE CHECK POINTS

For PROMs and CROMs, it is helpful to have data from several time points along the way, not only start and end points. This helps to monitor change and also ensures that change can still be assessed if service users drop out of treatment prematurely, or don't complete the final measure as planned.

Examples of relevant check points could be at pre-defined regular intervals (for example, every 3 months or at CPA review meetings) which make sense to the particular service and the length/ frequency of sessions on offer.

The choice of frequency also depends on the chosen measures. For example, some measures are short enough to be used in every appointment.

Measures could also be re-administered at specific "clinically significant times", which could follow:

- Birth (if original assessment was pre-birth)
- Change of team / service
- Change of intervention
- Significant life events (e.g. return to work, relationship breakdown, further pregnancy, bereavement)

FINAL TIME POINT

The final administration of measures could be done at:

- The last appointment
- The last session of a psychological intervention
- Discharge from inpatient care (e.g. MBU)

While it is useful and important for each service to have a consistent plan for how and when measures should be used in routine practice, sound clinical judgement should always be used in the implementation of ROMs. The needs of each individual service user should always take precedence over the need to implement measures at specific times and in specific ways.

2 SEVEN ELEMENTS FOR IMPLEMENTING ROUTINE OUTCOME MONITORING

Decisions about which measures to use and at which timepoints must sit within a wider context of improvement and implementation. Whatever stage you are at in implementing routine outcome monitoring, considering your approach in terms of the seven elements, as seen in *figure 2* can help you to highlight your successes and challenges, and plan for improvement.

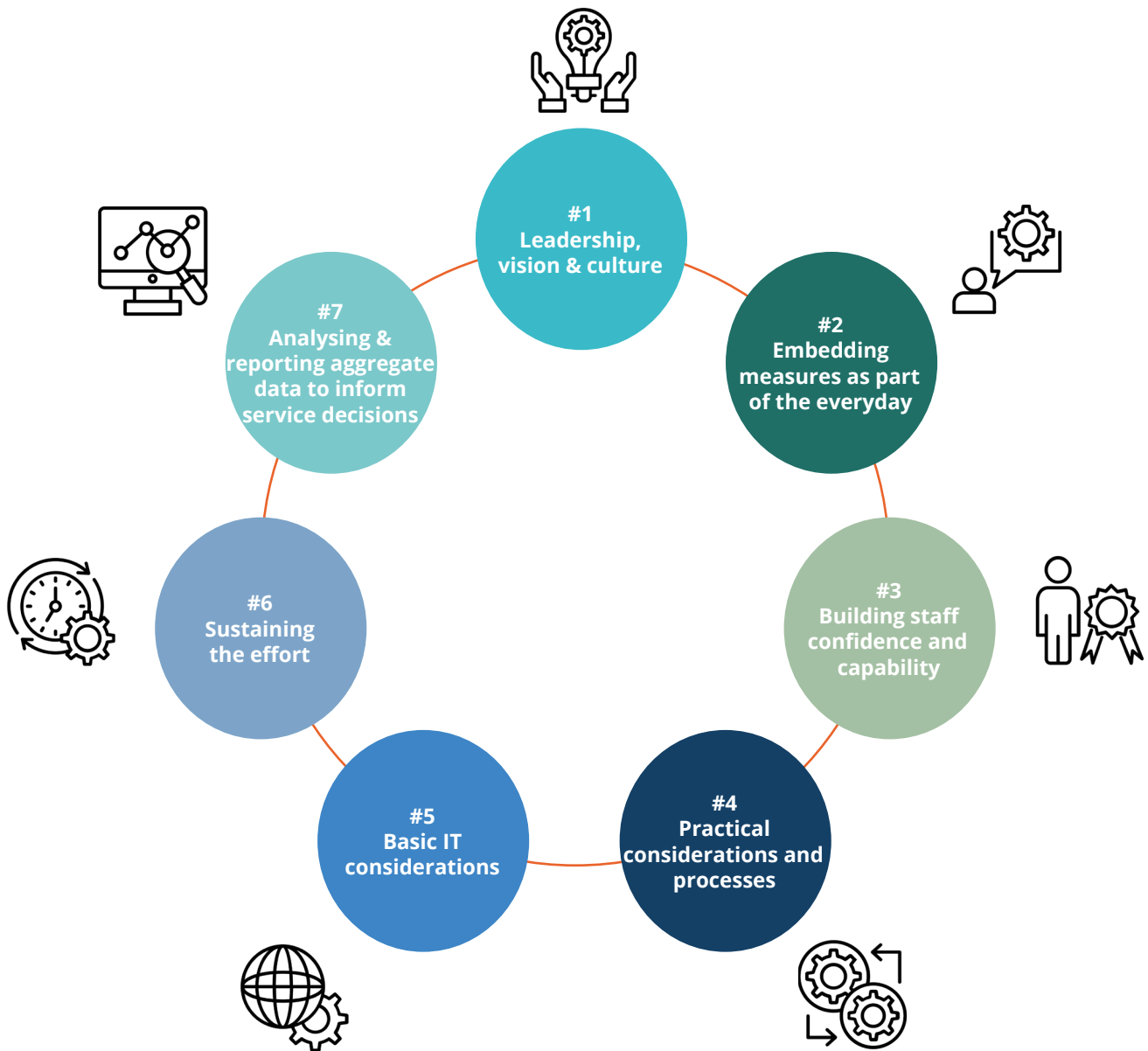
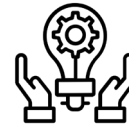


Fig. 2 Seven elements of implementation



#1 LEADERSHIP, VISION AND ORGANISATIONAL CULTURE

The meaningful collection and use of outcome measures requires senior organisational vision and support. Team leaders through to senior managers, board members and commissioners should have a shared and consistent vision.

This ensures that staff working to collect and use the data feel supported and empowered. Some things which can help to ensure ROM is valued throughout the hierarchy are:

COMMUNICATION

Have a clear vision statement which is in strategic documents (such as transformation plans) and shared through staff, public and service user communications. For example, "We routinely monitor outcomes through the use of measurement tools such as patient surveys and questionnaires. This helps to aid our practice, understand service users' needs and provide a person-centered service."

PROMINENCE

Ensure data from outcome and experience measures are presented in a meaningful way as part of management reporting, seen regularly by key stakeholders and given as much time and emphasis as traditional key performance indicators such as referrals and waiting times.

TRAINING

Deliver training to commissioners, board members and senior leaders about the measures being used and why, and how the information should be interpreted and used in key decisions in commissioning and developing SPMHS.

CULTURE

Create a culture of curiosity and learning. Data from outcome and experience measures should be used to explore successes and challenges within the service and should be considered alongside other forms of information such as presenting needs, levels of difficulty and professional insight.

INTERPRETATION

Ensure that data from outcome and experience measures are not seen as the only key performance indicators and targets. Too much emphasis on only this data, in the absence of contextual understanding, can become unhelpful and create anxiety for those collecting the data. Research suggests that where practitioners feel outcome data will be used punitively or misinterpreted, they are discouraged from collecting and using outcome measures consistently.

BUDGET

Dedicate a sustainable budget to training and equipment which will improve frontline collection and utilisation of outcome measures and ensure routine outcome monitoring is viewed as a corporate priority.

CASE STUDY #1

DEVELOPING AN OUTCOME FRAMEWORK

LEARNING FROM CAMBRIDGE AND PETERBOROUGH NHS FOUNDATION TRUST

Cambridge and Peterborough CCG have been working collaboratively with Cambridge and Peterborough NHS Foundation Trust (CPFT) to develop an outcome framework for use in the newly established Perinatal Mental Health Service.

The starting point for the development of our framework was to agree the desired outcomes for service users and then establish what questions needed to be answered to determine if those outcomes are being achieved.

The framework will be live from April 2019 and will consist of the following:

Outcomes	Outcome measure	Monitoring
Prevention of deterioration of MH during perinatal period & improved MH of target group experiencing severe MH difficulties	HONOS CORE-10	Monthly
Reduction in relapses	Number and percentage of women who have completed treatment who are referred back to the service within 30 days.	Monthly
Improved mother-child relationship	Postpartum bonding questionnaire.	Monthly
Women have a positive experience of care.	POEM	Monthly
Women are appropriately involved in decisions about their care.	Number and percentage of women reporting they felt appropriately involved in their care, as reported in the Patient Experience Questionnaire (PEQ)	Monthly

The first fundamental principle we had in developing this framework was that it should be done collaboratively between commissioner and service: this way the tools would be meaningful at the practice level and hopefully diminish any sense of top down, enforced measurement.

However, the timescales did impact on the number of individuals who could be involved in the process because we wanted to have it set up as early in the inception of the service as possible; it is easier to start off with such a framework in place than to retrofit it to embedded practice.

The second principle is that we are taking a test and learn approach to this framework. The reporting dashboard is in development and we are keeping dialogue open around how the data should be presented and what benchmarks and KPIs are appropriate.

The three tools recommended by NHS England (HoNOS, CORE-10 / CORE-OM, POEM) are part of the framework and so we recognised that these are fixed, but as there are six measures, we are open to testing the number of times they are each completed and if there is the right fit with the questions to be answered.

The most important thing is to ensure that the outcomes measures are clinically useful and the monitoring framework gives us timely and valuable information about the performance and quality of the service.



#2 EMBEDDING MEASURES AS PART OF THE EVERYDAY

MEETINGS

Discuss the measures being used and the resulting information from frontline team meetings through to board meetings. This ensures the voice of the service user is heard at every level of the organisation.

