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ROYAL COLLEGE OF PSYCHIATRISTS

PQN
PERINATAL
QUALITY NETWORK

Standards for Community Perinatal Mental Health Services

Sixth Edition
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Contents

Chair's Foreword

The first set of community standards for the Perinatal Quality Network were published in 2012. The past 13 years have seen a huge expansion of specialist community teams across all countries of the UK, bringing us closer to the gold standard that all women, wherever they live, have access to high quality perinatal mental health care. But teams do not develop in isolation. They are set in a landscape of increasing service complexity, of different service evolution in each of the four UK nations, and of national and worldwide environmental change. In its own way, this new edition of the standards reflects, and attempts to address, these challenges.

The different paths that nations have taken in developing perinatal mental health services has led, for the first time, to the creation of service standards specific to national, rather than UK-wide needs. In England, recommendations from the Long Term Plan on service extension to 24 months and the consequent need for increased staffing, have been acknowledged in the sections on Access and Staffing. This allows teams to be recognised where they have responded to this need but does not oblige services in other jurisdictions to follow suit. New core (that is, applicable to all quality networks) standards also emphasise the importance of sustainability in service provision and access for patients to green spaces.

Coming out of the pandemic, the new standards also recognise the use of virtual consultations, emphasising the importance of patient choice. Covid has led to significant changes in practice and a number of new challenges for teams. That our services continue to provide responsive, highly specialised care is a testament to the dedication of staff working through what have been very difficult times.

Increasing service complexity is reflected in the development of specific psychological interventions services in maternity settings (Maternal Mental Health Services in England; Maternity and Neonatal Psychological Interventions Services in Scotland) and in the need to adapt the standard model of community team provision to meet the needs of more rural and remote areas. Addressing the consequences of these changes for our standards will likely challenge the Network's Advisory Group over the coming year.

It is impossible to write the foreword this year without mentioning the loss of Margaret Oates. Margaret was the founding chair of the Advisory Group and indeed, of the Network itself. It was her model of community service provision that formed the basis of these standards, and her innovation, drive, and absolute commitment to the care of women and their infants has inspired many of today's practitioners across the UK. Her thinking permeates national service developments and, through her pioneering work with the Confidential Enquiries into Maternal Deaths, influences everyday clinical decision making on risk and patient safety. She will be hugely missed but has left a legacy which is unmatched.

Dr Roch Cantwell

Consultant Perinatal Psychiatrist; Co-Chair of the PQN Advisory Group and Chair of the PQN Accreditation Committee

Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patients & carers, and email forums with professional groups involved in the provision of community perinatal services. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to community perinatal services.

Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

Who are these standards for?

These standards are designed to be applicable to community perinatal services and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

CCQI core standards

The core standards are used by the quality networks and accreditation programmes within the College Centre for Quality Improvement (CCQI). Each project adopts the relevant core standards which will be used alongside the specialist standards that relate to the service type being reviewed. The core standard reference number can be viewed on the right-hand column throughout the document. Those that are not marked with a core number are specialist standards relating to community mental health services that are not included in the core set.

Criteria

All criteria are rated as Type 1, 2 or 3.

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: Expected standards that most services should meet.

Type 3: Desirable standards that high performing services should meet.

Sustainability Principles

The sixth edition of the PQN quality standards for community perinatal services has been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

(www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx)

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community

projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamworking facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Sustainability standards are marked throughout the document with the leaf icon.

Section 1: Access and Referral

Standard Number	Standard Type	Sixth Edition Criteria	CCQI Core standard
1.1		**The service is provided for the following groups in a defined catchment area:**	
1.1a	1	Women following discharge from an inpatient mental health unit.	
1.1b	1	Women experiencing Bipolar Disorder/ Postpartum Psychosis, other psychoses and Serious Affective Disorder, who can be safely managed in the community.	
1.1c	1	Women with moderate to severe non-psychotic conditions.	
1.1d	1	Women identified in pregnancy who are at risk of a recurrence/relapse of a psychotic or serious/complex non-psychotic condition. *Guidance: This includes women who are currently unwell and those who are well but at risk of becoming unwell.*	
1.1e	1	Women requiring pre-conception counselling.	
1.1f	1	Women with alcohol/substance misuse problems if there is also moderate to severe mental illness.	
1.2	1	The service provides information about how to make a referral, and waiting times for assessment and treatment.	1.3
1.3	1	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP/referrer is informed.	

