RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

PQN
PERINATAL
QUALITY NETWORK

The Perinatal Quality Network

Standards for Community Perinatal Mental Health Services

Key Changes

7th Edition

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PQN 7th Edition Key Changes

Previous Standard Number	Previous Standard Type	Previous Standard Criteria (6th Edition)	New Standard Number	New Standard Type	New Standard Criteria (7th Edition)	Changes Made	CCQI Core Standard Number
1.1f	**1**	Women with alcohol/substance misuse problems if there is also moderate to severe mental illness.	**1.1f**	**1**	Patients with alcohol/substance misuse problems if there is also moderate to severe mental illness. Guidance: The team should liaise and work jointly with community addiction/substance misuse services to facilitate care/treatment options.	**Standard wording updated** **Guidance added**	**10.3**
1.4	**1**	A clinical member of staff is available to discuss emergency referrals during working hours.	**1.4**	**1**	The team has a system to manage and respond to referrals in a safe and timely way. This includes: - A clinical member of staff being available to discuss urgent referrals during working hours; - Where referrals are made through a single point of access, these are passed on to the community team within one working day. Emergency referrals are passed across immediately.	**Standard wording and number updated**	**1.3**

PQN 7th Edition Key Changes

.11	**3**	The service provides a telephone advice line for professionals (e.g. midwives, GPs) at specific times of the week.	**1.7**	**2**	Services have a mechanism to offer proactive advice and guidance to professionals. Guidance: This can include a telephone advice line, emails or advice guidance app. This should include the service offering leadership for complex cases or patients with serious risk, even if they don't meet referral criteria.	**Standard wording and number updated** **Guidance added** **Standard type updated**	
			1.10	**2**	People who are waiting for assessment and/or treatment are given information and signposted to resources on support available whilst they are waiting. They are made aware of who to contact if their needs change and how and when to access crisis services. Guidance: Information given could include crisis lines, guided self-help techniques, resources relevant to the patient's treatment pathway, and voluntary organisations.	**New core standard**	**1.6**

PQN 7th Edition Key Changes

2.7	**1**	Patients have a comprehensive evidence-based assessment which includes their: - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development;	**2.6**	**1**	Patients have a comprehensive mental health assessment. The process involves the patient, their partner/chosen other, and other health/care providers as relevant and includes consideration of the patient's: - Strengths, goals and areas for development; - Mental health and medication; - Psychosocial and psychological needs; - Religious traditions and spiritual beliefs; - Advance choices; - Reasonable adjustments. Guidance: Where appropriate, the assessment should draw on information from a range of sources, including the patient, partner/chosen other, other involved services and agencies and past assessments or relevant information held by services.	**Standard wording and number updated** **Guidance added**	**2.2**
2.13	**1**	Patients identified as requiring a formal psychological intervention are offered an assessment with a qualified psychological practitioner and any treatment commenced within 28 days of the assessment. Guidance: Any exceptions and reasons for this are documented in the patient's notes. Practitioners	**2.12**	**1**	Patients requiring a formal psychological intervention are offered assessment and treatment within 18 weeks. Where a patient is assessed as not yet ready, this is documented and revisited as part of ongoing care planning.	**Standard wording and number updated** **Guidance removed**	

		delivering therapy must be appropriately trained and supervised.					
			2.13	**2**	Patients requiring a formal psychological intervention are offered assessment and treatment within 6 weeks. Where a patient is assessed as not yet ready, this is documented and revisited as part of ongoing care planning.	**New standard**	
2.14	**2**	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The patient receives a copy.	**2.14**	**1**	The team sends correspondence detailing the outcomes of the assessment to the patient, referrer, the GP and other relevant services.	**Standard wording updated** **Standard type updated**	**2.6**
			2.19	**1**	If patients are unable to be engaged, a decision is made by the team in collaboration with relevant parties, based on patient need and risk, as to how long to continue to follow up and try to engage the patient. Guidance: DNA (did not attend) should not be a reason for discharge. If/when discharge from the team occurs, a clear record of the decision-making process, who was involved in it and the safety	**New core standard**	**3.3**

