PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Community Perinatal Mental Health Services

Fifth Edition

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CHAIR'S FOREWORD

This is the fifth version of the PQN specialist standards for perinatal community teams. The Perinatal Quality Network began accreditation and peer appraisal of mother and baby units in 2007, extending to community teams in 2013. Since then, there has been a dramatic increase in the numbers of specialist community teams throughout the UK, with over 60 teams currently members and increasing. The numbers of women treated have also increased over this time. Membership of the PQN and the adoption of its quality assurance and improvement standards has never been more important.

The seven domains of standards have not changed throughout this time. However, the detail of the standards, whilst reflecting the same principles and philosophy of care, has gradually developed. There has been a broadening of the skill mix within teams, resulting in a much more balanced workforce, and recommended resources have increased to reflect the increased numbers of referrals. There is now specific reference to peer support workers and their vital role within the team, as well as an emphasis on the involvement of patients, their partners and families, and more attention to the needs of the infant. The services around us have changed, particularly mental health services, maternity services and primary care, and standards need to reflect these changes in service delivery.

The PQN is a network of its members, clinicians and patients. They set the standards informed by the available evidence and best practice. They are involved in visiting services and assessing them against standards. They are members of the Accreditation Committee and Advisory Group. They support each other, sharing innovation and learning, experience and problems. Our standards are not externally imposed but developed, owned and shared by all members. Without the active involvement of its members in all aspects of its work there would be no PQN.

When revising the standards in spring 2020, we were aware of NHSE's Long-Term Plan (LTP) with its expanded reach of perinatal services and increased staffing and skill mix. A decision was made to retain the current focus of community standards on the care of vulnerable women with moderate to severe conditions, and the resources needed to achieve this. We acknowledge that many teams will already be doing more than this, however, overall the details of the implementation of the LTP have not been clarified or finalised at the point of the current revision; in particular, whether perinatal services would be delivered by single or multiple teams. We felt that it was important that the peer appraisal and accreditation process should be able to assess services as they are currently functioning for the next two years until the sixth standards revision in 2022. It was also felt to be important to emphasise that the LTP was developed for England only and that PQN standards should be applicable to the whole of the United Kingdom.

Immediately after the first meeting of the standards revision group on 12 March 2020, the COVID-19 pandemic "lockdown" occurred, leading the College to close to all meetings and move towards remote working. Home working and social distancing has had a major impact on the way in which community teams deliver services. Whilst restrictions may gradually change, it is likely that social distancing will remain for some time to come and will continue to change those activities involving contacts with others, not just patient assessments and treatment, but training, supervision,

and team meetings to name but a few. Some of these changes may well be adopted after the requirements of the current situation end. We have therefore been careful to ensure that wording of the relevant standards allows for these changes.

The project team's workload has increased with the rising numbers of teams, members and visits. They work tirelessly with patience and good humour, and the PQN would not be as successful and influential as it is without them. Many heartfelt thanks to all our PQN colleagues at the CCQI.

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

Section 1: Access and Referral			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community 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: This 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.*	
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 discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	**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; • Substance misuse problems; • A severe, diagnosed personality disorder; • A learning disability.	
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	**3**	Everyone can access the service using public transport or transport provided by the service.	**1.2**

Section 2: Assessment			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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 until 24 months if clinically indicated). *Guidance: Any women who are not yet fully recovered by 12 months postpartum, were referred late with postpartum illness or were already pregnant again should be discussed with the referrer. If necessary, the referral is diverted to the appropriate service.*	
2.2	**1**	The team assess women who are referred to the service within 28 days for routine cases (or four hours for emergencies).	**1.6**
2.3	**1**	Pregnant women 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.*	
2.4	**1**	For non-emergency assessments, the team sends letters in advance to patients that include: • The name and designation 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**
2.5	**1**	If the service receives a referral for a woman who has been prescribed Sodium Valproate or Semi-Sodium Valproate (Depakote), it is the responsibility of the service to have an urgent discussion (within two working days) with the 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 (Depakote). 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.*	