ROLES & RESPONSIBILITIES

Write routine outcome monitoring into job roles. Having ROM use as an essential criterion on relevant job descriptions, and knowledge of ROM as a desirable criterion for other linked roles (such as administrative staff).

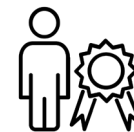
SUPERVISION

Ensure ROM is reviewed as a regular part of both managerial and clinical supervision discussions. During management supervision, checking how consistently measures are used in practice gives opportunity to address barriers to implementation and maintains them as a high priority. Talking through the ROM results will help with case management, identifying where support needs to change and planning next steps.

TRANSPARENCY

Service users should be informed from the first time they are in contact with the service about which measures are used, how the information is used, including how this information can be used to improve the support they (and others using the service) receive.

#3 BUILDING STAFF CONFIDENCE AND CAPABILITY



It is essential to keep staff engaged with the implementation process and remove any barriers which may prevent ROM becoming a valued part of their individual practice. Some aspects to consider for supporting staff are:

START SMALL

Trialing each measure you want to use with a small number of staff gives the service the opportunity to identify risks and challenges, and to work together to find mitigation and solution strategies. Introducing too many measures at once can be overwhelming so choosing one or two measures to pilot first is recommended.

NEW STARTERS

Use the induction process to introduce ROM for new starters. Most services have a corporate and team level induction procedure, so including ROM as an element of these will help new staff to hit the ground running. This would include an overview of the strategic vision but may also include things such as a video of an experienced clinician talking through their experience and the benefits of using ROM in the service.

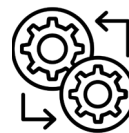
ROM TRAINING

Offer ROM training as part of your regular training programme and continuous professional development offer. This can be delivered externally or internally. Having refresher training as part of an ongoing learning and development plan can help to rejuvenate attitudes and understanding. Introducing, interpreting and discussing ROM data is a skill and allowing space for 'deliberate practice' is crucial.

PEER SUPERVISION

Peer supervision and team level discussions can also play an important role in building staff confidence in using outcome measures as it gives staff time to reflect on their experiences, share successes and challenges and learn from each other.

#4 PRACTICAL CONSIDERATIONS AND PROCESSES



Often, staff are on board with the collection and use of outcome measurement data, but the environment which they are operating in is not designed to facilitate them doing so. Here are some things to think about to support practitioners:

WHAT FORMAT OF MEASURES TO USE

There are different ways in which measures can be administered (paper, online, postal, in the waiting room, etc.). Such decisions need to be made locally and will depend on the setup and resources of each service. However, some tips for good practice in relation to the three different types of ROMs currently being used in SPMHS are given below:

CROMS

The most commonly used method for scoring CROMs, such as the HoNOS, is a paper version which is completed during or immediately after the session.

PROMS

The ideal way of using PROMs, such as the CORE, is as part of a clinical conversation.

- A paper or digital version which is completed by the service user and clinician in the session works well.
- The response rate to postal questionnaires is very low and this method is best avoided.
- Asking service users to complete the questionnaires in the waiting room can save clinical time, but this can feel depersonalised and it takes away the opportunity to talk through the responses.

PREMS

PREMs, such as the POEM, can be completed as online surveys or given as paper copies. There are advantages and disadvantages to both methods that need to be weighed up:

- The perinatal period is a busy time of life and service users may not feel they have the time to complete an online survey. However, this method has the advantage of keeping the responses separate from the service itself, allowing service users to feel more open and honest when responding. This method also means that responses do not need to be inputted into the computer separately.
- Paper copies can be completed in the clinic and may have better response rates. However, if this method is used, care needs to be taken that responses are anonymous (for example, have a closed feedback box where completed forms can be deposited). This method also then requires time for inputting data digitally.

EASY ACCESS TO PAPER VERSIONS OF THE TOOLS

Whilst this may seem obvious, and whilst everyone is striving to have the perfectly functioning paperless system, the availability of the tools at the last minute or in the event of IT failure can be detrimental to collection rates. Some suggestions to make the paper versions easily accessible are:

- Have copies of the measures available, in clearly labelled folders, in every consultation room.
- Have copies of the measures available in waiting rooms / staff rooms / any area with high foot traffic.
- Employ a 'Kanban' system for replenishment of the paper versions (i.e. 5 copies away from the end of the pile, insert a laminated copy of the measure with instructions of who to give it to so that more copies can be made and stock replenished).



EASY TO FOLLOW GUIDELINES IN PLAIN SIGHT

A simple flow chart of what to use and at what time points can be a welcome reminder, particularly whilst new processes are being embedded. It can also be useful to colour-code the different stages of the process and then print the paper version of the measures on coloured paper (or colour the tabs / buttons / links in IT systems) to co-ordinate with the relevant stage.

Research in the world of marketing says that a message needs to be seen eight times before it embeds in our brain – so having the process visible in as many places as possible would be beneficial.

INPUTTING INTO THE IT SYSTEM

If paper versions of the measures are being used, thought needs to be given to how that information is inputted / uploaded onto the patient record system (or equivalent).

- Having computers available in consultation rooms, or making sure that laptops have remote connectivity to the corporate IT system, can reduce the time lapse between collection and inputting.
- Training on how to upload the measures onto the system is crucial.
- Having a dedicated administrative staff member to input the data can be helpful. Having a budget for protected time for the inputting of data and having set timescales for this to be done can prevent delays.





#5 BASIC IT CONSIDERATIONS

In order to make the data accessible past the point of collection, the local IT system must be functional for collecting, storing and reporting ROM data for each service user (as part of their patient record):

RECORDING ELECTRONICALLY

The scores of each measure (for example the Total Clinical Score for the CORE-OM / CORE-10) needs to be recorded in a dedicated field on the system. An example is shown in *figure 3*.

CORE 10 Total Clinical Score (Time 1)	18
CORE 10 Total Clinical Score (Time 2)	11

Fig. 3 Example of score

Including scores within 'free text boxes' (i.e. not a dedicated field) can lead to problems with data quality (such as inconsistent format, missing data, typos) and extraction for reporting purposes. You must have a conversation with your local IT provider to understand what you need, what the system can do already, and what might need to be developed.

#6 SUSTAINING THE EFFORT

Implementing routine outcome monitoring to best effect demands a sustained focus and it can be easy to forget where you are on the journey.

SHARE SUCCESSES EARLY AND OFTEN

As it is an ongoing journey which may initially feel overwhelming, there can be a tendency to focus on the further work still required or to unpick what has gone less well so far. Whilst this is important, it is equally as important to recognise successes and share the positive learning from these in fun and inspiring ways to keep staff motivated.

CREATE A COMMUNITY OF PRACTICE

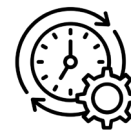
Other services will be experiencing similar challenges so getting together to share learning and ideas for improvement around these challenges can reduce isolation and spread best practice much more quickly. Using forums which are already in place and having ROM as a standard agenda item will reduce the time burden of accommodating a separate meeting. Perinatal Mental Health Clinical Networks are one example of an existing forum which could support this.

REPORTING PLAN

Develop your reporting specification first (i.e. what do you want to report on and how do you want to present that information?) and then make decisions on changing/building IT system so that those requirements can be met. The requirements of local audiences (Commissioners, NHS Trusts Boards etc.) will differ from area to area, so even off-the-shelf IT system such as Carenotes, IAPTUS or RiO will need some local-adaptation.

IT TRAINING

Staff need to be trained in using the IT system and top up training should be planned in as part of general Learning and Development. If staff are not trained to use the IT system properly, it can make the inputting of data from measures lengthy and anxiety-inducing and will lead to lower quality data.



FIND LEARNING IN THE DATA

It is sometimes easy to dismiss findings from the data because there is a feeling that it is not representative of the service or isn't telling us what we thought it would. If the only focus of data discussions is to talk about how to collect more data, this can undermine the effort which staff have put into collection and will demotivate them. However, showing that the information from the data was used to inform service decisions and links into their direct work will have the opposite effect.

BUILD A LEADING COALITION

A group of champions from different disciplines and from all levels of the hierarchy can help to keep this on everyone else's agenda. This also helps to make these champions visible to all staff so that they know who they can talk to about their own practice.



#7 ANALYSING AND REPORTING ON AGGREGATE DATA TO INFORM SERVICE DECISIONS

All mental health outcome data has a level of uncertainty surrounding it. Data can be subjective, fluctuating and difficult to collect 100% of the time. Because of this it is important that any analysis and interpretation, for all of the different possible stakeholder audiences, is mindful and consistent. Some basic reporting considerations are:

DATA COMPLETENESS

Larger volumes of data are generally considered to yield more analysis opportunities and give results that can be interpreted with more confidence. Data must also be representative of the population seen by the service (for example, do you have data from substantially more or less people of certain ethnic, diagnostic or age groups compared with all those who are using the service?).