1.4	1	A care pathway, including antenatal screening questions, is agreed with maternity services, GPs and adult mental health services to identify both those at risk of developing a serious mental illness following delivery and those who are currently unwell. *Guidance: These might need to be separate pathways for each service.*	
1.5	1	Priority care pathways are in place to allow for discussion of potential emergency, for example, conditions arising after 28 weeks and before six weeks postpartum. Contact with the referrer and/or patient should take place within two working days to establish the urgency of assessment. *Guidance: When a senior team member is not available another appropriate member of the team may be consulted for these discussions.*	
1.6	1	Referrals can be made directly to the service during working hours. *Guidance: Direct referrals should be encouraged where possible.*	
1.7	1	The service responds to urgent requests for telephone advice from other professionals within one working day.	
1.8	1	A clinical member of staff is available to discuss emergency referrals during working hours.	1.4
1.9	1	When the team are unable to conduct an emergency assessment, there is an agreed approach in place. *Guidance: This may include having arrangements in place with another service to cover this, e.g. crisis; liaison. If possible, perinatal teams should try to attend, otherwise this should be done by crisis, liaison, home treatment teams, or an equivalent service.*	

1.10	1	There is a procedure agreed with out of hours teams that, following assessment, patients requiring perinatal specialist care are referred the next working day.	
1.11	3	The service provides a telephone advice line for professionals (e.g. midwives, GPs) at specific times of the week.	
1.12	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an emergency referral which should be passed across immediately.	1.5
1.13	1	The team has a timetabled meeting at least once a week to provide oversight of allocation of referrals and clinical activity. *Guidance: During the working week teams may also screen referrals daily.*	5.2
1.14	1	Outcomes of accepted referrals are fed back to the referrer and patient within ten working days of the referral. If a referral is not accepted, the team advises the referrer and patient and on alternative options.	
1.15	1	The service has clear joint working protocols regarding working with: • Patients with disordered eating; • Patients with substance misuse problems; • Patients with a severe, diagnosed personality disorder; • Patients with a learning disability; • Unscheduled care teams/home treatment/crisis/liaison teams.	
1.16	1	The perinatal service works with the local CYP service to provide care to patients under the age of 18, where a perinatal psychiatric disorder dominates the clinical picture.	

1.17	2	The team offers appointments both in person and virtually, and patient preference is taken into account. *Guidance: This should include at least one 'face to face' contact either in person or via video call.*	1.7
1.18	3	Where appointments are face-to-face, these should be in accessible settings. Everyone can access the service using public transport or transport provided by the service.	1.2

Section 2: Assessment			
2.1	1	Teams assess women who are experiencing an episode of moderate to severe mental illness (in pregnancy and **until at least 12 months postpartum** with follow up beyond 12 months pospartum if the womens' needs are best met by the perinatal service).	
2.2	2	Teams assess women who are experiencing an episode of moderate to severe mental illness (in pregnancy and **until at least 24 months postpartum** if the womens' needs are best met by the perinatal service).	
2.3	1	The team assesses women, who are referred to the service, within an agreed timeframe. *Guidance: There should be a process to ensure urgent referrals are seen within the team or by another team following an agreed protocol. This should include an understanding of perinatal risks and the need for joint working.*	1.6

2.4	1	Pregnant patients referred with a previous history of serious mental illness, even if currently well, are offered an assessment to take place during their pregnancy. *Guidance: In some areas, this will involve collaborative working with other specialist services.*	
2.5	1	For non-emergency assessments, the team makes written communication in advance to patients that includes: • The name and role of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries, require support (e.g. an interpreter, child care, breast feeding facilities), need to change the appointment or have difficulty in attending appointments.	2.1
2.6	1	If the service receives a referral for a patient who has been prescribed Sodium Valproate or Semi-Sodium Valproate, it is the responsibility of the service to ensure MHRA guidance is followed. An urgent discussion is had (within two working days) with the patient, referrer and other appropriate clinical services. *Guidance: This discussion should include a rigorous assessment of the indications for using Sodium Valproate or Semi-Sodium Valproate. If it has been prescribed as a mood stabiliser by mental health services, this should be escalated to the relevant authority e.g. the clinical or medical director.*	
2.7	1	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development;	3.2

