



# Quality Network for Perinatal Mental Health Services Community Cycle 8 Annual Report

2021

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**PQN**  
PERINATAL  
QUALITY NETWORK



# Foreword

Forty-four community perinatal mental health services presented themselves for a review in 2021. Almost half were new to the process and many were relatively 'new teams' which have developed over the last two to three years.

There are still many teams who are members of our network but did not feel ready to proceed to accreditation yet.

It is not possible for us to reliably compare the current situation with the previous years due to the significant changes and adaptations brought by the pandemic.

Whilst the overall compliance with standards met is almost 90%, there are standards where the compliance is lower and at least 20% of services are not meeting them. A number of services have also presented to the accreditation committees with relatively large numbers of unmet type one standards. Notable amongst these are staffing difficulties, particularly meeting the standards on clinical psychologists, occupational therapists, nursery nurses and low compliance with the standard on social workers.

A fifth of services had problems with providing information for referrers, patients and carers. A similar proportion did not have clear processes for working relationships with key partners such as crisis and home treatment teams and maternity services, as well as a lack of protocols for other services such as

substance misuse and eating disorders services.

While detailed comparison with previous years are not possible, issues with staffing are familiar but do seem to be improving.

What does seem to be new are the difficulties in meeting the training requirements of staff, no doubt in part due to the constraints of the pandemic restrictions.

An essential function of the PQN is providing a community of specialists which goes some way to reduce the potential isolation of solitary services in trusts and health boards. Team meetings and online conferences are a poor substitute for face-to-face contact with colleagues nationally, and in-person participation in peer reviews has been a sad loss over the last two years.

There have also been other challenges familiar to those of us involved in developing the accreditation process of mother and baby units. In the beginning there were many unwarranted variations in care, particularly involving access and the acuity of patients managed. These were largely resolved by 2007 when the first accreditations took place.

At the moment there is a considerable variation for services in the size of the birth population [1000/37,000], caseloads [50/800] and numbers of referrals. Smaller teams struggled to meet staffing standards and may have difficulties maintaining the knowledge and skills involved in treating a whole

range of disorders, particularly those with serious mental illness. Larger teams may face difficulty maintaining cohesive working relationships and administering large staff numbers.

This underpins the importance of data collection and audit so that we can work towards equitable service provision across the United Kingdom.

Some of these difficulties will be improved by the new standards and many by the relaxation of pandemic restrictions and once again being able to meet each other face-to-face.

I would strongly recommend all colleagues to re-read the Maternal Deaths Enquiry reports. Many of the findings and recommendations underpin our standards but many findings have remained unchanged over the years. It is obvious more needs to be done and to incorporate the lessons from the enquiries into our clinical practice.

For the last two years we have been in the throes of the pandemic. To the credit of our members, they have kept the perinatal mental health services running with timely assessments, maintaining therapeutic relationships and innovative approaches to treatments, all using previously unfamiliar technologies. They deserve many congratulations for all their hard work.

**Dr Margaret Oates**

**Chair of the PQN Advisory Group,  
Retired Consultant Perinatal  
Psychiatrist**

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# Introduction

The Perinatal Quality Network (PQN) works with inpatient and community services to assure and improve the quality of services treating women in the perinatal period who are living with a mental illness.

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care, and support other services to achieve these.

Involving patients and carers in PQN is a priority, and people with first-hand experience of using perinatal mental health services are encouraged to get involved in all stages of the review process.

## Cycle 8

Forty-four community perinatal mental health services participated in Cycle 8 (see Appendix 3 for a full list of services). There were 33 peer reviews, six accreditation reviews, and five annual self-reviews. The cycle ran from January to June 2021 and all reviews were carried out virtually using Microsoft Teams.

Throughout the cycle we noticed that there were more unmet type one standards across services which underwent accreditation, particularly concerning training standards. This may be a reflection of the pandemic itself as teams told us that a lot of their training had to be postponed or cancelled. Therefore, we decided to

publish this report as a standalone report rather than providing comparison with the previous cycle as we would normally.