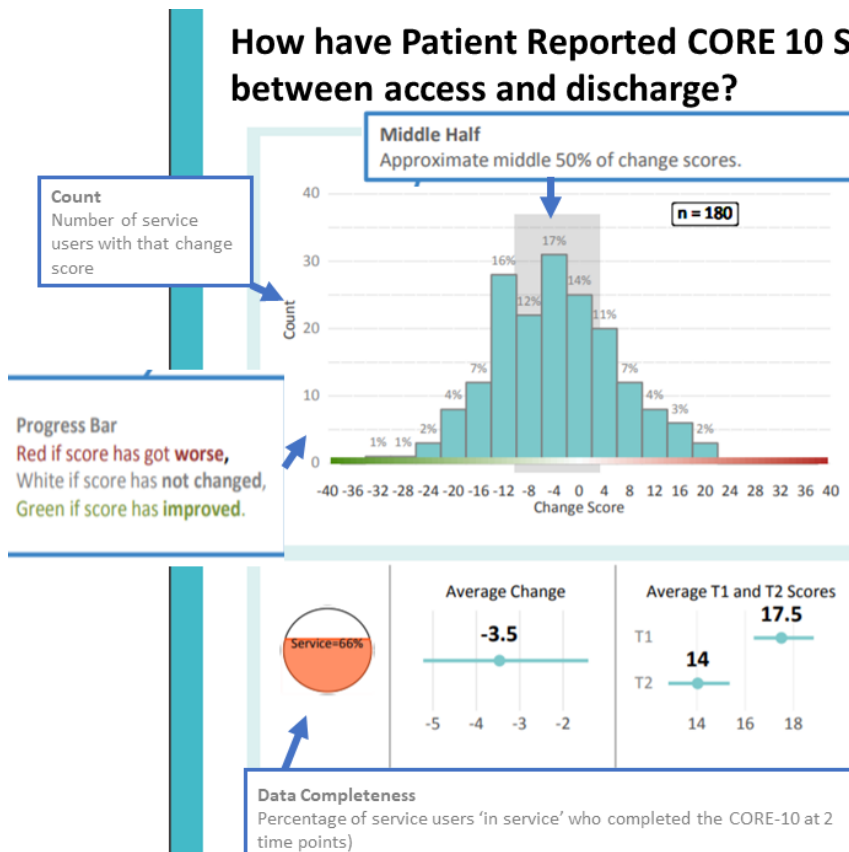
A RANGE OF IMPACT INFORMATION

Reporting on a single metric (e.g. average change in CORE-10) does not allow for much discussion and is an unhelpful basis for decisions; a mean in particular can be misleading as they are easily skewed by extreme cases. Therefore, presenting outcome data as a suite of information is more helpful. *Figure 4* is an example of how this could be done.

DIFFERENT SERVICE USER GROUPINGS

Analysing all service user data together may not be helpful as the aims of the interventions and the expected outcomes could be different for different groups. Clinically informed decisions can be made to separate out data from some subgroups in the analyses. For example, a mother who has come into service for 'secondary prevention' and is well at the time of referral will score differently to a mother entering service at the point of being unwell.

To do this, there must be the ability to mark/identify the relevant categories when recording the data. It is more efficient if these identifiers are decided on early, then they can be identified at the point of entry into the service and this can be clear in the database.



Results included
All paired scores for the CORE 10 (n=180)

How representative is this sample?
66% of those with a time 1 Total Clinical Score (TCS), had a corresponding time 2 TCS. The follow up rate suggests the sample is representative of about two thirds of service users who completed the CORE 10 at the first time point.

What do the plots show?
The middle 50% of service users either had a similar TCS at time 2, or improved by up to 10 points (on a scale of 1 to 40). The top quarter improved by between 10 and 30 points, however the bottom quarter deteriorated by up to 23 points. In the long run, we estimate that the average improvement of service users like those contained in the sample would be between 1 and 6 points.

Conclusion
Most of the service users have made modest improvements in their CORE 10 TCS. With a higher follow up rate, these results could be generalizable to all service users who completed the CORE 10 at a first time point.



3 CROMS CLINICIAN RATED OUTCOME MEASURES

Clinician Rated Outcome Measures (CROMs) are routinely used across many different health settings and can offer several benefits. A reliable and valid tool provides:

- Information that can be used to inform assessment, help in designing care, and monitor progress
- A common reference point for professionals across services in relation to difficulties and needs

USING AND EMBEDDING CROMS IN PRACTICE

[The Perinatal Mental Health Care Pathways guidance](#), includes a number of outcome measures suitable for use in perinatal mental health services (MBUs and specialist community perinatal mental health teams). More recently the Royal College of Psychiatrists has published the [Framework for Routine Outcome Measures in Perinatal Psychiatry](#) which expands upon this list with additional measures for consideration. This document focuses on three generic measures used in existing perinatal mental health services in England. However, the decision about which outcome measure to use should be informed by the situation, condition and evidence-based recommendations.

EXAMPLE CROM: HEALTH OF THE NATION OUTCOME SCALES (HoNOS)



HoNOS data can already be flowed to the MHSDS and is regularly used for clustering. It is important to consider completing CROMs at significant times in a person's journey (see page 9) – and on a minimum of two time-points, particularly AT ASSESSMENT AND AT DISCHARGE. For technical guidance on how to send HoNOS data to NHS Digital for the Mental Health Services Data Set (MHSDS), please see [Section 8](#).

HoNOS was developed over 20 years ago as a clinician rated outcome measure (Wing et al, 1996). It is used in most trusts (www.rcpsych.ac.uk/clinicalservicestandards/honos.aspx).

HoNOS comprises a 12-item scale which cover psychiatric symptoms, functioning and social circumstances.

Each scale is rated 0 for no problem, 1 for a problem that would not normally need intervention, and 2, 3 and 4 corresponding to a mild, moderate or severe problem.

Scores of 3 and above are considered to be severe. Trusts that have used HoNOS in perinatal services have tailored them to perinatal psychiatry. For example, where the scale asks about the effects of mental disorder on relationships, staff rated the scale with the quality of the relationship with the mother's baby and/or partner in mind.

HoNOS and other tools that are available on the MHSDS can be accessed through the National Clinical Content Repository - <https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service/nccr-tools-and-measures-library>.

TIPS AND FEEDBACK FOR USING

CROMS IN SPECIALIST PERINATAL MENTAL HEALTH SETTINGS

#1 TRANSPARENCY

There is no specific guidance that states that these measures should or should not be used as part of a collaborative conversation. The clinician decides whether to discuss them with the service user. However, being open and honest with service users about these measures, their purpose and the benefits of using them can help to build trust and address any concerns service users may have.

#2 TALKING THROUGH SCORES AS A TEAM

In some cases, practitioners have found that discussing individual cases as a team and scoring them together can help build confidence.

#3 INTERPRETING THE DATA FROM CROMS

Information drawn from outcome measures should not be interpreted or acted upon in isolation from other information. CROMs articulate the professionals' views of how service users are doing. They are a crucial element of outcome monitoring, but it should be recognised that they represent a singular perspective and need to be considered together with other information available, for example the perspective of the service user about their progress through treatment.

The Birmingham inpatient Mother and Baby Unit is a 10 bedded ward admitting women from 32 weeks gestation up to 12 months postnatal.

Like all of the 19 MBUs in England, we are a national service and so accept referrals from anywhere in the country.

Admissions can take place at any time during the week. On admission, a full psychiatric history is obtained by the medics and the nurses.

This helps to inform the assessment process.

CASE STUDY #2

SCORING THE HoNOS AS A TEAM

LEARNING FROM BIRMINGHAM MOTHER AND BABY UNIT

Every Monday morning, we hold a Multi-disciplinary Team meeting, where all professionals are represented (nurses, medics, clinical psychologists, nursery nurses, health visitors and occupational therapists). The care of all patients is reviewed and aims for the week ahead are identified.

All new inpatients are discussed in more detail and we are able to review the assessments that have been completed so far, helping us to identify any gaps in our knowledge and plan for how we will complete the assessment. We also complete a HoNOS score at this time using the collective information from the various professionals - agreeing a score for each domain.

There are certain aspects which have specific significance for women in the perinatal period:

- **Question 5** asks about physical illness or disability. It is important to consider the impact of the pregnancy, the birth and any consequences arising from them.
- **Question 9** asks about problems with relationships. It is important to consider the relationship with the baby and any other children as well as adult family members.
- **Questions 10** asks about problems with activities of daily living. It is important to consider the skills that new mothers must learn when becoming parents, as well as personal self-care activities.
- **Question 11** asks about problems with living conditions. This needs to include a consideration of the needs of the baby and how it allows the mother to reach her full potential as a parent.
- **Question 12** asks about problems with occupation and activities. This needs to consider the needs of the mother as a parent. Does she have access to socially supportive activities such as Children's Centres or stay and play groups? Does she have sufficient support from support workers, nursery nurses so that both mother and baby can attend these facilities.

This scoring takes place as soon after admission as possible and when we have all of the detailed information necessary to give a representative score. It is then repeated at any stage of significant change - specifically shortly after childbirth, but also at any major changes in mental state.

In Birmingham, we have a planned Care Programme Approach (CPA) review every 4 weeks when we invite all key professionals to attend a larger meeting to plan for discharge and moving onto the next steps. Therefore every 4 weeks we ask whether we should be repeating the HoNOS score depending upon the mum's presentation over the previous 4 weeks. Sometimes it is useful to repeat the scoring so that we can identify the areas where we are making progress but also, more importantly, those areas where we are not making progress. Sometimes areas can be missed - where there is dramatic improvement in mental state - we may overlook some of the social needs for this new family.

We always repeat the HoNOS score when we are planning to discharge the mother. As a team it is useful for us to compare the before and after HoNOS scores. This gives us an objective measure of change. If it is thought this will be helpful to the mum, this can be shared with the family and the CPA team at the discharge planning meeting. Even though it may seem clear that great progress has been made, having an objective score is positively reinforcing for care providers and receivers alike.

As a service we hold an annual review and we present the finding of the HoNOS scores once they have been collated. This helps to recognise objectively the impact the team has had on those using the service. These findings are reported, together with the POEM and with real time patient feedback about how the service is doing, the areas we need to continue to maintain and those where we could improve further.