2.8	1	A physical health review takes place as part of the initial assessment, or as soon as possible. *Guidance: The patient's assessment should include a general health review taking into account the patient's pregnant or postnatal state. Any concerns identified result in further assessment and investigation by either the team or another appropriate service such as their GP or Maternity Service.*	3.3 Sustainability Principle: Prioritise Prevention 
2.9	1	Patients have a risk assessment and management plan which is co-produced where possible, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). Guidance: The assessment considers risk to self, risk to the baby/pregnancy, risk to others and risk from others.	3.4 Sustainability Principle: Prioritise Prevention 
2.10	1	For women assessed in pregnancy, there is a peripartum management plan formulated and recorded in the handheld records (or equivalent) by 32 weeks of pregnancy, that is shared with the patient, their family or chosen others (where appropriate), GP, Midwife, Health Visitor, Obstetrician and any other relevant professionals or organisations. *Guidance: Any exceptions should be documented in the patient's notes along with reasons for this (e.g. if they were a late referral).*	
2.11		The peripartum management plan should include:	The peripartum management plan should include:
2.11a	1	Nature of the risk and condition.	
2.11b	1	Details of current medication and any intended changes in late pregnancy and the early postpartum period.	

2.11c	1	Consideration of whether the mother intends to breastfeed.	
2.11d	1	Professionals involved and frequency of contact. *Guidance: For example, frequency of contact with health visitor, GP etc.*	
2.11e	1	The patient's chosen emergency contact's details.	
2.11f	1	Admission to a Mother and Baby Unit if necessary and any plans or special requirements for a maternity admission.	
2.12	1	Women referred in pregnancy who are at high risk of serious illness are assessed by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed.	
2.13	1	Women identified as requiring a formal psychological intervention are offered an assessment with a qualified psychological practitioner and any treatment commenced within 28 days of the assessment. *Guidance: Any exceptions and reasons for this are documented in the patient's notes. Practitioners delivering therapy must be appropriately trained and supervised.*	
2.14	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The patient receives a copy.	3.6
2.15	1	Patients are asked if they and their partner and/or chosen others wish to have copies of letters about their health and treatment.	15.1

2.16	1	Confidentiality and its limits are explained to the patient and partner/chosen other, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	16.1
2.17	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. Guidance: Where patients consent, the carer is contacted.	4.1
2.18	1	If a patient does not attend for an assessment/ appointment, the assessor contacts the referrer. *Guidance: If the patient is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.*	4.2
2.19	1	Patients feel respected by staff members when attending their appointments. *Guidance: Staff members introduce themselves to patients and address them using their name and correct pronouns, titles, and name pronunciations.*	3.1
2.20	2	The service can conduct assessments in a variety of settings and, where possible, patients are offered a choice.	
2.21	2	The environment is clean, comfortable and welcoming.	17.1
2.22	1	Clinical rooms are private and conversations cannot be overheard.	17.2

2.23	1	The environment complies with current legislation on accessible environments. *Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.*	17.3
2.24	1	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of service user identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	16.4
2.25	1	There is a system by which staff are able to raise an alarm if needed. *Guidance: There should be a protocol in place to ensure staff are safe.*	17.5
2.26	2	The service has facilities available that are suitable for small babies and siblings. *Guidance: E.g. suitable toys and a room for baby-changing and breastfeeding).*	

