PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Community Perinatal Mental Health Services

4th Edition

Editor: Zara Schneider (Project Worker, Perinatal Quality Network)

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Introduction

Background

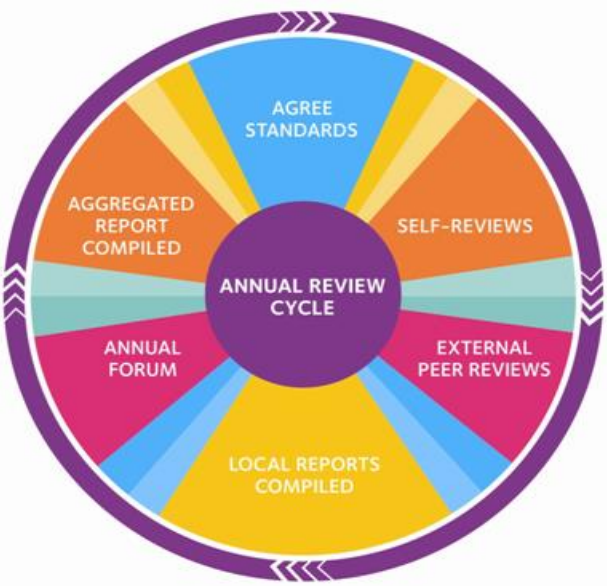
Following the inquiry into the deaths of Daksha and Freya Emson in October 2003 and the publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004, the Royal College of Psychiatrists made a commitment to promote perinatal mental health.

Initial funding was provided for the College Centre for Quality Improvement (CCQI) to complete a national survey of Specialist Perinatal Mental Health Services and to set up a network.

The Quality Network for Perinatal Mental Health Services was launched in June 2007, as part of this commitment, to develop and maintain standards for mother and baby units. The network engages with frontline staff and applies a clinical audit method within a peer-support network. In 2012, the network first developed standards for community perinatal mental health services.

The Review Process

The standards represent just one part of the cycle: the real benefit for services is in taking part in the process of reviews. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see figure below).



Updating the standards

This fourth edition of the Perinatal community standards has been informed by a standards workshop which was held on 25th April 2018, to which all members of the network were invited, to gain expert opinion and consensus. A good range of services were represented at the workshop. A wide range of disciplines were also represented alongside patient representatives.

Once additions and changes had been proposed there was a wider consultation with all members of the network via a consultation document which was sent out to over 500 members via the Perinatal-Chat email discussion group. The document listed suggested criteria additions, changes and removals. We accepted criteria where there was clear consensus; otherwise a decision was negotiated within the project team with the clinical leads for the network.

Categorisation of standards

To support their use in the accreditation process, each standard has been categorised as follows:

- Type 1: criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;

- Type 2: criteria that a service would be expected to meet;

- Type 3: criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The full set of standards is aspirational and it is unlikely that any service would meet them all. In order to achieve accreditation, a service must meet 100% type 1 standards, at least 80% type 2 standards and 60% type 3 standards.

Important Note

Data collection tools adapted from these standards will be provided with guidance notes to members before reviews take place. This document is provided for reference and not for data collection.

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Section One: Access and Referral

Standard No.	Standard Description	Standard Type
1.1	Clear information is made available, in paper and/or electronic format, to patients, partners/significant others and healthcare practitioners (this should be two separate pieces of information): • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the service, including emergency and out of hours details. *Guidance: The information is produced together with patients. Co-production should reflect the diversity of the population that it serves. Services may choose to have two information leaflets, one for patients/partners and family members and one for health professionals.*	1
1.2	The service is provided for the following groups in a defined catchment area: *Guidance: This includes women who are currently unwell and those who are well but at risk of becoming unwell*.	
1.2a	Women following discharge from an inpatient stay.	1
1.2b	Women experiencing Bipolar Disorder/ Postpartum Psychosis, other psychoses and Serious Affective Disorder, who can be safely managed in the community.	1
1.2c	Women with severe non-psychotic conditions.	1
1.2d	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
1.2e	Women requiring pre-conception counselling.	1
1.3	The service also accepts referrals for:	
1.3a	Women with moderate mental health problems whose needs cannot be effectively managed by primary care services.	1
1.3b	Women with alcohol/substance misuse problems, if there is also (or suspected) moderate to severe mental illness.	1