CASE STUDY #3

MAKING THE MOST OF THE HoNOS

LEARNING FROM SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST (SLaM)

SLaM have been using the Health of the Nation Outcome Scale (HoNOS) as one of the clinician rated outcome measures, both in the Channi Kumar Mother and Baby Unit (MBU) and Specialist Community Perinatal Mental Health Teams across the boroughs of Lambeth, Southwark, Lewisham and Croydon.

It is usually used at initial assessment, discharge and at key points of change (e.g. birth of the baby) and usually a minimum of every 6 months. In the community, not everyone will get a second rating due to e.g. only having a single assessment or not completing the treatment if an episode of care ended in an unplanned way.

HoNOS is usually completed by the psychiatrists and nurses and there are discussions about the ratings between staff to ensure reliability. The data is discussed with teams at least annually, if possible 6-12 months. SLaM are in the process of developing a HoNOS dashboard in order to extract and demonstrate the data more easily and share with services users on a regular basis. SLaM is involved in a Trust-wide Quality Improvement programme to create a culture of embedding routine clinical outcome measures into clinical practice, as a way of improving quality for service users and carers.

MOTHER AND BABY UNIT

The graph above demonstrates significant improvement in HoNOS total scores (n=141) between admission and discharge, irrespective of diagnostic group. There were significant improvements in all HoNOS domain scores, except in living conditions domain, irrespective of diagnostic group. The relationship domain includes difficulties in relationship with partner/others including the baby. As the MBU does not accept women with a primary substance misuse/alcohol problem, this domain is 'zero'.

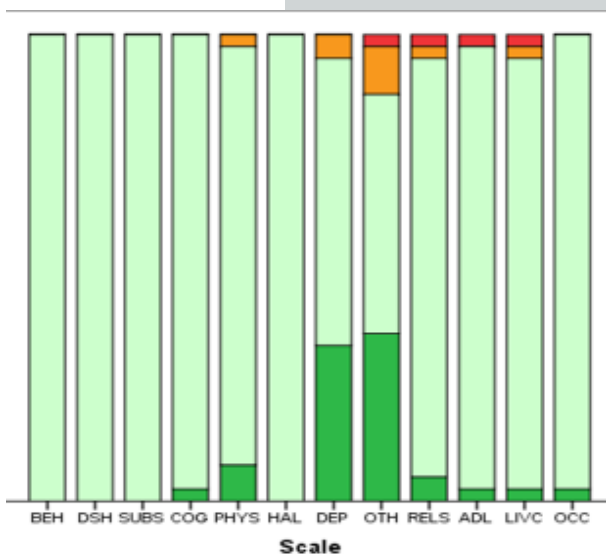
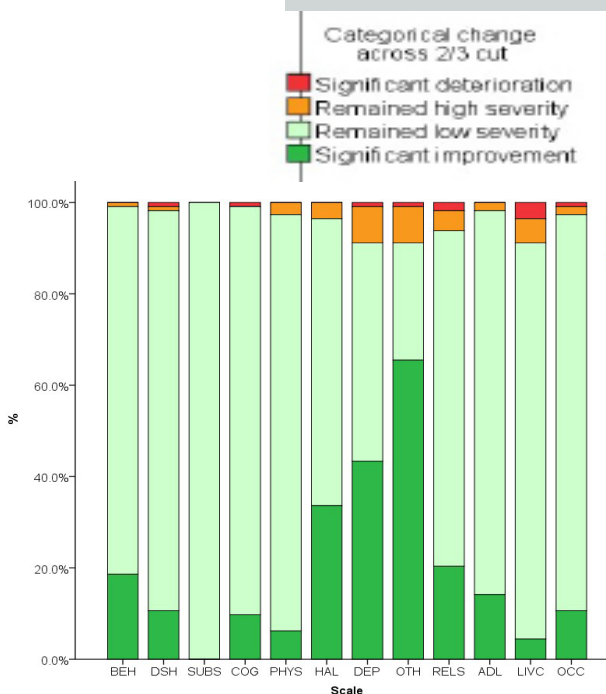
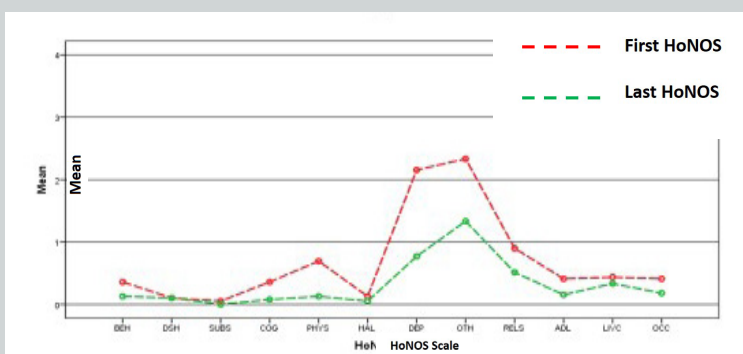
Published in: Stephenson, L. A., Macdonald, A. J., Seneviratne, G., Waites, F., & Pawlby, S. (2018). Mother and Baby Units matter: improved outcomes for both. *BJPsych Open*, 4(3), 119-125.

SPECIALIST COMMUNITY PERINATAL MENTAL HEALTH TEAMS

Paired HoNOS data for one team are presented over a six month period, analysed for those service users who had completed their treatment and had a HoNOS score at both assessment and at discharge (n=39). Effect size was large 1.76 (for Cohen's d, an effect size above 0.8 is considered large).

This analysis did not differentiate women who presented as well at the time of assessment but were seen because they were at high risk of relapse (e.g. diagnosis of bipolar disorder or history of post-partum psychosis). However, the presence of these women would reduce the effect size rather than inflate it, so it does not detract from the validity of the finding. Using a larger data set from a longer time period might enable these data to be separated and analysed more meaningfully. Future reporting will also consider other issues such as length of treatment, diagnosis and ethnicity.

Summary of Results



4 PROMS

PATIENT REPORTED OUTCOME MEASURES

Patient Reported Outcome Measures (PROMs) are a key element of person-centred care. They can:

- Support service users and practitioners in developing a shared understanding of the nature and level of difficulties
- Inform assessment care planning and progress monitoring
- Identify areas of difficulty which may otherwise have been missed through discussion alone, or which may otherwise have taken longer to identify
- Identify specific functions or symptoms that the service users may want to work on
- Provide a routine mechanism for securing service user feedback about progress, to inform responsive care
- Help the service user to articulate difficulties in cases where they may not have the words to express thoughts and feelings
- Help the service user to recognise that the way they are feeling is not unusual (someone, somewhere must have felt like this before because they have written it down)

USING AND EMBEDDING PROMS IN PRACTICE

[The Perinatal Mental Health Care Pathways guidance](#), includes a number of outcome measures suitable for use in perinatal mental health services (MBUs and specialist community perinatal mental health teams). More recently the Royal College of Psychiatrists has published the [Framework for Routine Outcome Measures in Perinatal Psychiatry](#) which expands upon this list with additional measures for consideration. This document focuses on three generic measures used in existing perinatal mental health services in England. However, the decision about which outcome measure to use should be informed by the situation, condition and evidence-based recommendations.

EXAMPLE PROM: CORE-10 & CORE-OM

SPMHS should be collecting PROMs that have been validated for use with women in the perinatal period to support delivery of care and service improvement. [The Perinatal Mental Health Pathways](#) and the [Framework for Routine Outcome Measures in Perinatal Psychiatry](#) published by RCPsyc both include CORE-10 or CORE-OM, which may be a helpful starting point for services who are not currently collecting PROMs. Services should complete either of the CORE measures, or another appropriate PROM, at a minimum of two time points in the service user journey, specifically AT ASSESSMENT AND AT DISCHARGE. It can be helpful to both patient and clinician to have these completed more regularly.

For service users going on to receive psychological treatments, the CORE-OM is recommended for pre- and post-intervention.

The CORE-10 can be used for checkpoints along the treatment pathway if considered to be more efficient. Both CORE-OM and CORE-10 are free to use, requiring no license (www.coresystemtrust.org.uk/home/copyright-licensing/).

CORE-10 can also be accessed through the National Clinical Content Repository - <https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service/nccr-tools-and-measures-library>

For technical guidance on how to send CORE Outcome Measures data to NHS Digital for the Mental Health Services Data Set (MHSDS), please see [Section 8](#).

CORE-OM

This is a 34-item questionnaire designed to be administered at assessment and discharge. It measures 4 dimensions: subjective wellbeing; problem/symptoms; life functioning; risk/harm

The service user is asked to respond to the 34 items about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'.

CORE-10

This is a subset of 10 items from the CORE-OM and can be used as a brief version of the questionnaire. The 10 questions, which are rated on a 5-point scale, give a total clinical score of general functioning.

Both measures are relevant to the adult population so can be used effectively with service users during the perinatal period. However, they do not have any items relating specifically to perinatal mental health or the parent-infant relationship.

As the CORE-OM and CORE-10 look at global distress, they do not include symptoms of some specific disorders (e.g. compulsions in obsessive-compulsive disorder (OCD), avoidance of going out in panic disorder with agoraphobia) and therefore it may sometimes be advisable to use a disorder-specific measure as well.