Section 3: Discharge and Transfer of Care			
3.1	2	A discharge letter is sent to the patient (with the patient's consent) and all relevant parties within 10 working days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the patient as appropriate; • Assessment of the quality of mother-infant interaction; • Risk assessment (mother and child).	9.1
3.2	1	When patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment. *Guidance: This should also include a needs assessment and transfer to a general mental health team as well as within perinatal teams.*	9.3
3.3	2	Teams provide support to patients when their care is being transferred to another community team, or back to the care of their GP.	9.4
3.4	1	For any patients who are discharged from inpatient care, follow up is arranged by the perinatal community team and they (or alternative out-of-hours provision) see the patient within three days.	9.2

3.5	1	The potential for admission is communicated verbally to the patient and their family, and written information provided. This is recorded in the written care plan and communicated to the patient's GP, midwife and health visitor if there has been any potential for admission to inpatient care.	
3.6	1	As soon as possible after admission to a Mother and Baby Unit, a perinatal community practitioner is allocated to the patient and attends all appropriate meetings, including the patient's multidisciplinary ward review and pre-discharge meeting. *Guidance: If they are unable to attend in person they should participate by phone or videolink.*	
3.7	2	When a patient is admitted to an inpatient mental health unit, a community perinatal mental health team representative contributes and attends ward rounds and discharge planning in person (where possible) or remotely. *Guidance: If attendance is not possible, the community team should make contact via phone/video-link.*	
3.8	1	Partners and/or chosen others (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. This includes attendance at review meetings where the patient consents.	13.1
3.9	3	The service is actively involved with their regional perinatal clinical network.	

Section 4: Care and Treatment			
4.1	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their partners/family members (with patient consent) when developing the care plan and they are offered a copy. *Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.*	5.3
4.2	1	All patients have a documented diagnosis and/or formulation which is shared with the patient. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised. *Guidance: This can be devised by any suitable clinician.*	3.5
4.3	1	Patients (and partners and/or chosen others with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.*	 6.1.8 Sustainability Principle: Empowering Individuals
4.4	1	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and are supported in self-management.	12.4

4.5	1	The teams provide a range of therapeutic interventions for the mother, the baby, and the family/chosen others including: • Establishing and maintaining a therapeutic relationship with the team; • Nurse-led therapeutic interventions; • Pharmacological interventions; • Evidence-based psychological therapies, such as individual, couple's or family-based interventions; • Evidence-based mother and baby interventions; • Occupational therapy.	
4.6	3	The teams provide a range of therapeutic interventions for the patients, the baby, and the family including: • Sustainable interventions such as walking groups and using green space; • Recreational and creative activities. *Guidance: Teams should maintain an awareness of, and follow, evidence around sustainable and recreational interventions.*	
4.7	2	The team supports patients to access activities that are meaningful to them. *Guidance: this might include:* *• Activities that promote enjoyment and interaction with the baby and social engagement (such as swimming lessons, sensory activities, music groups);* *• Voluntary organisations;* *• Community centres;* *• Local religious/cultural groups;* *• Peer support networks;* *• Recovery colleges.*	6.1.6

4.8	3	The team supports patients to access local green and blue spaces on a regular basis. *Guidance: This could include signposting to local walking groups or arranging regular group activities to visit green spaces. Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot- or rainwear. Examples of blue spaces include rivers, lakes, and coastal waters.*	6.1.7
4.9	1	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services; • Domestic abuse services; • Immigration services; • Drug and alcohol services. *Guidance: The team should have joint working protocols with relevant organisations. Staff should know how to access policies and protocols around joint working.*	10.2
4.10	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	6.2.1
4.11	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	6.2.2 Sustainability Principle: Consider Carbon
4.12	1	All women taking medication will receive regular medication reviews at a frequency determined by the gestation, with particular emphasis on the potential effects of the medication on the pregnancy and changes in the bioavailability of medication as the pregnancy progresses. The team	

		ensures that the relevant maternity services are aware of these issues.	
4.13	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). The team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for the duration that the patient is under the team (carried out by the team or in a shared care arrangement with the patient's GP). *Guidance: Abnormalities or changes in the patient's condition or treatment should prompt a medical review or be acted upon appropriately. Teams should use the most up to date NICE guidelines or equivalent for the frequency of physical health assessments for each medication, taking into account any modifying effects of pregnancy, childbirth, or lactation on biochemical/neurohormonal markers.*	7.4
4.14	3	Patients and carers are able to discuss medications with a specialist pharmacist. *Guidance: A Specialist Pharmacist needs to have mental health knowledge but not necessarily perinatal, and should have established links to the service. The Pharmacist does not have to be directly contactable by the patients or carers but could meet with them via a request from other members of the MDT. It would not be expected for a service to routinely give details of pharmacist to patients or carers.*	6.2.3
4.15	1	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible.*	23.1