2.6	**1**	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk, including risk to self, the baby and others.	**3.2**
2.7	**1**	A physical health review takes place as part of the initial assessment, or as soon as possible.	**3.3**
2.8	**1**	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to the baby/pregnancy, risk to others and risk from others.	**3.4**
2.9	**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 woman, her family (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).*	
2.10	The peripartum management plan should include:		
2.10a	**1**	Nature of the risk and condition.	
2.10b	**1**	Details of current medication and any intended changes in late pregnancy and the early postpartum period.	
2.10c	**1**	Consideration of whether the mother intends to breastfeed.	
2.10d	**1**	Professionals involved and frequency of contact. *Guidance: For example, frequency of contact with health visitor, GP etc*.	
2.10e	**1**	The patient's chosen emergency contact's details.	
2.10f	**1**	Admission to a mother and baby unit if necessary and any plans or special requirements for a maternity admission.	
2.11	**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.	

2.12	**1**	Women identified as requiring a psychological intervention are offered an assessment with a clinical psychologist and any treatment commenced within 28 days of the assessment. *Guidance: Any exceptions and reasons for this are documented in the patient's notes. Treatment could be offered by another suitably qualified member of the team, under the supervision of the team's psychologist.*	
2.13	**2**	The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	**3.6**
2.14	**1**	Patients are asked if they and their partner/family member wish to have copies of letters about their health and treatment.	**15.1**
2.15	**1**	Confidentiality and its limits are explained to the patient and partner/family member, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	**16.1**
2.16	**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.	**4.1**
2.17	**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**
2.18	**1**	Patients feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to patients and address them using the name and title they prefer.*	**3.1**
2.19	**2**	The service can conduct assessments in a variety of settings and, where possible, patients are offered a choice.	
2.20	**2**	The environment is clean, comfortable and welcoming.	**17.1**
2.21	**1**	Clinical rooms are private, and conversations cannot be overheard.	**17.2**

2.22	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.*	**17.3**
2.23	**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**
2.24	**1**	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, significant others and staff members.	**17.5**
2.25	**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

Standard number	Standard type	Criteria	CCQI Core Community Standard
3.1	**1**	A discharge letter is sent to the patient and all relevant parties within 10 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 specific transition 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 her 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 appropriate.	
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 video-link.*	

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/family members (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	**13.1**
3.9	**3**	The service is actively involved with their regional perinatal clinical network.	

Section 4: Care and Treatment			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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: The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or statements that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	**5.3**
4.2	**1**	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	**3.5**
4.3	**1**	Patients (and partners/family members, 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.*	**6.1.7**
4.4	**1**	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	**12.3**
4.5	**1**	The teams provide a range of therapeutic interventions for the mother, the baby, and the family including: • Pharmacological interventions; • Evidence-based psychological therapies; • Evidence-based mother and baby interventions; • Occupational therapy.	

4.6	**3**	The teams provide a range of therapeutic interventions for the mother, the baby, and the family including: • Evidence-based family and couple's interventions; • Recreational and creative activities. *Guidance: If not provided directly by the service, patients are supported to access these within their local area.*	
4.7	**2**	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. *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.*	
4.8	**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. *Guidance: The team should have joint working protocols with relevant organisations.*	**10.2**
4.9	**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**
4.10	**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**
4.11	**1**	For patients who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication until the end of care by the perinatal team. Thereafter, the responsibility for this monitoring may be transferred to the general adult mental health team or primary care under shared care arrangements.	**6.2.4**

4.12	**1**	Patients who are prescribed a new course of mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment by the team (baseline) and there is a six-week follow-up.	**7.4**
4.13	**1**	Women in pregnancy or with a new-born who are taking mood stabilisers or antipsychotics receive regular medical 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.	
4.14	**1**	Postnatal women who are taking mood stabilisers or antipsychotics receive physical health assessments at the start of treatment and at least every three months until the end of care by the team. Changes in the patient's condition or treatment should prompt a medical review.	
4.15	**1**	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	**6.2.3**
4.16	**1**	Clinical outcome measurement data, including progress against user defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	**23.1**
4.17	**2**	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	**23.2**
4.18	**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**
4.19	**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**
4.20	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency, including obstetric and gynaecological emergencies. *Guidance: This includes guidance about when to call 999 and how and when to arrange transfer to A&E from a mental health or antenatal outpatient clinic on a general hospital site.*	**7.3**