					management plan is included within the patients' electronic record. This is shared with relevant parties.		
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.	**3.2**	**1**	When patients are transferred between community services, there is a handover process prior to discharge which ensures seamless transfer of care to a new named person and transfer of information including: - Patient preferences for engagement; - Relapse indicators and actions needed in event of them; - Current medication, indication, monitoring arrangements; - An up-to-date care plan, risk assessment and safety plan.	**Standard wording updated** **Guidance removed**	**9.3**
			3.8	**1**	The team follows a protocol to manage patients who discharge themselves against medical advice. This includes: • Recording the patient's capacity to understand the risks of self-discharge; • Exploring the reasons why a patient may want to discharge themselves and actively try and address these issues, where possible; • Contacting relevant parties (e.g. other agencies, primary care) to notify them	**New core standard**	**9.5**

					of the discharge.		
			4.2	**2**	Care plans are routinely reviewed as part of an ongoing process to support assessment of response to treatment/interventions and changes in goals and needs. Guidance: Additional reviews may be initiated when requested by the patient, partner/chosen other or other involved agency, when there is a significant change in circumstances impacting the patient's mental health and/or a change in their presenting problems or needs.	**New core standard**	**4.3**
4.7	**2**	The team supports patients to access activities that are meaningful to them. Guidance: This might include: • Activities that promote enjoyment and interaction with the baby and social engagement (such as swimming lessons, sensory activities, music groups); • Voluntary organisations;	**4.6**	**1**	The team supports patients to undertake structured activities such as work, education and volunteering. Guidance: This might include: • Activities that promote enjoyment and interaction with the baby and social engagement (such as swimming lessons, sensory activities, music groups);	**Standard wording and number updated** **Standard type updated**	**5.5**

PQN 7th Edition Key Changes

		• Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges			• Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.		
4.10	**1**	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	**4.9**	**1**	When medication is prescribed, the risks and benefits are discussed with the patient and partner/chosen other (with patient consent). The following are discussed and recorded: - The intended outcome of the intervention; - Timescale for response; - Monitoring requirements; - Patient consent and capacity to consent. Guidance: This should involve joint decision making between patient and prescriber.	**Standard wording and number updated** **Guidance added**	**6.1**
4.11	**1**	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Guidance: Side effect monitoring tools can be used to support	**4.10**	**1**	Patients have their medications reviewed regularly, if these medications are prescribed by perinatal services. Medication reviews include an assessment of therapeutic response, adherence, safety and management of side effects, including during medication changes and when	**Standard wording and number updated** **Guidance updated**	**6.2**

		reviews.			medications are being stopped/ withdrawn. Guidance: Side effect monitoring tools can be used to support reviews. There should be particular emphasis on the potential effects of the medication on the pregnancy and changes in the bioavailability of medication as the pregnancy progresses.		
4.13	**1**	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). The team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for the duration that the patient is under the team (carried out by the team or in a shared care arrangement with the patient's GP). Guidance: Abnormalities or changes in the patient's condition or treatment should prompt a medical review or be acted upon appropriately. Teams should use the most up to date NICE guidelines or equivalent for the frequency of physical health assessments for each medication, taking into account any modifying effects of pregnancy, childbirth, or lactation on biochemical/neurohormonal	**4.11**	**1**	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon. Ongoing monitoring and prescribing plans are developed collaboratively with primary care in order to best meet the patient's needs.	**Standard wording and number updated** **Guidance removed**	**6.4**

		markers.					
4.14	**3**	Patients and carers are able to discuss medications with a specialist pharmacist. Guidance: A Specialist Pharmacist needs to have mental health knowledge but not necessarily perinatal, and should have established links to the service. The Pharmacist does not have to be directly contactable by the patients or carers but could meet with them via a request from other members of the MDT. It would not be expected for a service to routinely give details of pharmacist to patients or carers.	**4.12**	**2**	Patients and partners/chosen others are able to discuss medications with a specialist pharmacist. Guidance: This role should be provided by a clinical pharmacist with perinatal mental health expertise. The pharmacist contributes to prescribing decisions, patient and carer counselling, staff education, complex risk–benefit assessments, and safeguarding of medication use.	**Standard wording and number updated** **Guidance updated** **Standard type updated**	**6.3**
			4.17	**2**	There are systems in place to ensure that patients with serious mental illness (SMI) receive annual physical health checks. Guidance: This could be done within the team or through another community service and reasonable adjustments to support attendance are put in place.	**New core standard**	**7.3**