SCORING AND INTERPRETING THE CORE

Each of the 34 items of the CORE-OM are scored on a 5-point scale from 0-4. The CORE-OM can be divided into 4 subscales:

- Subjective Wellbeing (4 items)
- Problems/symptoms (12 items)
- Life functioning (12 items)
- Risk/harm (6 items)

The measure is used to give a "Total Clinical Score" (TCS) and is calculated by adding all of the scores from every item answered (0-136), dividing by the number of items answered (up to 34) and multiplying by 10 to give a TCS. The TCS can range from 0 to 40, a higher TCS meaning higher levels of mental health difficulty / distress.



Service user comments on CORE-10

Service users said that they liked the combination of positive and negative statements, so it doesn't feel like it's all "doom and gloom" and the range of options for replying was considered to be good.

"Really straightforward and easy, easy enough for anybody of any level to be able to understand"

An example of scoring the CORE-OM can be seen in [figure 5](#).

The CORE-10 does not have any subscales. It has a "Total Clinical Score" (TCS) between 0-40, with a higher TCS meaning higher levels of mental health difficulty / distress.

There are two ways to calculate the TCS:

1. IF ALL 10 ITEMS HAVE BEEN ANSWERED simply add them together to give a score out of 40
2. IF LESS THAN ALL 10 ITEMS HAVE BEEN ANSWERED add the item scores together (each item will be between 0-4), then divide by the number of items answered and then multiply by 10. An example can be seen in [figure 6](#).

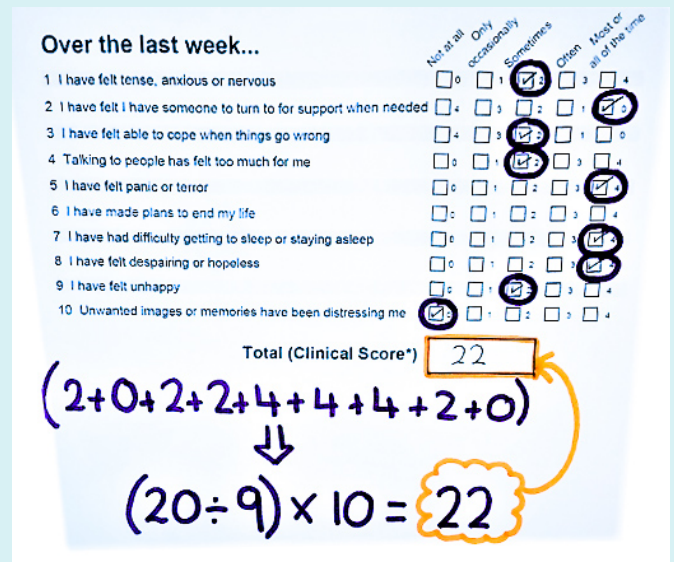


Fig. 6 Example CORE-10 Scoring

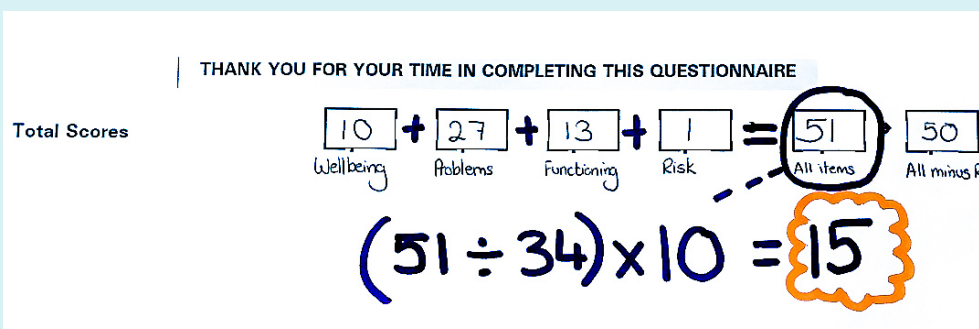


Fig. 5 Example CORE-OM Scoring

The scores are interpreted as:

25+	Severe
20-24	Moderate to severe
15-19	Moderate
10-18	Mild
6-9	Low-level
0-5	Healthy

This clinical cut-off was derived from studies asking large samples of the UK population to complete the questionnaire and comparing their scores statistically with those for large samples of clients in therapy.

Calculating Change Scores

Change scores are important because they show if a service user has got better, worse or not changed over time. It is calculated by subtracting the most recent total clinical score from the first total clinical score.

- A negative change score demonstrates improvement of mental health difficulties / distress.
- A positive change score demonstrates a worsening of mental health difficulties / distress.

On the CORE, it is possible to work out if the service user has made reliable change (either improved or worsening) and if they have made clinically significant change.

Reliable Change: Change that exceeds that which might be expected by chance alone or measurement error. For CORE Outcome Measures, reliable change (either improved or declined) is a movement of 5 points or more.

Clinical Change: Has the service user score moved from the clinical to the non-clinical range? (i.e. above 10 at intake and below 10 at discharge).

Further guidance on the CORE Outcome Measures can be found here - <http://www.coreims.co.uk/>.

CORE OUTCOME MEASURES IN SPMHS SETTINGS

It is important to understand the scores of any questionnaires in the context of the service users' current circumstances. There are some items in the CORE which service users may naturally rate more highly during the perinatal period, regardless of their current mental health; for example:

1. I have felt tense, anxious or nervous (it is natural to feel tense, anxious or nervous in the run up to giving birth or in the new role of being a mother; this should be a discussion point)
2. I have had difficulty getting to sleep or staying asleep (physical issues during pregnancy or after birth can impact on sleep and it is naturally more sporadic post-birth; this should be a discussion point)

At the first point of contact with a service/ clinician, service users may feel concerned about admitting to difficulties. Over time, and as the trust and rapport is established, they may feel better able to respond honestly.

Reporting may, therefore, show that scores from the initial CORE are not as high (higher scores indicate higher levels of difficulty) as follow up scores. Completing the CORE at more than two time-points will help to address for this.





TIPS AND FEEDBACK FOR USING PROMS IN PERINATAL MENTAL HEALTH SETTINGS

#1 GETTING SERVICE USERS ONBOARD

To get the most out of PROMs, both practitioner and service user need to understand their value and relevance to the service user's care. Feedback suggests that where practitioners do not understand the value in asking service users to complete measures, PROMs can be interpreted as "tick-box exercises" creating a process that does not contribute to improving outcomes for service users or make suitable use of practitioner time. Using them in this way can feel disjointed and burdensome. If the clinician sees value in the measures, they will be able to support service users to engage with them meaningfully.

Some dos and don'ts:

- **Do** explain how the measure is relevant to individual care or development of the service
- **Do** explain honestly what it is being used for, who is going to look at the responses and why
- **Do** be knowledgeable about the questionnaire you use and the types of concerns or questions it may generate from service users to ensure you are confident providing helpful answers
- **Don't** introduce the questionnaire as something that "needs to be done"
- **Don't** "feel silly" about standard questions from the questionnaires - let the service user be the person who feeds back as to what feels relevant, and why

“

If the clinician thinks the measure is important and useful, they need to work hard to get the patient on board, to be honest, having conversations about results. If they have bought into it, they will get the patient onboard.

Service User

#2 BUILDING TRUST

Trust is crucial: service users may not always feel like they can answer the questionnaires honestly. Many service users fear they may be judged as parents if they admit to difficult feelings in the perinatal period, even fearing their baby will be taken away. This may result in them giving more socially desirable answers, especially early on as they are still establishing a relationship with the person giving the questionnaire.

The key to helping service users to respond honestly to PROMs is the relationship they have with the person administering the questionnaire.

- Where possible, PROMs should be administered by someone who is seen to be there in a supporting role. For example, the clinician who will be seeing the service user most regularly, which may be different in different settings.
- Service users feel more able to be honest if the person giving the questionnaire is seen to be:
 - Empathic
 - Honest
 - Trustworthy
 - Open
 - Consistent

“

I often put my scores lower, because there was a really real fear that if I score highly on these, my baby will be taken away. I also didn't want to recognise the guilt and shame I felt.

Service User

#3 USING PROMS AS PART OF THE CLINICAL CONVERSATION

A benefit of PROMs reported by service users is that the questions can open-up conversations that might not spontaneously happen. They can also help service users to express difficult feelings.

However, where questionnaires are given to service users without the space to discuss the answers to the questions, there is a risk they will feel judged, anxious about how the information will be interpreted, or not listened to. This is why it is highly recommended that the questionnaire forms part of the therapy session and is not seen as a separate administrative exercise. Useful tips on how to do this are outlined below:

- **Do** introduce the questionnaire as the start of a conversation, not just a questionnaire. Weave the questionnaire into the session rather than making it feel like an add-on.
- **Do**, where possible offer a choice as to whether the service user completes the measure alone, to be discussed together afterwards, or whether they will complete this alongside the practitioner.
- **Do** look at the responses alongside the service users, and ensure there is time and space for them to explain, elaborate or contextualise their responses to the questionnaires.
- **Do** have discussions about the personal meaning of responses to questions, and understand change/lack of change within the wider context of what is happening in the service user's life.
- **Do** have copies of previous responses, if you are using a measure more than once, so you can look at changes and discuss these together.
- **Don't** feedback a score (just a number) without any conversation about what it means.

“

Questionnaires can put people at ease. It can get patients to talk about things. If you see it on paper, it's recognised and now you can talk about it. Lots of these things you keep for yourself.

Service User

“

If things have gotten worse, you need to be making a plan together. And if things have got better, that's really helpful to know. If she can see the small nuggets of changes, that's really helpful.