4.21	**1**	Patients know who is co-ordinating their care and how to contact them if they have any questions.	**5.1**
4.22	**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/home treatment teams, psychiatric liaison teams and telephone helplines.*	**10.1**
4.23	**2**	The team provides each partner/family member 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;* *• Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	**13.4**
4.24	**1**	Partners/significant others are advised on how 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**
4.25	**1**	Partners/significant others are offered individual time with staff members to discuss concerns, family history and their own needs.	**13.3**
4.26	**3**	The service actively encourages partners/family members to attend carer support networks or groups. There is a designated staff member to support carers.	**13.5**
4.27	**1**	The team follows a protocol for responding to partners/significant others when the patient does not consent to their involvement.	**16.3**
4.28	**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 offered should be age-appropriate.*	
4.29	**1**	Staff members treat patients and partners/family members with compassion, dignity and respect.	**14.1**
4.30	**1**	Patients feel listened to and understood by staff members.	**14.2**
4.31	**1**	When talking to patients and partners/family members, health professionals communicate clearly, avoiding the use of jargon.	

4.32	**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

Standard number	Standard type	Criteria	CCQI Core Community Standard
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; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	**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	During the initial assessment process for the patient, the emotional and physical care needs of the infant are assessed. This assessment should include:		
5.5a	**1**	The baby's age and date of birth or due date.	
5.5b	**1**	Parental responsibility for the infant.	
5.5c	**1**	Name and contact numbers of GP, health visitor, midwife, obstetrician, any social worker or paediatrician involved and any other relevant professionals or agencies.	
5.5d	**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.*	

5.5e	**1**	Mode of delivery and obstetric complications during birth.	
5.5f	**1**	Current or planned mode of feeding and any previous or current problems with feeding.	
5.5g	**1**	A brief assessment of mother-infant interaction, care and relationship.	
5.5h	**1**	The occupants of the household.	
5.6	**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.*	
5.7	**1**	Mother-infant relationship and care are observed and recorded in the patients notes every three months or more frequently should the patient's mental state and behaviour change.	
5.8	A risk assessment of mother and infant is undertaken during the initial assessment process and if the mother's condition changes. This should include:		
5.8a	**1**	Disclosures of harmful or potentially harmful acts.	
5.8b	**1**	Any delusions/overvalued ideas or hallucinations involving the pregnancy, infant or other children.	
5.8c	**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.*	
5.8d	**1**	Hostility, irritability and/or rejection towards the unborn baby, infant or other children.	
5.8e	**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.*	
5.8f	**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.*	
5.8g	**1**	Thoughts and behaviours about estrangement from the baby and severe maternal inadequacy.	

5.9	**2**	The risk assessment tool is designed or modified for use by perinatal community mental health services.	
5.10	**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.	
5.11	Case notes include:		
5.11a	**1**	Any maternal concerns in relation to the pregnancy/infant.	
5.11b	**1**	The patient's care of the pregnancy/infant.	
5.11c	**1**	The patient's enjoyment of the pregnancy/infant.	
5.11d	**1**	If the infant is absent from an appointment the reason why is recorded.	
5.12	**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.	
5.13	**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.	
5.14	**1**	Local safeguarding and child protection guidance is available and accessible to all staff members.	
5.15	**1**	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details.	
5.16	**3**	A member of the perinatal mental health team is part of the Trust-wide safeguarding group.	

Section 6: Staffing and Training			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
6.1	The multi-disciplinary team comprises, as a minimum:		
6.1a	**1**	1 WTE Consultant Perinatal Psychiatrist input per 10,000 births (as a minimum). *Guidance: This should be comprised of no more than two Consultant Perinatal Psychiatrists.*	
6.1b	**2**	1 WTE non-Consultant Psychiatrist input per 10,000 births.	
6.1c	**1**	5 WTE Perinatal Community Psychiatric nurses per 10,000 births. *Guidance: This ratio should be adjusted based on geographical area*.	
6.1d	**2**	0.5 WTE Social Worker per 10,000 births. *Guidance: This should be one Social Worker.*	
6.1e	**1**	1 WTE Clinical Psychologist per 10,000 births.	
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 per 10,000 births.	
6.1h	**1**	1 WTE Occupational Therapist per 10,000 births.	
6.1i	**3**	1 WTE Parent-Infant Therapist.	
6.1j	**1**	1 WTE Administrator (band 3 or above or local equivalent).	
6.2	**1**	The team has a dedicated specialist team manager.	
6.3	**1**	There are written documents that specify professional, organisational and line management responsibilities.	