4.16	2	Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.	23.2
4.17	1	Staff members support patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.	7.1
4.18	1	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.	7.2 Sustainability Principle: Consider Carbon
4.19	1	The team, including bank and agency staff, is able to identify and manage an acute physical health emergency.	7.3 Sustainability Principle: Prioritise Prevention
4.20	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	5.1
4.21	1	Patients can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis lines / crisis resolution and home treatment teams, or psychiatric liaison teams.*	10.1

4.22	2	The team provides each partner and/or chosen other with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	13.4
4.23	1	Partners/chosen others are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.*	13.2
4.24	2	Partners/chosen others are offered individual time with staff members to discuss the needs of the family. *Guidance: This should be offered where appropriate. Staff should signpost partners to support (i.e. appropriate local services) as required.*	13.3 Sustainability Principle: Empowering Individuals 
4.25	3	The team actively encourages partners and/or chosen others to attend carer support networks or groups. There is a designated staff member to support carers.	13.5
4.26	1	The team follows a protocol for responding to partners/chosen others when the patient does not consent to their involvement.	16.2
4.27	3	The service ensures that older children and other dependants are supported appropriately. *Guidance: This may be achieved through referral or signposting to other services, e.g. social services, health visitor. Any materials should be age-appropriate.*	

4.28	1	Staff members treat patients and partners/chosen others with compassion, dignity and respect. *Guidance: Staff should make an active effort to be aware of, and provide sensitive care in line with, individuals' cultural and religious differences.*	14.1
4.29	1	Patients feel listened to and understood by staff members.	14.2
4.30	1	When talking to patients and partners/chosen others, health professionals communicate clearly, avoiding the use of jargon.	
4.31	1	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	15.2

Section 5: Rights, Infant Welfare and Safeguarding			
5.1	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: Their rights regarding consent to treatment and consent to treatment; • How to access advocacy services; • How to access a second opinion; • How to view their health records; • How to raise concerns, complaints and give compliments • Where relevant, how to access interpreting services; • Where relevant, their rights under the Mental Health Act.	2.2
5.2	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation.	11.1
5.3	1	When patients lack capacity to consent to interventions, decisions are made in their best interests and that of the family (with consideration of safeguarding and appropriate use of the Mental Health Act).	
5.4	1	There are systems in place to ensure that the service takes account of any advance directives or statements that the patient has made. *Guidance: These are accessible and staff members know where to find them.*	
5.5	1	The team records which children or vulnerable adults the patient has responsibility for and takes safeguarding action where needed.	

5.6		During the initial assessment process for the patient, the emotional and physical care needs of the infant are assessed. This assessment should include:	
5.6a	1	The baby's age and date of birth or due date.	
5.6b	1	Parental responsibility for the infant.	
5.6c	1	Name and contact numbers of GP, Health Visitor, Midwife, Obstetrician, any Social Worker or Paediatrician involved and any other relevant professionals or agencies.	
5.6d	1	If the child is the subject of a Child in Need Plan/ Looked After Child Plan/Child Protection Plan/Care Proceedings. *Guidance; Pertinent negatives must also be recorded, i.e. that the child is not the subject of a Child Protection Plan.*	
5.6e	1	Mode of delivery and obstetric complications during birth.	
5.6f	1	Current or planned mode of feeding and any previous or current problems with feeding.	
5.6g	1	A brief assessment of mother-infant interaction, care and relationship.	
5.6h	1	The occupants of the household.	
5.7	1	The team has a mechanism for recognising areas of concern and identifying an appropriate course of action. *Guidance: E.g. discussion at a safeguarding meeting or supervision.*	