Service User



CASE STUDY #4

USING CORE-10 SESSION BY SESSION

LEARNING FROM COLLEAGUES IN IMPERIAL COLLEGE HEALTHCARE NHS TRUST

We set up a 10-session antenatal group for couples with a history of traumatic events associated with becoming a parent (fertility difficulties, miscarriage, stillbirth and Neonatal Intensive Care Unit admission).

The group was intentionally set up to meet the needs of couples who did not meet threshold for PTSD but were still experiencing significant psychological distress. Therefore, before the start of the group, we also did a PTSD screen and referred expectant parents for individual trauma-focused therapies if they met the threshold.

We administered the CORE-OM before the first session and at the end of the last session to measure change in "psychological distress" over the course of the group programme. In conjunction with the CORE-OM, we also used the CORE-10 (and the group session rating scales) at the end of each individual session to monitor changes in psychological distress on a session by session basis.

This was built into the group time and every session ended in the same way so it was expected by the group members. As it is only 10 questions, it never took very long and we never had any resistance to completing it each session. Afterwards, one of the group facilitators led a brief grounding/mindfulness exercise to "bring everyone back into the present" and leave the session with a sense of calm.

During this time, the other co-facilitator would briefly review all the completed measures and ascertain if there were any concerns that needed to be picked up with individuals before they left (i.e. a deterioration of difficulties).

Administering the CORE-10 every session was really helpful to understand patterns of change across sessions, critical points in the group programme in which change happened, and differences in change within couples and the wider group across time.

The CORE-10 also really lent itself to sessional completion in a group programme as it has a specific risk question "I have made plans to end my life" and trauma question "unwanted images or memories have been distressing me", which may not have otherwise come up in a group discussion and therefore can still be monitored and escalated if required.



5 PREMS

PATIENT REPORTED EXPERIENCE MEASURES

Patient Reported Experience Measures (PREMs) are reflective tools to help service users feedback on their experience of care. PREMs may explore the quality of practical or functional aspects of care, for example appointments being convenient or the facilities being appropriate. They may also look at relational aspects of care, for example if a service user has felt listened to by the professional/s. All aspects of someone's care experience contribute to their outcomes, so giving services the opportunity to learn about where they are doing well and how their processes can be improved will have a positive impact.

As with CROMs and PROMs, the value of such data is seen when it is collected with a genuine desire to take action in response to the results.

USING AND EMBEDDING PREMS IN PRACTICE

[The Perinatal Mental Health Care Pathways guidance](#), includes a number of outcome measures suitable for use in perinatal mental health services (MBUs and specialist community perinatal mental health teams). More recently the Royal College of Psychiatrists has published the [Framework for Routine Outcome Measures in Perinatal Psychiatry](#) which expands upon this list with additional measures for consideration. This document focuses on three generic measures used in existing perinatal mental health services in England. However, the decision about which outcome measure to use should be informed by the situation, condition and evidence-based recommendations.



EXAMPLE PREM: PATIENT OUTCOME AND EXPERIENCE MEASURE

SPMHS should be using PREMs to support service improvement, every service is recommended to complete a PREM at discharge from the service and report this at a local level. The Perinatal Mental Health Pathways and the Framework for Routine Outcome Measures in Perinatal Psychiatry published by RCPsych, both highlighted the POEM as useful PREM for SPMHS.

POEM captures satisfaction over time and can be used routinely to evaluate perinatal services in both MBUs and community teams. It has been selected by the Royal College of Psychiatry's Centre for Quality Improvement (CCQI) as a continuous routine evaluation to collate feedback from patients and families. The measure can be used to benchmark services against each other. There are two versions of the measure:

- 1. Community:** Two questions on mental health at first contact and discharge from service using a 5-point scale and 12 questions on patient experience using a 4-point scale and,
- 2. MBU:** the above plus an additional 6 questions specific to the MBU that also use a 4-point scale.

The POEM is available to use, free of charge, from the Perinatal Quality Network: <https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/perinatal-community-teams>.

COLLECTING POEM

There are two possible methods for collecting and reporting the POEM:

Through the Perinatal Quality Network (PQN):

An electronic link is provided by the PQN which is then sent to the service users. They complete the survey online and the results get returned directly to the PQN. The PQN will produce a report for the service on request, summarising all of the responses for the specified timescale (for example quarterly or annually); it also offers benchmarking within this report. Services can request this method of administration directly from the PQN (perinatal-chat@rcpsych.ac.uk).

This will minimise the workload for services so that the focus can be on trying to encourage as many patients and partners/family to complete it as possible. This method also keeps the measure separate from the service so that service users feel that their responses are anonymous and they can respond honestly. Copies of anonymised raw data for each service can also be sent on request.

In House:

The individual service administers the questionnaire (paper versions of the questionnaire can be requested from the PQN (perinatal-chat@rcpsych.ac.uk) and records the results within the local IT system.

The service is responsible for analysing and reporting their own data; the PQN no longer accepts paper versions to input and report on.

SCORING AND INTERPRETING THE POEM

There are three sections to the POEM; each section should be looked at separately as the answer scales are slightly different. There are no numerical scores and no total or subscale scores to compute.

Community SPMHS should only ask service users to complete the first and second sections; the third section is an additional section to be used if the service user is accessing an MBU.

Scoring and Interpreting Section 1: Patient-Rated Mental Health (2 items)

These 2 items have five possible answers, ranging from "Very well" to "Extremely unwell". As there are no numerical values to accompany the answers, a simple bar graph showing how people have responded can be used (see figure 7).

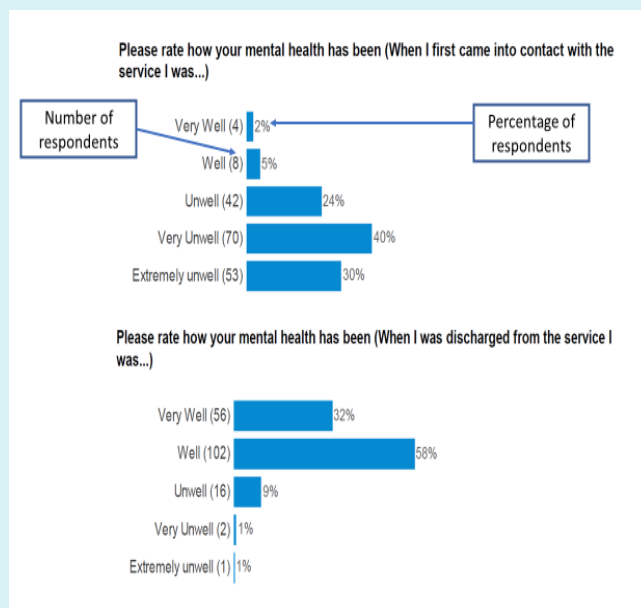


Fig. 7 Example of a Perinatal Quality Network Report

It should be noted that this representation of the data does not link individual responses (for example there is no way to see if those who answered, "Extremely unwell" for question 1 have gone on to answer question 2 as "Well" or "Very well"). However, generally the service can see that there has been a shift to more service users reporting they now feel "Well" or "Very well".

Scoring and Interpreting Section 2: Service experience (12 items)

These 12 items have four possible answers, ranging from “Strongly agree” to “Strongly Disagree”. As there are no numerical values to accompany the answers, a simple bar graph showing how people have responded can be used.

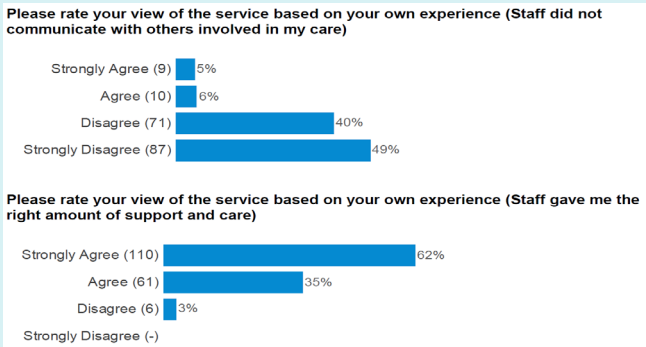


Fig. 8 Example of a Perinatal Quality Network Report

It should be noted that there is a mixture of both positive and negative items. Therefore (as in the example in figure 8), “Strongly agree” is a negative result for item 1, but “Strongly agree” is a positive result for item 2.

If this data is produced in local reports, colour-coding the responses to show where responses are positive or negative could aid in the interpretation of results (see figure 9).

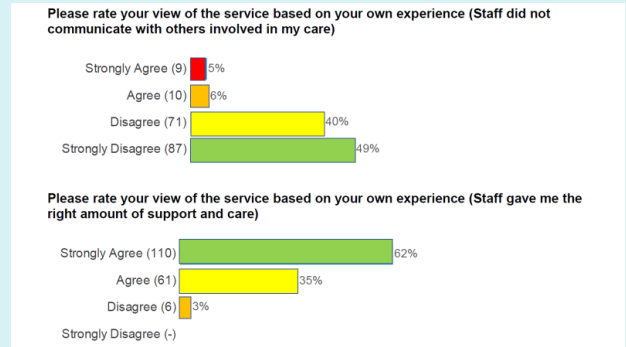


Fig. 9 Example of a Perinatal Quality Network Report

Scoring and interpreting section 3 (MBUs ONLY): Experience of the MBU (6 items)

These six items have four possible answers, ranging from “Strongly agree” to “Strongly Disagree”. As there are no numerical values to accompany the answers, a simple bar graph showing how people have responded can be used.

There are a mixture of positive and negative items where “Strongly agree” can either be a positive or a negative result, so colour-coding as described above could aid in the interpretation of results.