PQN 7th Edition Key Changes

4.22	**2**	The team provides each partner and/or chosen other with accessible carer's information. Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.	**4.21**	**1**	The team provides each partner and/or chosen other with accessible carer's information. Guidance: Information is provided verbally and in writing and/or digitally (e.g. carer's pack). It 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.	**Standard number updated** **Guidance updated** **Standard type updated**	**13.4**
			4.23	**2**	Where a patient or patient's family member is identified as a young carer, the service is able to signpost to specific young carer support.	**New standard**	
4.24	**2**	Partners/chosen others are offered individual time with staff members to discuss the needs of the family. Guidance: This should be offered where appropriate. Staff should signpost partners to support (i.e. appropriate local services) as required.	**4.24**	**1**	Partners/chosen others are offered individual time with staff members to discuss concerns, family history and their own needs.	**Standard wording updated** **Guidance removed** **Standard type updated**	**13.3**

PQN 7th Edition Key Changes

4.25	**3**	The team actively encourages partners and/or chosen others to attend carer support networks or groups. There is a designated staff member to support carers.	**4.25**	**2**	The team actively encourages partners and/or chosen others to attend carer support networks or groups. There is a designated staff member to support carers.	**Standard type updated**	**13.5**
			4.31	**1**	Reasonable adjustments are made to how care is delivered, if required, for patients with disability, including those with autism and/or learning disability. Any reasonable adjustments are recorded in the patient's notes and in line with any relevant legal or regulatory recording requirements.	**New core standard**	**14.4**
4.31	**1**	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.	**4.32**	**2**	The team works with interpreters to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. Guidance: If the patient's first language is not English, an assessment is made as to whether they can accurately describe their symptoms, difficulties and needs. If not, an interpreter is booked for subsequent reviews.	**Standard wording and number updated** **Guidance updated** **Standard type updated**	**15.3**

PQN 7th Edition Key Changes

			4.33	**2**	Information for patients and partners/chosen others is available in accessible formats for neurodiverse people and people with sight/hearing/cognitive difficulties or learning disabilities. It can be provided in languages other than English (ensuring cultural relevance, if necessary). Guidance: In Wales, services and communication (written and spoken) comply with the relevant Welsh Language legislation.	**New core standard**	**15.1**
5.14	**3**	If a patient and infant or older children are seen in an outpatient clinic or other mental health facility, the waiting area is exclusively for the use of the Perinatal and/or maternity services during that session.	**5.14**	**2**	If a patient and infant or older children are seen in an outpatient clinic or other mental health facility, the waiting area is appropriate for the use of the Perinatal service during that session.	**Standard wording updated** **Standard type updated**	
6.1e	**1**	1 WTE Clinical Psychologist.	**6.1e**	**1**	1 WTE Consultant Clinical or Counselling Psychologist Guidance: The psychologist provides the psychological professions team with strategic leadership, professional support and accountability.	**Standard wording updated** **Guidance added**	
6.1f	**2**	1 WTE additional Clinical or Counselling Psychologist.	**6.1f**	**2**	2 WTE psychological professionals Guidance: This can include: • CBT therapist	**Standard wording updated**	

PQN 7th Edition Key Changes

		Guidance: This should be a qualified professional and not an assistant or trainee.			• Systemic psychotherapist • Adult psychotherapist	**Guidance updated**	
6.1g	**2**	2.5 WTE Nursery Nurses.	**6.1g**	**1**	2.5 WTE Nursery Nurses.	**Standard type updated**	
6.2g	**3**	4 WTE Nursery Nurses	**6.2g**	**2**	4 WTE Nursery Nurses	**Standard type updated**	
6.2l	**3**	0.5 WTE Pharmacist	**6.2l**	**2**	1.0 WTE Specialist Pharmacist Guidance: This role should be provided by a clinical pharmacist with perinatal mental health expertise. The pharmacist contributes to prescribing decisions, patient and carer counselling, staff education, complex risk–benefit assessments, and safeguarding of medication use.	**Standard wording updated** **Guidance added** **Standard type updated**	