1.4	The service has clear joint working protocols regarding working with patients with: • Disordered eating; • Substance misuse problems; • A diagnosed personality disorder.	1
1.5	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
1.6	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP/referrer is informed.	1
1.7	The team accepts patients who have been referred to the service onto their caseload, within a timeframe which complies with national standards as set by the NHS or other professional bodies.	1
1.8	Referrals from Children's Social Services can only be accepted if the mother meets the usual clinical criteria.	2
1.9	The referral criteria ensure that a Personality Disorder diagnosis is not a barrier to care. *Guidance: In certain circumstances, joint working with a Personality Disorder service may take place.*	1
1.10	Referrals can be made directly to the service during working hours.	1
1.11	The service responds to urgent requests for telephone advice from other professionals within one working day.	1
1.12	A clinical member of staff is available to discuss emergency referrals during working hours.	1
1.13	The service provides a telephone advice line for professionals (e.g. midwives, GPs) at specific times of the week.	3
1.14	When the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this.	1
1.15	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
1.16	Where referrals are made through a single point of access, these are passed on to the community team within one working day.	2
1.17	Outcomes of accepted referrals are fed back to the referrer, patient and partner/significant other (with the patient's consent) within two working weeks of the referral. If a referral is not accepted, the team advises the referrer, patient and partner/significant other on alternative options.	1

1.18	There are systems in place to monitor waiting times and ensure adherence to national waiting times standards. *Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment.*	1
1.19	The team provides patients and partners/significant others with information about expected waiting times for appointments, assessment and treatment. *Guidance: patients on a waiting list are provided with updates of any changes to their appointment, as well as details of how they can access further support while waiting.*	1
1.20	For planned 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.	1
1.21	The assessing professional can promptly access notes (past and current) about the patient from primary and secondary care.	2
1.22	Patients are asked if they and their partner/family member wish to have copies of letters about their health and treatment.	1
1.23	When talking to patients and partners/family members, health professionals communicate clearly, avoiding the use of jargon.	1
1.24	The team can access IT resources to enable them to make contemporaneous records at assessment and referral meetings.	2
1.25	The service provided should be accessible using public transport or transport provided by the service.	2

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Section Two: Assessment

Standard No.	Standard Description	Standard Type
2.1	Teams assess women who are experiencing an episode of moderate to severe mental illness (in pregnancy and until at least 12months postpartum with follow up to 12 months). *Guidance: Referrals later in the postnatal period, e.g. after 9 months, who are likely to need care beyond one year postnatal, should be discussed with the referrer. If necessary the referral is diverted to the appropriate service.*	1
2.2	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
2.3	Women currently in the care of secondary care mental health services may be managed by the Perinatal team or collaboratively with their usual secondary care mental health team, depending on clinical need and the patient's wishes.	1
2.4	The service can conduct assessments in a variety of settings and where possible, patients are offered a choice.	2
2.5	Priority care pathways should be in place to allow for discussion of potential emergency, for example, conditions arising after 28 weeks and before 6 weeks postpartum. Contact with the referrer and/or patient should take place within 2 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
2.6	Pregnant women referred with a previous history of Serious Affective Disorder / Psychosis / Anxiety Disorder / Eating Disorder / Obsessive Compulsive Disorder, even if currently well, should be offered an assessment to take place during their pregnancy. *Guidance: In some areas, this will involve collaborative working with other specialist services.*	1