6.4	**1**	The service has a mechanism for responding to low staffing 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**
6.5	**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**
6.6	**2**	Appropriately experienced patient or partner/family member representatives are involved in the interview process for recruiting staff members. *Guidance: This could include co-producing interview questions or sitting on the interview panel.*	**20.1**
6.7	**1**	There is an identified senior clinician available at all times who can attend the team base within an hour. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	**19.3**
6.8	**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.*	
6.9	**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.* *This induction should also include self-assessment using an agreed competency framework, which can be used to identify areas for further development and to inform staff's personal development plan.*	**20.2**

6.10	**2**	All new staff members are allocated a mentor to oversee their transition into the service. This should be a mentor with experience in perinatal mental health.	
6.11	**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.	
6.12	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:		**22.1**
6.12a	**1**	Statutory and mandatory training. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention of aggression and violence.*	**22.1f**
6.12b	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	**22.1a**
6.12c	**1**	Physical health assessment. *Guidance: This could include training in understanding common physical disorders in pregnancy and the early postnatal period, physical observations and when to refer the patient for specialist input.*	**22.1b**
6.12d	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	**22.1c**
6.12e	**1**	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	**22.1d**
6.12f	**1**	The range of perinatal disorders and normal emotional changes in pregnancy and after birth.	
6.12g	**1**	Basic infant development including emotional developmental milestones.	
6.12h	**2**	Supporting parents in a culturally sensitive way with particular relevance to the local population.	
6.12i	**1**	Understanding and promoting the mother-infant interaction and relationship.	

6.12j	**2**	Infant mental health training. *Guidance: This can be accessed locally or from designated providers.*	
6.12k	**1**	Recognising and communicating with patients with cognitive impairment or learning disabilities.	**22.1e**
6.12l	**1**	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (this is updated at least annually).	
6.12m	**2**	Contraception and sexual health.	
6.12n	**2**	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	**22.1g**
6.12o	**1**	Infant feeding (including breastfeeding).	
6.13	**1**	Where peer support workers are used by the service (whether in a voluntary or paid role) they have a defined role description that is understood by the rest of the team.	
6.14	**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.	
6.15	**2**	Staff who use clinical outcome measures have received relevant training.	
6.16	**2**	Experts by experience are involved in delivering and developing staff training face-to-face. *Guidance: This may include training around the role of peer support and its value.*	**22.2**
6.17	**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**
6.18	**2**	All staff members receive individual line management supervision at least monthly.	**20.4**

6.19	**2**	Staff members in training and newly qualified staff members receive weekly supervision, in line with professional requirements.	
6.20	**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.*	
6.21	**2**	The team holds business meetings at least once a month.	
6.22	**3**	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	
6.23	**2**	Frontline staff members are involved in key decisions about the service provided.	
6.24	**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.	
6.25	**1**	The team has a fixed base and office accommodation, which adequately meets the need of the staffing group.	
6.26	**1**	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information.	
6.27	**1**	Staff members are easily identifiable to patients (for example, by wearing appropriate identification).	
6.28	**1**	Staff members follow a lone working policy and feel safe when conducting home visits.	**17.4**
6.29	**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**

6.30	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	**21.2**
6.31	**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**
6.32	**2**	Peer support workers have access to group supervision with others in similar roles.	
6.33	**1**	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	**21.3**
6.34	**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. *Guidance: This includes decisions about care, treatment and how the service operates.*	**18.2**
6.35	**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.*	
6.36	**2**	The team has protected time for team-building and discussing service development at least once a year.	

Section 7: Recording and Audit			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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.	
7.3	**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/significant other representatives.*	
7.5	**2**	The service's clinical outcome data are reviewed at least every six months. The data is 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 quickly and effectively report incidents 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 themselves 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**
7.11	**2**	Services are developed in partnership with appropriately experienced patient and carers and have an active role in decision making.	**12.2**
7.12	**2**	The team use quality improvement methods to implement service improvements.	**24.4**
7.13	**2**	The team actively encourage patients and carers to be involved in QI initiatives.	**24.5**

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