5.8	1	Mother-infant relationship and care are observed and recorded in the patient's notes every three months or more frequently should the patient's mental state and behaviour change.	
5.9		A risk assessment of mother and infant is undertaken during the initial assessment process and if the mother's condition changes. This should include:	
5.9a	1	Disclosures of harmful or potentially harmful acts.	
5.9b	1	Any delusions / overvalued ideas or hallucinations involving the pregnancy, infant or other children.	
5.9c	1	Any thoughts, plans or intentions of harming the pregnancy, infant or other children. *Guidance: The assessment should consider that the phenomena could be intrusive obsessional thoughts.*	
5.9d	1	Hostility, irritability and/or rejection towards the unborn baby, infant or other children.	
5.9e	1	Any involvement with Children's Social Care. *Guidance: For example an unborn baby, infant or older children subject to Child Protection Plan or child care proceedings.*	
5.9f	1	Any concern about any other person who may pose a risk to the unborn baby, child or other children. *Guidance: This includes anyone on the Sex Offender's Register, anyone with a drug/alcohol dependency, anyone with supervised access to children or anyone who has been refused access to other children.*	

5.9g	1	The mother's thoughts and behaviours about estrangement from the baby and severe maternal inadequacy.	
5.10	2	The risk assessment tool is designed or modified for use by perinatal community mental health services.	
5.11	1	At each stage of care and risk assessment, consideration is given as to whether it is appropriate to initiate a Common Assessment Framework (or local equivalent) to better assess any additional needs the baby or older children of the family may have.	
5.12		Case notes include:	
5.12a	1	Any maternal concerns in relation to the pregnancy/infant.	
5.12b	1	Their care of the pregnancy/infant.	
5.12c	1	Their enjoyment of the pregnancy/infant.	
5.12d	1	If the infant is absent from an appointment, the reason why is recorded.	
5.13	1	Where the service is prescribing psychotropic medication for breastfeeding mothers, it is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration.	
5.14	3	If a patient and infant or older children are seen in an outpatient clinic or other mental health facility, the waiting area is exclusively for the use of the Perinatal and/or maternity services during that session.	
5.15	1	Local safeguarding and child protection guidance is available and accessible to all staff members.	

5.16	1	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details.	
5.17	3	A member of the perinatal mental health team is part of the Trustwide safeguarding group.	

Section 6: Staffing and Training

6.1		The multi-disciplinary team comprises, as a minimum (**per 10,000 births**): *Guidance: All teams ought to complete 6.1 regardless of offering.*	
6.1a	1	1 WTE Consultant Perinatal Psychiatrist input. *Guidance: This should be comprised of no more than two Consultant Perinatal Psychiatrists.*	
6.1b	2	1 WTE non-consultant Psychiatrist input.	
6.1c	1	5 WTE Perinatal Community Psychiatric nurses. *Guidance: This ratio should be adjusted based on geographical area.*	
6.1d	2	0.5 WTE Social Worker. *Guidance: This should be one Social Worker.*	
6.1e	1	1 WTE Clinical Psychologist.	
6.1f	2	1 WTE additional Clinical or Counselling Psychologist. *Guidance: This should be a qualified professional and not an assistant or trainee.*	
6.1g	2	2.5 WTE Nursery Nurses.	

6.1h	1	1 WTE Occupational Therapist.	
6.1i	2	1 WTE Parent-Infant Therapist.	
6.1j	1	1 WTE Administrator (band 3 or above, or local equivalent).	
6.2		For teams providing a service up to **24 months** postpartum, the multi-disciplinary team comprises, as a minimum (**per 10,000 births**): *Guidance: Standards 6.2a - 6.2l can be scored as N/A for services not currently providing a service up to 24 months postpartum.*	
6.2a	2	2.5 WTE Consultant Perinatal Psychiatrist	
6.2b	3	2.5 WTE non-consultant Psychiatrist	
6.2c	2	8 WTE Perinatal Community Psychiatric Nurses *Guidance: This ratio should be adjusted based on geographical area.*	
6.2d	3	2 WTE Social Worker *Guidance: This should be comprised of no more than two Social Workers*	
6.2e	3	5 WTE additional psychological professionals. *Guidance: This could include counselling psychology, CBT therapist, systemic psychotherapist and adult psychotherapist. This would be in line with the objectives set out in the NHS Long Term Plan.*	
6.2f	3	2 WTE Team Manager. *Guidance: This should include 1 WTE Band 8a managerial, 05 WTE Band 7 deputy and 0.5 WTE clinical/managerial.*	
6.2g	3	4 WTE Nursery Nurses	
6.2h	2	2 WTE Occupational Therapists	