2.7	Women identified as requiring a psychological intervention, should be offered an appointment with a suitably qualified and supervised clinician within one month of assessment. *Guidance: This could be offered by another member of the team, under the supervision of the team's psychologist.*	1
2.8	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.*	1
2.9	Patients have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and the patient. This includes a comprehensive assessment of: • Risk to self; • Risk to others; • Risk from others; • A risk management plan.	1
2.10	A physical health review takes place as part of the initial assessment. The review includes but is not limited to: • Details of past medical history, including obstetric history; • Current physical health problems and medication, including side effects and compliance with medication regime; • Mode of infant feeding; • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual health, drug and alcohol use.	1
2.11	All women have a named mental healthcare professional, and are addressed by the name and title they prefer. They are told how and who to contact if this person is not available in an emergency	1

2.12	Every patient has a written care plan, reflecting their individual needs. *Guidance: This clearly outlines:* *• Agreed intervention strategies for physical and mental health;* *• Measurable goals and outcomes;* *• Strategies for self-management;* *• Any advance directives or stated wishes that the patient has made;* *• Crisis and contingency plans;* *• Review dates and discharge framework.*	1
2.13	Care plans are reviewed at least every 3 months. *Guidance: For patients with complex needs on CPA (or local equivalent, this should be a formal review involving members of the multi-disciplinary team and other relevant professionals. For patients not on a CPA (or local equivalent), the review may be conducted by the professional(s) from the service directly involved with the patient's care.*	1
2.14	The practitioner develops the care plan collaboratively with the patient and their partner/family member (with patient consent).	1
2.15	The patient and their partner/family member (with patient consent) are offered a copy of the care plan and the opportunity to review this.	1
2.16	For women seen 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. **The plan should include:**	1
2.16a	Nature of the risk and condition.	1
2.16b	Details of current medication and any intended changes in late pregnancy and the early postpartum period.	1
2.16c	Consideration of whether the mother intends to breastfeed.	1
2.16d	Professionals involved and frequency of contact. *Guidance: For example, frequency of contact with health*	1

	visitor, GP etc	
2.16e	The patient's chosen emergency contact's details	1
2.16f	Admission to a Mother and Baby Unit if necessary and any plans for a maternity admission.	1
2.16g	The Perinatal team should be notified once the patient has delivered.	1
2.17	Women referred in pregnancy who are at high risk of serious illness are seen by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed.	1
2.18	Following assessment, all patients should receive an initial diagnosis. This should be documented alongside any clinical formulation. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.*	1
2.19	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.	2
2.20	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	1
2.21	Confidentiality and its limits are explained to the patient and partner/significant other at the first assessment, both verbally and in writing. *Guidance: For partner/significant others this includes confidentiality in relation to third party information.*	1
2.22	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.*	1
2.23	Patient preferences for sharing information with their partner/family member are established, respected and	1

	reviewed throughout their care.	
2.24	If a patient does not attend an assessment, the team contacts the referrer. *Guidance: If the patient is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan.*	1
2.25	The team has a policy for those who do not attend an appointment/assessment or who do not engage as per local policy. *Guidance: This could include making a phone call, sending a letter, visiting service users at home or another suitable venue, using text alerts, or engaging with their partners/significant others/family members. If service users continue to not engage, a decision is made by the assessor/team, based on service user need and risk, as to how long to continue to attempt follow-up.*	

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Section Three: Discharge

Standard No.	Standard Description	Standard Type
3.1	Discharge or onward care planning is discussed at care plan reviews as and when deemed appropriate.	2
3.2	Partners/family members (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. *Guidance: This could be through formal meetings, such as care plan meetings or discharge meetings, with the patient's consent.*	1
3.3	The team follows a protocol to manage patients who disengage from the community Perinatal mental health team: • Reviewing the notes to assess risk; • Recording the patient's capacity to understand the risks of self-discharge; • Putting a crisis plan in place; • Contacting relevant agencies to notify them of the discharge; • In the case of concerns, efforts are made to re-engage the patient.	1
3.4	When a patient is admitted to hospital, 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*	2
3.4	Patients who are discharged from hospital to the care of the community Perinatal mental health team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk. *Guidance: The community Perinatal mental health team should liaise with the inpatient team to arrange this for service users who are under their care, unless the 48-hour follow-up is being done by the inpatient or home treatment team.* *Follow up can be in person or on the telephone. The exact timing will depend on clinical need and there is a policy in place to manage situations where this does not happen.*	1
3.5	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; • There is a meeting in which a key member of each team meet with the patient and partner/family member (with patient's consent) to discuss transfer of care. *Guidance: This should also include a needs assessment and*	1