PQN 7th Edition Key Changes

6.1i	**2**	1 WTE Parent-Infant Therapist.	**6.4**	**2**	The team have dedicated staff who deliver parent-infant therapy. Guidance: Staff who deliver parent-infant interventions should have appropriate training and receive regular supervision from a psychological professional.	**Standard wording and number updated** **Guidance added**	
			6.5	**3**	The team has access to Allied Health Professionals to meet a range of patient needs that may be identified as part of care and treatment planning. There is sufficient sessional time and/or a pathway/shared care arrangements in place to draw on these staff on an as needed basis. Guidance: As a minimum, this includes dietetics, physiotherapy and speech and language therapy with appropriate experience in mental health.	**New core standard**	**5.4**
			6.14k	**2**	Trauma-informed care.	**New core standard**	**22.1.6**
			6.14l	**2**	Identification of co-occurring substance use with specific focus on alcohol and commonly used drugs. This may include updates on substance misuse trends, awareness of evidence-based brief interventions and harm reduction advice.	**New core standard**	**22.1.7**

PQN 7th Edition Key Changes

6.14m	**1**	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	**6.14o**	**2**	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care including cultural competence and awareness of the importance of faith/spirituality. Guidance: Training should address all nine protected characteristics and their relevance to delivering equitable mental health care.	**Standard wording and number updated** **Guidance added** **Standard type updated**	**22.1.8**
6.14n	**2**	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	**6.14p**	**1**	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	**Standard number updated** **Standard type updated**	**22.1.9**
6.27	**1**	The team has a fixed base and office accommodation, which meets the need of the staffing group, including adequate clinical space.	**6.25**	**1**	The team has access to office accommodation and clinical spaces which meets the needs of the service model and patient cohort. Guidance: This can be split across different bases.	**Standard wording and number updated** **Guidance added**	**17.4**

PQN 7th Edition Key Changes

6.33	**3**	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.	**6.31**	**2**	There is regular reflective practice available of sufficient frequency to ensure that all staff can access this at least every six weeks. Guidance: Reflective practice is facilitated by someone with experience in managing a group process.	**Standard wording and number updated** **Guidance added** **Standard type updated**	**18.1**
			6.35	**2**	Those in service and team leadership roles are visible and present at the team base and actively role model and promote an open learning culture. They are confident and competent in both listening up and following up in line with Freedom to Speak Up principles. Guidance: Staff know that incident reporting, learning from incidents and responsiveness to feedback are leadership priorities. If staff raise concerns, they are confident their leadership will address them.	**New core standard**	**18.2**
			6.36	**3**	The team has a system for reviewing culture in the team and takes action on findings. Guidance: This may include reviewing incident data, patient and partner/chosen other feedback, staffing and employee relations data and/or use of a validated staff survey, culture of care or safety culture tool/survey.	**New core standard**	**18.3**

PQN 7th Edition Key Changes

			7.3	**2**	The team has embedded standard operating processes and clinical governance to: - Hold oversight of and manage size and clinical need of caseloads; - Hold oversight of and manage size and safety of waiting lists.	**New core standard**	**8.2**
7.5	**2**	The service's clinical outcome data are reviewed at least six-monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	**7.6**	**1**	The service's clinical outcome data are collated, analysed and reported at least bi-annually (every 6 months). Access, experience and outcomes data are shared with commissioners, the team, patients and partners/chosen others, and used to make improvements to the service.	**Standard wording and number updated** **Standard type updated**	**23.3**
7.11	**2**	Feedback received from patients and partners/chosen others is analysed and explored to identify any differences of experiences according to protected characteristics.	**7.12**	**1**	Feedback received from patients and partners/chosen is analysed to identify any differences of experiences by protected characteristics. Guidance: Complaints, compliments and other feedback sources include the option to share demographic information.	**Standard wording and number updated** **Guidance added** **Standard type updated**	**12.2**

PQN 7th Edition Key Changes

7.15	**3**	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Guidance: Progress against this improvement plan is reviewed at least annually with the team.	**7.16**	**2**	The team reviews its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services. Progress against the plan is reviewed at regular time points throughout the year and the plan is refreshed annually. Guidance: Good practice includes adopting practices in line with recommendations in RCPsych Net Zero Guidance. This may include, for example, assigning a Sustainability Champion role, staff undertaking training in sustainable practice, developing a green transport plan for the team, reviewing practices to improve continuity of care.	**Standard wording and number updated** **Guidance updated** **Standard type updated**	**18.5**
			7.18	**3**	The team consistently records the provision of psychological interventions using standardised SNOMED CT codes to support local audit, national reporting and improvements in patient outcomes.	**New standard**	