From the patient perspective, it's good to collect this kind of feedback.

Service User

TIPS AND FEEDBACK FOR USING PREMS IN PERINATAL MENTAL HEALTH SETTINGS

Service users have stated that they value the opportunity to give feedback on their experiences of a service and felt positive about using questionnaires to do this.

- **Do** offer anonymity: If the PREM is directly administered by the clinician/service and not anonymous, service users may not feel able to answer honestly. Similarly, service users could feel anxious about non-anonymised online submissions that include personal information.
- **Don't** ask service users to complete PREMs in the presence of the clinician.
- **Do** facilitate a relationship where patients feel sufficiently confident to voice concerns about their experience with practitioners directly - in addition to requesting confidential feedback through PREMs at the end of treatment.

- **Do** offer a choice of format (online, paper, text message, in person) - different service users will have different preferences/ language abilities/ reading levels (although digital methods seem to be the most popular).
- **Do** have a formal process in place for monitoring and utilising PREMs feedback to improve quality of care and importantly, respond to those individuals who have expressed a wish to have their views, concerns or complaints followed up directly (there must be space for individuals to provide contact details clearly marked as optional).
- **Do** display or publish recent feedback about the service, and the actions that are being taken in response: this should be visible to service users so that they know their feedback is respected and meaningfully used.

6 SPECIAL CONSIDERATIONS

USING MEASURES IN SECONDARY PREVENTION WORK

Service users who may be well at the point of entry into the service and for whom the goal of the service is to prevent the relapse of chronic mental illness during the perinatal period, need some special consideration when using and interpreting measures. Outcome measures over time will not look the same for this group as they may be well at the point of referral and the goal of treatment is not to alleviate symptoms but to maintain their current wellbeing during pregnancy, childbirth and the postnatal period. For example, for this group of service users, a good outcome will be that their HoNOS and CORE-10 scores do not deteriorate over time.

- The same set of measures that are used in the SPMHS may still be used with service users who are receiving preventative treatment.
- However, services may want to differentiate these cases from other treatment cases at the level of data analysis and interpretation of change.

To separate out data for different subgroups of service users, it is helpful if these cases are identified from the outset and this is indicated in the database. This will enable these cases to be easily identified and therefore analysed separately from other cases.

Consultations with perinatal psychiatrists suggest that the service users most likely to be receiving this kind of preventative care would be those with a diagnosis of affective and non-affective psychotic illness (e.g. BPAD, psychotic depression, Schizoaffective illness, Schizophrenia, acute and transient psychosis, other non-organic psychosis). These service users may also have low HoNOS scores at the first assessment.

There is also a question of how to best capture the outcomes for this group. One suggestion is to record relapse rates and compare these with the literature.

USING MEASURES IN MOTHER AND BABY UNITS (MBU)

The HoNOS, CORE and POEM are a minimum recommendation across all SPMHS including Mother and Baby Units. However, service users within MBUs understandably have a higher level of need and may have entered the unit during crisis or have multiple problems/difficulties.

Therefore, thought needs to be given about the timing of introducing PROMs and the balance of those being used.

- Using PROMs in times of crisis: it is not recommended to use these measures whilst the service user is in a heightened state of distress as this could exacerbate the situation. Use clinical judgement to decide when is the best time to give them the choice of completing a PROM (but they should still be given the choice).

- Tracking multiple problems: not one measure will cover all difficulties they might be experiencing and so a suite of measures should be considered.
- Complete more frequently: as the period of stay in MBUs is generally shorter, change will happen more quickly and so it is legitimate to ask the service user to complete the measures more frequently (explaining why this is happening and why it is of benefit)

Some measures have been developed specifically to be used in Mother Baby Units (MBU) and these may be the measures of choice. These include:

- An inpatient version of the POEM
- The Bethlem Mother–Infant Interaction Scale (BMIS)

7 ADDITIONAL MEASURES

OCCUPATIONAL THERAPY

SPMHS Occupational Therapists explore the impact of perinatal mental health difficulties on the service user's daily functioning and wellbeing and support the service user and their family to anticipate and adjust to the effects of occupational changes during the transition to parenthood. Whilst currently there are no occupation-specific perinatal mental health measures, there are a range of occupation-focused outcome measures and

individualised occupation-centred goal-attainment tools that occupational therapists are using in SPMHS, which include:

- [Model of Human Occupation Screening Tool](#)
- [Occupational Self Assessment](#)
- [Occupational Circumstances Assessment Interview and Rating Scale](#)
- [Canadian Occupational Performance Measure](#)

PARENT-INFANT RELATIONSHIP

SPMHS provide support for service users and their babies. The quality of the relationship between mother and baby may be an important part of the presenting difficulties and supporting this relationship is frequently one of the key goals of treatment. The assessment and monitoring of the mother-infant relationship is a key quality standard in community perinatal mental health care provision (Royal College of Psychiatrists, 2013). It may be the area that service users feel most relevant to the support they are receiving.

The Royal College of Psychiatrists have provided a list of mother-infant relationship measures and provided recommendations for instruments that may be used in SPMHS.

Currently, there is not enough evidence to be able to make recommendations on a specific measure of the parent-infant relationship for use across all SPMHS. Further evidence is needed for the psychometric properties and feasibility in frontline clinical practice for the various measures. Many of the measures require extensive training and are time consuming to administer and score reliably, so there are additional challenges in incorporating these into routine practice.

Clinicians or clinical teams may choose to use any of the measures listed by the Royal College of Psychiatrists as useful instruments for clinical assessment and outcome monitoring.

“

Questionnaires should include questions about how you feel about your baby or what your relationship with your baby is like. If not, you may not get to the root of the problem.

Service User



GOAL BASED OUTCOMES

Setting and monitoring shared goals can help practitioners and service users to focus their work together. They can help to track progress against objectives that are most meaningful to the service user, alongside more standardised or clinically-inspired measures. Setting and tracking goals can also help with engagement and reinforce the working alliance.

One tool for monitoring progress against collaboratively set goals is the Goal Based Outcome (GBO) measure, a tool suitable for use in any setting which is change-focused and goal-orientated. Setting a meaningful, achievable and mutually agreeable (between professional and service user) goal is a skill and can demand practice. Published guidance to support practitioners in using GBOs can be found here: <https://goals-in-therapy.com/2018/12/07/guidance-notes-for-using-the-goal-based-outcome-gbo-tool/>.

Examples of how GBOs could be used in SPMS work include helping service users to improve their:

- Mental health and wellbeing, focusing on a particular area of distress / difficulty
- Parenting skills; this could be around a specific area such as sleep or more general baby care
- Mother – infant relationship
- Other close relationships (e.g. with partner)

The advantage of incorporating GBOs in the suite of measures used by SPMS is that they allow service users a chance to decide for themselves what elements of their health and wellbeing should be measured and monitored.

This helps everyone to maintain focus. In SPMS, this is especially important. Many SPMS users have said that they find some other measures of functioning (such as the CORE) too prescriptive - they do not take into account the natural ups and downs of the perinatal period and they do not necessarily capture what the service user sees as the “root of the problem”.

Supplementing the generic measures with more subjective measures such as the GBOs can help the service user feel that they have personalised individual outcomes to work toward.



CASE STUDY #5

USING GOAL BASED OUTCOMES IN PARENT-INFANT PSYCHOTHERAPY

LEARNING FROM THE ANNA FREUD CENTRE PARENT-INFANT PROJECT (PIP)

The PIP service has been using GBOs as part of their package of routine outcome measures for several years. We have found that setting goals with our parents at the outset of Parent Infant Psychotherapy can:

1. Support the treatment alliance- they are the family's goals, not therapists' goals, but the therapist immediately is joining them in problem solving (they are no longer alone)
2. Orient the parent towards the help that we can focus on: i.e. improving the relationship with the baby; rather than for example, focusing solely on mood improvement in the parent.
3. Offer something quantitative and tangible that suggests at the outset that the "problem" can be verbalised/ outlined (thus is hopefully less overwhelming) and suggests it will be able to improve with support.

Examples:

A parent described a goal 'to feel less resentful of her mother in law's "intrusive" offers of help'. This led to a discussion and working through of her loss of her own mother in adolescence (which she thought she had dealt with) and reliving this bereavement having made the transition to motherhood herself.

A parent states that their goal is 'to feel less anxious and happier', (i.e. is self-directed, when the PIP model is relational). We would probe about how - in relation to baby - they might achieve or know they had achieved an improvement in their state of mind and link this to aiming to gain a better ability in reading their baby's mood/states and how both may impact one another.

Thus, we are already working in the goal setting, in a way that promotes an increased awareness of their own and their baby's internal states, as well as increasing curiosity. We ask questions like:

- How will you know when you feel happier?
- What might be different in you, and in Baby?
- How do you think Baby feels about this- how can you tell?

We might further suggest that they might then be able to read their baby's responses or cues more sensitively with support of PIP and receive further feedback from their baby. We would indicate through these reflections and questions that Baby is an active and independent participant in this shared treatment and goal of mood improvement for both.

Often parents feel they reach a goal after a few months and in reviewing these we would then ask if they felt this goal was still relevant and could then set further goals or set a date for the work to conclude if a goal had been achieved.



FLOWING DATA TO NHS DIGITAL MHSDS TECHNICAL SPECIFICATION

This section is aimed at helping Data or Informatic Leads to ensure data can be sent to NHS Digital in the correct format to be compliant with the Mental Health Services Data Set.