	transfer to a general mental health team as well as within perinatal teams.	
3.6	A discharge summary is given to the patient upon discharge and is sent to their GP within 24 hours.	1
3.7	A full MDT discharge letter setting out a clear discharge plan is sent to the patient and all relevant parties within 10 days of discharge. The plan includes details of: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication; • 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).	1

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Section Four: Care and Treatment

Standard No.	Standard Description	Standard Type
4.1	The teams provide a range of therapeutic interventions for the mother, the baby, and the family including:	
4.1a	Targeted evidence based pharmacological interventions prescribed by an appropriately trained professional. Any deviations from standard practice are documented in the case notes.	1
4.1b	Evidence based psychological therapies delivered by an appropriately trained and supervised practitioner. *Guidance: The number, type and frequency of psychological therapies offered are informed by the evidence base.*	1
4.1c	Evidence based mother and baby interventions from an appropriately trained and supervised practitioner.	1
4.1d	Evidence based family and couple's interventions from an appropriately trained and supervised practitioner.	3
4.1e	A range of recreational and creative activities is provided by the service, or patients are helped to access these within the local area.	3
4.1f	Occupational therapy *Guidance: Occupational Therapists should be a member of the Perinatal mental health team and should contribute to the planning of care for the patient and if necessary, undertake specific Occupational Therapy interventions. For example, problems with activities of daily living, creative and diversionary activities and problems with mobility etc.*	1
4.2	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan. *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.*	2
4.3	Patients' preferences are considered during the selection of medication, therapies and activities and are acted upon as far as possible.	1

4.4	When medication is prescribed: -Patients are given written and verbal information to ensure they understand the purpose, expected outcomes, interactions and limitations and side effects; - Risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded; - Patients have their medications reviewed at a frequency according to the evidence base and clinical need; -Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime; - When patients experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this.	1
4.5	Patients and their partner/significant others (with patient consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.	1
4.6	Patients have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews. Long-term medication is reviewed by the prescribing clinician.*	1
4.7	Where concerns about a patient's physical health are identified, the team arranges or ensures that the patient receives assessment from primary or secondary healthcare services. This is documented in the patient's care plan.	1
4.8	The team gives personalised lifestyle advice to patients where necessary. This includes: • Smoking cessation information; • Healthy eating information; • Physical exercise information; • Alcohol information; • Contraception advice.	1

4.9	The team understands and follows an agreed protocol for the management of an acute physical health emergency, including obstetric 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.*	1
4.10	The service has a policy or protocol for the care of patients with dual diagnosis that includes: • Liaison and shared protocols between mental health and substance misuse services to enable joint working; • Drug/alcohol screening to support decisions about care/treatment options; • Liaison between mental health, statutory and voluntary agencies; • Staff training; • Access to evidence based treatments. *Guidance: If a Trust policy is used, it should reflect the perinatal context.*	1
4.11	The perinatal team ensures that patients who are prescribed mood stabilisers or antipsychotics receive and are encouraged to have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises. This includes: • A personal/family history (at baseline); • Lifestyle review (at every review); • Weight (at every review); • Fasting plasma glucose/ HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review). *Guidance: Patients are advised to monitor their own weight every week for the first 6 weeks and to contact the service if they have concerns about weight gain* *Where concerns about a patient's physical health are identified, the team arranges or ensures that the patient receives further assessment, investigations and management from primary or secondary healthcare services*.	1