6.2i	3	2 WTE Parent-infant Therapist/ staff trained in parent-infant therapy	
6.2j	3	4 Peer support workers (band 4 or above or local equivalent) *Guidance: This should include a peer support lead.*	
6.2k	2	5 WTE Administrator (band 3 or above or local equivalent)	
6.2l	3	0.5 WTE Pharmacist	
6.3	3	There is dedicated sessional input from arts or creative therapists.	6.1.5
6.4	1	The team has a dedicated specialist team manager.	
6.5	1	There are written documents that specify professional, organisational and line management responsibilities.	
6.6	1	The service has a mechanism for responding to low/unsafe staffing levels when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	19.1 Sustainability Principle: Staff Empowerment 
6.7	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	19.2
6.8	2	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: These representatives should have experience of the relevant service.*	20.1 Sustainability Principle: Empowering Individuals 
6.9	1	During operational hours, there is an identified senior clinician available at all times who can attend the team base within an hour.	19.3

		Guidance: The senior clinician can be available over the phone or video. The service can decide who fulfils this role. Some services may have an agreement with a local GP to provide this medical cover.	
6.10	1	Staff members receive an induction programme specific to the perinatal mental health service, which covers key information including: • The team's mission statement and core identity; • Aims of the service; • Key policies; • Referral and care pathways. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.*	
6.11	1	New staff members, including agency staff, receive an induction based on an agreed list of core competencies (such as the HEE Perinatal Mental Health Competencies Framework or NHS Education for Scotland's Curricular Framework). *Guidance: This should include arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, being observed and receiving enhanced supervision until core competencies have been assessed as met.*	20.2
6.12	2	All new staff members are allocated a mentor to oversee their transition into the service. *Guidance: A mentor does not need to be a formal supervisor and may be an established member of the team who has experience in perinatal mental health.*	
6.13	3	All supervisors have received specific training to provide supervision that is consistent with their professional background. This training is refreshed in line with local guidance.	

6.14		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: *Guidance: Teams should review the need for refresher trainings at regular intervals to ensure staff competencies remain current.*	22.1
6.14a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
6.14b	1	Physical health assessment. *Guidance: This could include training in understanding common physical disorders in pregnancy and the early postnatal period, physical observations, basic life support and when to refer the patient for specialist input.*	22.1b
6.14c	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	22.1c Sustainability Principle: Prioritise Prevention 
6.14d	1	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm.*	22.1d
6.14e	1	The range of perinatal disorders and normal emotional changes in pregnancy and after birth.	
6.14f	1	Basic infant development including emotional developmental milestones. *Guidance: This should be refreshed annually.*	
6.14g	2	Supporting parents in a culturally sensitive way with particular relevance to the local population.	

6.14h	1	Understanding and promoting mother-infant interaction and relationship. *Guidance: This should be refreshed annually.*	
6.14i	2	Infant mental health training. *Guidance: This can be accessed locally or from designated providers.*	
6.14j	1	Recognising and communicating with patients with cognitive impairment or learning disabilities.	22.1e
6.14k	1	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (this is updated at least annually).	
6.14l	2	Contraception and sexual health.	
6.14m	1	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	22.1f
6.14n	2	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	22.1g
6.14o	1	Infant feeding (including breastfeeding). *Guidance: This should be refreshed annually.*	
6.15	1	Peer support workers are provided with a bespoke training programme appropriate to their role, which includes: • Listening and facilitation skills; • Negotiating boundaries; • Common issues relating to perinatal mental health, including feeding and birth trauma.	
6.16	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	6.1.9