Data which is stored in local IT systems must be extracted/downloaded and sent to NHS Digital monthly. For more detailed information please visit: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/how-do-i-submit-data-to-the-mental-health-services-data-set>

The following information is specific to the HoNOS and CORE Outcome Measures and details the specific pieces of data that should be collected locally in order to be able to extract/download and flow them.

HoNOS

To flow the HoNOS to NHS Digital, as a stand-alone Care Assessment tool, you will need the following data:

TABLE MHS 606

Coded Scored Assessment (Referral)

For outcome measures being flowed as part of the Referral but NOT linked to a Care Contact

Service Request Identifier	All of the relevant data can be found in MHS 101 and 102
Coded Assessment Tool Type (SNOMED CT)	Input the correct SNOMED codes for HoNOS There are 13 separate SNOMED codes for each of the 12 HoNOS items (Item 8, other mental and behavioral problems, requires both a score of 0-4, and then a letter A-J corresponding to a category for other mental health/behavioural problems)
Person Score	The score for 0-4 against each of the 12 items plus letter A-J against item 8 (13 scores in total)
Assessment tool completion date	The date when the HoNOS was completed

TABLE MHS 607

Coded Scored Assessment (Care Activity)

For outcome measures being flowed as part of a Care Contact (linked to Care Activity)

Care Activity Identifier	All of the relevant data can be found in MHS 201 and MHS 202
Coded Assessment Tool Type (SNOMED CT)	As above – SNOMED codes for HoNOS (13 codes in total against 12 items)
Person Score	The score for 0-4 against each of the 12 items plus letter A-J against item 8 (13 scores in total)

To flow the HoNOS to NHS Digital as part of a Clustering Tool Assessment you will need the following data:

TABLE MHS 802 Coded Scored Assessment (Clustering Tool)	
Cluster Tool Assessment Identifier	All of the relevant data can be found in MHS 801
Coded Assessment Tool Type (SNOMED CT)	You need to input the correct SNOMED code for your chosen CROM
Person Score	The score from 0-4 against EACH of the 12 items and letter A-J against item 8

CORE-10

To flow the CORE-OM or CORE-10 to NHS Digital, you will need the following data:

TABLE MHS 606 Coded Scored Assessment (Referral) For outcome measures being flowed as part of the Referral but NOT linked to a Care Contact	
Service Request Identifier	All of the relevant data can be found in MHS 101 and 102
Coded Assessment Tool Type (SNOMED CT)	You need to input the correct SNOMED code for the PROM this can be found at [insert link]
Person Score	This will be the Total Clinical Score for either measure
Assessment tool completion date	The date when the PROM was completed (could be at either assessment or follow up)

TABLE MHS 607 Coded Scored Assessment (Care Activity) For outcome measures being flowed as part of a Care Contact (linked to Care Activity)	
Care Activity Identifier	All of the relevant data can be found in MHS 201 and MHS 202
Coded Assessment Tool Type (SNOMED CT)	You need to input the correct SNOMED code for the PROM
Person Score	This will be the Total Clinical Score from either measure
NOTE: This table can be submitted multiple times if the assessment tool has been completed at multiple time points: one table is needed for each completion.	

All SNOMED Codes can be found here: <https://termbrowser.nhs.uk/> (Technical Output Specification).

9 APPENDICES

APPENDIX 1: IMPLEMENTATION SELF-ASSESSMENT

APPENDIX 2: CORE-OM

APPENDIX 3: CORE-10

APPENDIX 4: POEM

APPENDIX 1: IMPLEMENTATION SELF-ASSESSMENT



IMPLEMENTING ROUTINE OUTCOME MONITORING IN SPMHS

	WHAT DOES GOOD LOOK LIKE	SUCCESSES	CHALLENGES	ACTIONS FOR IMPROVEMENT
#1 LEADERSHIP, VISION AND CULTURE	<ul style="list-style-type: none"> • Every member of the service, from front line staff through to senior leaders and board members, understands which measures are used in service and why • The language of ROM is included in strategic documents and there is a clear vision statement around collection and use • There is a continuous drive to improve practices around outcome and feedback measures 			
#2 EMBEDDING MEASURES AS PART OF THE EVERY DAY	<ul style="list-style-type: none"> • ROM data is given as much time / emphasis as traditional key performance indicators such as referrals and waiting times • Experience and knowledge of ROM forms part of the recruitment process • Feedback from measures is reviewed as part of supervision discussions • Service users are informed, upfront, which measures are used and why they are important 			
#3 BUILDING STAFF CONFIDENCE AND CAPABILITY	<ul style="list-style-type: none"> • Staff work together to find solutions and strategies to mitigate risks and challenges • ROM training is part of the induction process • ROM training is part of any corporate training programme and continuous professional development offer • Team meetings promote ROM discussion and shared learning 			
#4 PRACTICAL CONSIDERATIONS AND PROCESSES	<ul style="list-style-type: none"> • There is easy access to paper versions of the tools • Written processes, detailing which tools to use and when, are in plain sight • It is clear how data is inputted and stored in IT Systems 			
#5 BASIC IT REQUIREMENTS	<ul style="list-style-type: none"> • Investment has been made to make systems fit for purpose • ROM data is easily extractable and reportable • Staff are formally trained in how to use the IT correctly 			
#6 SUSTAINING THE EFFORT	<ul style="list-style-type: none"> • ROM successes are celebrated and there are clear feedback loops to show how ROM data has aided service decisions • ROM staff champions are clearly visible and accessible • Communities of practice are embraced and supported through regular attendance and contribution 			
#7 ANALYSING AND REPORTING AGGREGATED DATA TO INFORM SERVICE DECISIONS	<ul style="list-style-type: none"> • There is a good level of data completeness and representativeness within reporting periods • Data is grouped appropriately and interpreted at the right level • A range of impact information forms a comprehensive dash board 			

APPENDIX 2: CORE-OM

**CLINICAL
OUTCOMES in
ROUTINE
EVALUATION**

**OUTCOME
MEASURE**

Site ID

letters only numbers only

Client ID

Therapist ID numbers only (1) numbers only (2)

Sub codes / /

Date form given

Age Male Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt O.K. about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

Please turn over

Survey : 151

Copyright MHF and CORE System Group.

Page : 1

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most of all the time	OFFICE USE ONLY
15 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17 I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
19 I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
20 My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
21 I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
22 I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
23 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
24 I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
25 I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
26 I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
27 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
28 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
29 I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
30 I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
31 I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
32 I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
33 I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
34 I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	→	<input style="width: 50px; height: 20px;" type="text"/>	→	<input style="width: 50px; height: 20px;" type="text"/>
Mean Scores <small>(Total score for each dimension divided by number of items completed in that dimension)</small>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>		<input style="width: 50px; height: 20px;" type="text"/>		<input style="width: 50px; height: 20px;" type="text"/>
	(W)	(P)	(F)	(R)		All items		All minus R

APPENDIX 3: CORE-10

**CLINICAL
OUTCOMES in
ROUTINE
EVALUATION**

**CORE-10
Screening
Measure**

Site ID <input type="text"/>	Stage Completed S Screening R Referral A Assessment F First Therapy Session P Pre-therapy (unspecified) D During Therapy L Last therapy session X Follow up 1 Y Follow up 2
Client ID <input type="text"/> / <input type="text"/> <small>letters only numbers only</small>	
Sub codes <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Therapist ID numbers only (1) numbers only (2)</small>	Episode <input type="text"/> Stage <input type="text"/>
Date form given <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> <small>D D M M Y Y Y Y</small>	Gender <input type="checkbox"/> Male Age <input type="text"/> <input type="checkbox"/> Female

IMPORTANT - PLEASE READ THIS FIRST
 This form has 10 statements about how you have been OVER THE LAST WEEK.
 Please read each statement and think how often you felt that way last week.
 Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 I have made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Total (Clinical Score*)

* Procedure: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.
 Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

CORE-10 Copyright CORE System Trust (February 2006)



APPENDIX 4: POEM

Unit/Service Name **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.

Please answer all the questions.

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

1. Please rate how your mental health has been	<i>Very well</i>	<i>Well</i>	<i>Unwell</i>	<i>Very unwell</i>	<i>Extremely unwell</i>
When I first came into contact with the service, I was					
When I was discharged from the service, I was					

2. Please rate your view of the service based on your own experiences. Please try to tick one answer for each of the questions:	<i>Strongly agree</i>	<i>Agree</i>	<i>Disagree</i>	<i>Strongly disagree</i>
Staff did not communicate with others involved in my care				
Staff gave me the right amount of support				
I did not get help quickly enough after referral				
Staff listened to me and understood my problems				
Staff did not involve me enough in my care and treatment				
The service provided me with the information I needed				
Staff were not sensitive to my needs				
Staff helped me to understand my illness/difficulties				
Staff were not sensitive to the needs of my baby				
Staff helped me be more confident with caring for my baby				
The service involved other relevant people in a helpful way				
I would recommend this service to others				

Turn over →



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3. ONLY answer these questions if you are being discharged from INPATIENT CARE IN A MOTHER AND BABY UNIT (MBU).	Strongly agree	Agree	Disagree	Strongly disagree
The unit was clean and hygienic				
The unit did not provide a good place for me to recover in				
The unit did not provide helpful activities and therapies				
The unit provided a good place for my baby to be with me				
The unit supported me in my contact with family and friends				
The food provided was not acceptable to me				

4. Please use this space for any other comments about the service and how we could improve it

Thank you for completing this questionnaire. Please put it in the envelope provided and send it back to us, or give the envelope to any member of staff.

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. ©RCPsych

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