4.12	The clinical members of the team can advise (working with other professionals) the patient, partner and family on:	
4.12a	Typical mother-infant care and relationship (including feeding and sleeping).	1
4.12b	Infant physical and emotional development.	1
4.13	Partners and designated family members are involved in decisions about care, where the patient consents.	1
4.14	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.*	1
4.15	The team provides each partner/significant other with a specific information pack. *Guidance: Information is provided verbally and in writing (e.g. partners/significant other 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 other local sources of advice and support such as local partners/significant other groups/workshops and relevant charities.*	2
4.16	Partners/significant others are offered individual time with staff members to discuss concerns, family history and their own needs.	1
4.17	Partners/significant others have access to a support network or group. This could be provided by the service or the team could signpost partner/significant others to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	2
4.18	The team follows a protocol for responding to partners/significant others when the patient does not consent to their involvement.	1
4.19	The service ensures that older children and other dependents are supported appropriately. *Guidance: This may be done via other services, e.g. social services, health visitor. Any materials should be age-appropriate.*	3
4.20	The team have established working relationships with local Mother and Baby Units. *Guidance: This should include agreed policies and discharge from the Mother and Baby Unit*.	2

4.21a	The team: • Informs a mother and baby unit of women at high risk of a potential admission; • Wherever possible, informs a patient about this contact, giving them written and verbal information about the mother and baby unit in question, with the opportunity to visit the unit in person or through virtual means. *Guidance: This includes women with a history of Puerperal psychosis / Bipolar Disorder / Serious Affective Disorder and women with serious illness currently managed in the community*	2
4.21b	The potential for admission is communicated verbally to the patient and her family and recorded in the written care plan and communicated to her GP, midwife and health visitor if appropriate.	1
4.21c	Written and verbal information is given to the patient, her partner and family about the Mother and Baby Unit.	2
4.21d	Patients and their partner/significant others are given the opportunity to visit the mother and baby unit if admission is being considered. *Guidance: This could be facilitated through virtual tours.*	2
4.22	As soon as possible after admission to a Mother and Baby Unit, a Perinatal community practitioner should be allocated to the patient.	1
4.23	If the patient has been admitted to an acute psychiatric ward or MBU, the allocated Perinatal community team member, or nominated deputy, 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.*	1
4.24	Staff members follow a lone working policy and feel safe when conducting home visits.	1
4.25	Patients are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.	1
4.26	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.	1

4.27	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).	1
4.28	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.*	1
4.29	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a person's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*	1
4.30	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.*	1

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Section Five: Infant Welfare and Safeguarding

Standard No.	Standard Description	Standard Type
5.1	During the initial assessment process for the patient, the emotional and physical care needs of the infant will be assessed.This assessment will include:	
5.1a	The baby's age and date of birth or due date.	1
5.1b	Parental responsibility for the infant.	1
5.1c	Name and contact numbers of GP, Health Visitor, Midwife, Obstetrician, any Social Worker or Paediatrician involved and any other relevant professionals or agencies.	1
5.1d	If the child or unborn child is the subject of a Child in Need Plan/ Looked After Child Plan/At Risk Register/Care Proceedings. *Guidance; Pertinent negatives must also be recorded i.e. that the child is not the subject of a Child Protection Plan.*	1
5.1e	Mode of delivery and obstetric complications during birth.	1
5.1f	Current or planned mode of feeding and any previous or current problems with feeding.	1
5.1g	A brief assessment of mother-infant interaction, care and relationship.	1
5.1h	The occupants of the household.	1
5.2	If areas of concern are highlighted then the professional who has identified the problems ensures an appropriate referral or assessment is made. *Guidance: Drawing on a multi-disciplinary team and joint working where appropriate.*	1
5.3	Mother-infant relationship and care should be observed and recorded in the patients notes every 3 months or more frequently should the patient's mental state and behaviour change.	1
5.4	Whenever mother and baby are seen together, the mother and infant interaction is recorded.	1
5.5	Risk Assessment of the Infant and other children	
5.6	A risk assessment of mother and infant must be undertaken during the initial assessment process by the service. This should include:	