6.17	2	Staff who use clinical outcome measures have received relevant training.	
6.18	2	Experts by experience are involved in delivering and developing staff training. *Guidance: This may include training around the role of peer support and its value.*	22.2
6.19	1	All clinical staff members (including peer support workers) receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific and could be on a group or individual basis. Supervision should be provided by someone with appropriate clinical experience and qualifications.*	20.3
6.20	2	All staff members receive individual line management supervision at least monthly.	20.4
6.21	2	Staff members in training and newly qualified staff members receive weekly supervision, in line with professional requirements. *Guidance: The duration of this will be agreed with supervisor and supervisee at the beginning and be in line with the new starter's needs.*	
6.22	1	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs, and should be informed by self-assessment against an agreed competency framework.*	
6.23	2	The team holds business meetings at least once a month.	
6.24	3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	

6.25	2	Frontline staff members are involved in key decisions about the service provided.	
6.26	1	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that frontline staff members find accessible and easy to use.	
6.27	1	The team has a fixed base and office accommodation, which meets the need of the staffing group, including adequate clinical space.	
6.28	1	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information.	
6.29	1	Staff members are easily identifiable to patients (for example, by wearing appropriate identification).	
6.30	1	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: • Having a lone working policy in place; • Conducting a risk assessment; • Identifying control measures that prevent or reduce any risks identified.	17.4
6.31	1	The service actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	21.1 Sustainability Principle: Staff Empowerment 
6.32	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	21.2

6.33	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.	18.1 Sustainability Principle: Staff Empowerment 
6.34	2	Peer support workers have access to group supervision with others in similar roles.	
6.35	1	Staff members, patients and carers who are affected by a serious incident are offered post-incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.*	21.3 Sustainability Principle: Empowering Individuals 
6.36	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	18.2 Sustainability Principle: Staff Empowerment 
6.37	3	In-house multi-disciplinary team education and practice development activities occur in the service at least every three months. *Guidance: This should be available to all staff, including healthcare assistants, nursery nurses and peer support workers.*	
6.38	2	The team has protected time for team-building and discussing service development at least once a year.	

Section 7: Recording and Audit			
7.1	1	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	1.1
7.2		The service evaluates annually:	
7.2a	2	Feedback from referrers.	
7.2b	2	Feedback from service staff.	
7.2c	2	Analysis of complaints.	
7.2d	2	The findings of audits.	
7.2e	2	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data).	
7.2f	1	Women involved in Care Proceedings / Child Safeguarding Protection Plans.	
7.2g	3	Data on the demographic breakdown in their area. Guidance: Teams should take meaningful action to address inequality and improve access.	
7.3	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored.	
7.4	2	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as patient and partner/chosen other representatives.*	

7.5	2	The service's clinical outcome data are reviewed at least six-monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	23.3
7.6	1	Systems are in place to enable staff members to report incidents quickly and effectively, and managers encourage staff members to do this.	24.1
7.7	1	When mistakes are made in care this is discussed with the patient themself and their carer, in line with the Duty of Candour agreement.	24.2
7.8	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	24.3
7.9	1	Any serious untoward incident, including those involving a child and any emergency child protection order, is reviewed within six weeks and chaired by a suitably qualified clinician external to the service.	
7.10	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	12.1 Sustainability Principle: Empowering Individuals 
7.11	2	Feedback received from patients and partners/chosen others is analysed and explored to identify any differences of experiences according to protected characteristics.	12.2
7.12	2	Services are developed in partnership with appropriately experienced patient and carers and have an active role in decision making.	12.3
7.13	2	The team is actively involved in QI activity. *Guidance: This may include audits, developing policies/protocols, activities around development of service and involving patients and partners/chosen others.*	24.4

7.14	2	The team actively encourage patients and carers to be involved in QI initiatives.	24.5
7.15	3	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). *Guidance: Progress against this improvement plan is reviewed at least annually with the team.*	18.3
7.16	3	The organisation has a research friendly culture which provides staff with the opportunity to take part in research projects.	

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