5.6a	Disclosures of harmful or potentially harmful acts.	1
5.6b	Any delusions / overvalued ideas or hallucinations involving the unborn baby, infant or other children.	1
5.6c	Any thoughts, plans or intentions of harming the unborn baby, infant or other children. *Guidance: The assessment should consider that the phenomena could be intrusive obsessional thoughts.*	1
5.6d	Hostility and / or irritability towards the unborn baby, infant or other children.	1
5.6e	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.*	1
5.6f	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.*	1
5.6g	Thoughts and behaviours about estrangement from the baby and severe feelings of maternal inadequacy.	1
5.7	The risk assessment tool is designed or modified for use by Perinatal community mental health services. Risk assessments and management plans are updated according to clinical need. *Guidance: This could include a measure adapted or developed by the service*.	1
5.8	Risk assessments are completed prior to discharge and a summary is sent to all relevant agencies involved in care.	1
5.9	At each stage of Care and Risk Assessment consideration is given as to whether it is appropriate to initiate a CAF (or local equivalent) to better assess any additional needs the baby or older children of the family may have (www.ecm.gov.uk/caf).	1
5.10	Case notes include:	
5.10a	Any maternal concerns in relation to the pregnancy/infant.	1
5.10b	Her care of the pregnancy/infant.	1
5.10c	Her enjoyment of the pregnancy/infant.	1
5.10d	If the infant is absent from an appointment the reason why is recorded.	1

5.11	Staff encourage the involvement of partners/significant others in the care of the mother and her infant, unless detrimental to the mother or infant or the mother doesn't consent. *Guidance: Record of this should be included in the care plan.*	2
5.12	Women who choose to breastfeed are supported and encouraged by the following:	
5.12a	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.	1
5.12b	Clinical staff have annual training/updates on prescribing and breastfeeding.	1
5.13	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.	3
5.14	Local safeguarding and child protection guidance is available and accessible to all staff members.	1
5.15	The child protection status and the responsible Social Worker are recorded in the patient's notes, with contact details.	1
5.16	A member of the Perinatal mental health team is a member of the local safeguarding group or child protection.	3
5.17	Referral to Children and Family Services should be made based on a risk assessment and should not be "routine" (i.e. not just because the mother is mentally ill).	1
5.18	When the following factors are identified a referral to Children and Family Services should be made:	
5.18a	Concern from risk assessment about the immediate safety of the infant from its mother, partner or any other person.	1
5.18b	An assessment identifies that the child is at ongoing risk of harm.	1
5.18c	Current domestic violence.	1
5.18d	Evidence that harm has already occurred.	1
5.19	Any safeguarding referral is made in accordance with local NHS Trust (or equivalent body) and county council procedures.	1
5.20	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	1

5.21	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. This information covers: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	1

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Section Six: Staffing and Training

Standard No.	Standard Description	Standard type
6.1	Staff members receive an induction programme specific to the perinatal mental health service, which covers: • The purpose of the service; • The team's clinical approach; • The roles and responsibilities of staff members; • Referral threshold; • Basics of mother infant interaction and relationship; • The importance of family and partner/significant others; • Care pathways with other services. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.*	1
6.1a	New staff members, including agency staff, receive an induction based on an agreed list of core competencies (such as the Tavistock Core Competencies or NHS Education in Scotland). *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.*	1
6.1b	All newly qualified staff members are allocated a preceptor to oversee their transition into the service. *Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body.* *See http://www.rcn.org.uk/data/assets/pdf_file/0010/307756/ Preceptorship_framework.pdf for more practical advice.*	1
6.1c	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.	2
6.1d	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	2
6.1e	The organisation's leaders provide opportunities for positive relationships to develop between all team members.	3
6.2	Staff have received training in (this could be delivered in house by staff with relevant experience from within or outside the service).	
6.2a	The range of perinatal disorders and normal emotional changes in pregnancy and after birth.	1
6.2b	Staff who use clinical outcome measures have received relevant training.	2
6.2c	Basic infant development including developmental milestones.	1

6.2d	Supporting parents in a culturally sensitive way with particular relevance to the local population.	1
6.2e	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1
6.2f	Understanding and promoting mother-infant interaction and relationship.	1
6.2g	Physical health assessment. *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.*	1
6.2h	Infant mental health training. *Guidance: This can be accessed locally or from designated providers.*	2
6.2i	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities. This includes when to refer to specialist services, social services and an understanding of joint working protocols	1
6.2j	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist).	1
6.2k	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (this is updated at least annually).	1
6.2l	All staff have an understanding of the range of interventions available at the service and this understanding is sufficient to be able to describe the intervention to a patient and make an appropriate referral.	1
6.2m	Contraception and sexual health.	2
6.2n	Smoking cessation	1
6.2o	Family awareness, family inclusive practice and social systems, including partner/significant others' rights in relation to confidentiality.	2
6.2p	Infant feeding (including breastfeeding)	1
6.2q	Staff members can access leadership and management training appropriate to their role and specialty.	2

6.3	The team receives training consistent with their roles on risk assessment and risk management. This is refreshed every two years. This includes, but is not limited to, training on: • Safeguarding vulnerable adults (or local equivalent); • Safeguarding children Level 3 (or local equivalent); • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence; • Prevent training; • Recognising and responding to the signs of abuse, exploitation or neglect. NB - This also includes safeguarding supervision training.	1
6.4	Patients, partners/significant others and staff members are involved in devising and delivering Perinatal mental health training	2
6.5	In-house multi-disciplinary team education and practice development activities occur in the service at least every 3 months.	3
6.6	Staff members have time to support relevant research and academic activity.	2
6.7	All clinical staff attend an external specialist perinatal training day at a minimum of once every two years.	2
6.8	At least two member of the clinical team should take part in Perinatal Quality Network reviews annually.	3
6.9	The team provide an annual training plan or strategy about perinatal mental health and its services which is appropriate for and accessible to midwives, health visitors, GPs, Obstetricians, Social Workers and Mental Health workers.	2
6.10	All clinical staff members 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.*	1
6.10a	All staff members receive individual line management supervision at least monthly.	1
6.10b	Staff members in training and newly qualified staff members receive weekly line management supervision.	2
6.11	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	2
6.12	The team holds business meetings that are held at least monthly.	2
6.13	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	3

6.14	Front-line staff members are involved in key decisions about the service provided.	2
6.15	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that front-line staff members find accessible and easy to use.	2
6.16	The service is composed of	
6.16a	1 WTE Consultant Perinatal Psychiatrist input per 10,000 births. *Guidance: This should be comprised of no more than two Consultant Perinatal Psychiatrists.*	1
6.16b	1 WTE non-consultant Psychiatrist input per 10,000 births. *Guidance: This could be a Psychiatrist in training.*	2
6.16c	5 WTE Perinatal Community Psychiatric nurses per 10,000 births. *Guidance: This ratio should be adjusted based on geographical area*	1
6.16d	0.50 WTE Social Worker per 10,000 births. *Guidance: This should be one Social Worker*	2
6.16e	1 WTE Clinical Psychologist per 10,000 births *Guidance: This should be in place by October 2020 and annual evidenced progress reports will be required to maintain accreditation.*	1
6.16f	2.50 WTE Nursery Nurses per 10,000 births	2
6.16g	1 WTE Occupational Therapist per 10,000 births *Guidance: This should be in place by October 2020 and annual evidenced progress reports will be required to maintain accreditation.*	1
6.16h	Dedicated administrative support	1
6.17	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.	1
6.18	Members of the team can contact a specialist Perinatal Psychiatrist during working hours	1
6.19	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	2
6.20	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.*	1

6.21	The team has a fixed base and office accommodation, which adequately meets the need of the staffing group	1
6.22	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information	1
6.23	Staff members are easily identifiable (for example, by wearing appropriate identification).	1
6.24	All staff access performance and quality data on both their own patients and the team as a whole, including the regular reviewing of outcome measures to inform patient care and team development.	2
6.25	There are written documents that specify professional, organisational and line management responsibilities.	1
6.26	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.*	1
6.27	Staff members feel able to raise any concerns they may have about standards of care.	1
6.28	The team has protected time for team-building and discussing service development at least once a year.	2
6.29.a	Patients and 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.*	2
6.29.b	A senior clinician from the team should be a member of both the interview panel and appointment committee. *Guidance: This includes involvement in the shortlisting process*.	1
6.30	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.*	1
6.31	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.*	1
6.32	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice	2

6.34	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services; · Drug/alcohol services; · Domestic abuse services; · Immigration services. *Additional guidance: The team should have joint working protocols with relevant organisations.*	1
6.35	Patients can access help, from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams and telephone helplines.*	1
6.36	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	1
6.37	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.*	3
6.38	Patient representatives attend and contribute to local and service level meetings and committees.	2
6.39	Women with lived experience (whether in groups or individually) are consulted about and invited to participate in service development, recruitment, training and service evaluation.	3
6.40	Every community Perinatal team has a dedicated specialist team manager.	1
6.41	Where peer support workers are used by the service (whether in a voluntary or paid role) they have both a defined role description and regular supervision	1
6.42	There is adequate access to clinic space to allow for maximum efficiency of clinical staff who need to see patients in a clinic setting (including trainees)	1

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Section Seven: Recording and Audit

Standard No.	Standard Description	Standard type
7.1	The service evaluates annually:	
7.1a	Feedback from referrers.	2
7.1b	Feedback from service staff.	2
7.1c	Accident and incident records. *Guidance: The service should provide the quality network with information of any SUIs, investigations or complaints since their last peer review.*	2
7.1d	Analysis of complaints.	2
7.1e	The findings of audits.	2
7.1f	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data).	2
7.1g	Action plans are developed based on the service evaluation and resulting quality improvement is monitored.	2
7.1h	Women involved in Care Proceedings / Child Safeguarding Protection Plans.	1
7.2	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.	2
7.3	Any serious untoward incident including those involving a child and any emergency child protection order should be audited within 6 weeks and chaired by a suitably qualified clinician external to the service.	1
7.4	The service keeps a record of any difficulties / undue delay in transferring the patient to another community mental health service.	1
7.5	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice.	2
7.6	Service users and their partners/family members are encouraged to feedback confidentially about their experiences of using the service, and their feedback is used to improve the service. *Guidance: Feedback is independently sought (i.e. not by the clinical team). Their feedback is triangulated with other feedback to make it as accurate as possible. Staff members are informed of feedback from service users.*	1

Glossary

Advance statement/ directive	A document drawn up by a person when they are well, saying how they want to be cared for if they become unwell.
Carers' assessment	An assessment that looks at how caring affects their life, including for example, physical, mental and emotional needs, support they may need and whether they are able or willing to carry on caring.
Clinical supervision	A professional relationship between a staff member and their supervisor. A clinical supervisor's key duties are: ● Monitoring employees' work with patients; ● Maintaining ethical and professional standards in clinical practice.
Evidence based treatments	Any practice that has been established as effective through robust research
Managerial supervision	Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice.
MDT	Multidisciplinary team - a team made up of different kinds of health professionals.
Mental Capacity Act[1]	The Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others.
Operational policy	A policy document that outlines the role and aims of services.

[1] Mental Health Foundation (2015). The Mental Capacity Act

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