## Review process

The reviews aim to improve services incrementally by applying standards and using the principles of the clinical audit cycle. The standards are applied through a process of self-review and external peer review where members visit each other's service. The self-review questionnaire is a checklist of PQN standards against which teams rate themselves, supplemented with more exploratory items to encourage discussion around achievements and ideas for improvement. The self-review process helps staff to prepare for the external peer review and become familiar with the standards.

Prior to the peer review, feedback on the service was collected through interviews/surveys with patients, family members, partner agencies (and service staff for accreditation reviews). A tour of the team base was conducted on the review day so that reviewers can see what environment looks like and how it functions.

The results are fed back in local and national reports. Services are encouraged to take action to address any developmental needs that have been identified.

# This report

## What is in this report?

This national report contains the aggregated results of the reviews undertaken by 44 community perinatal mental health services. It examines contextual data obtained from all services, including staff mix, number of births within the local population, number of days open a year, total active caseload, number of referrals made in the last 12 months, number of accepted referrals, average waiting time for routine assessments, and the average waiting time for treatment.

The PQN team carried out peer reviews based on the self-reported data from services. The standards were then scored by the reviewing team accordingly. Quantitative analysis was conducted using these scores. The main body of the report highlights key achievements and areas for improvement across services from each domain of the Fifth Edition of the PQN Community Standards. The overall adherence (those marked as met or N/A) to these subsections are shown on page 9 of this report. The number of standards met by each team in each domain are shown in graphs. Averages have been taken based on available data, where data has been given in inconsistent formats then an approximate average has been calculated. Included throughout the report are quotes from patients,

partners/family members, and staff members, as well as examples of good practice, and recommendations for standards which were consistently not met by all services.

Finally, a full summary detailing the average scores for each criterion for all teams is included (see Appendix 1). This enables teams to benchmark themselves against other teams who participated in Cycle 8.

## How to use this report

Average scores for teams involved in Cycle 8 are detailed in this report so services can determine how well they are doing compared with other member services. Teams can also compare their activity, resources and outcomes with those of the network as a whole. We recommend that services use this report in conjunction with their local report to inform discussions with their commissioners and to demonstrate their team's performance.

Each team's local report provides a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of each team's overall performance for each section of the service standards.

# The standards

The Fifth Edition of the PQN Community Standards against which the performance in the initial year was assessed, can be found in Appendix 1.

The standards are drawn from a range of authoritative sources and incorporate feedback from patient and carer representatives, and experts from a range of relevant professions.

The standards were used to generate a series of data collection tools for use in the self-, peer, and accreditation review processes. Participating teams rate themselves against the seven sections of the PQN Community Standards via an annual process of self- and peer-review. This model aims to facilitate incremental improvements in service quality.

## Types of standard

Throughout the report standards are referred to as a type 1, 2 or 3.

**Type 1 standards** relate to patient safety, rights or dignity. Failure to meet these standards would represent a significant threat to patients and/or would break the law.

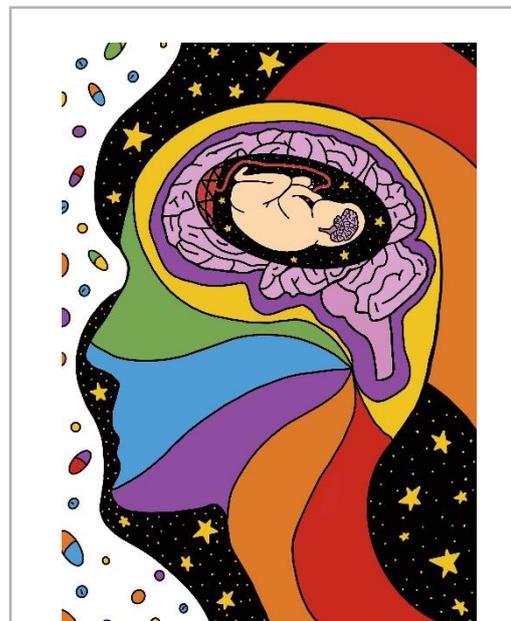
**Type 2 standards** are standards we expect services to meet.

**Type 3 standards** are criteria that an excellent service should meet or are standards that are not the direct responsibility of the team.

## Standards sections

The PQN Community Standards are grouped into 7 domains:

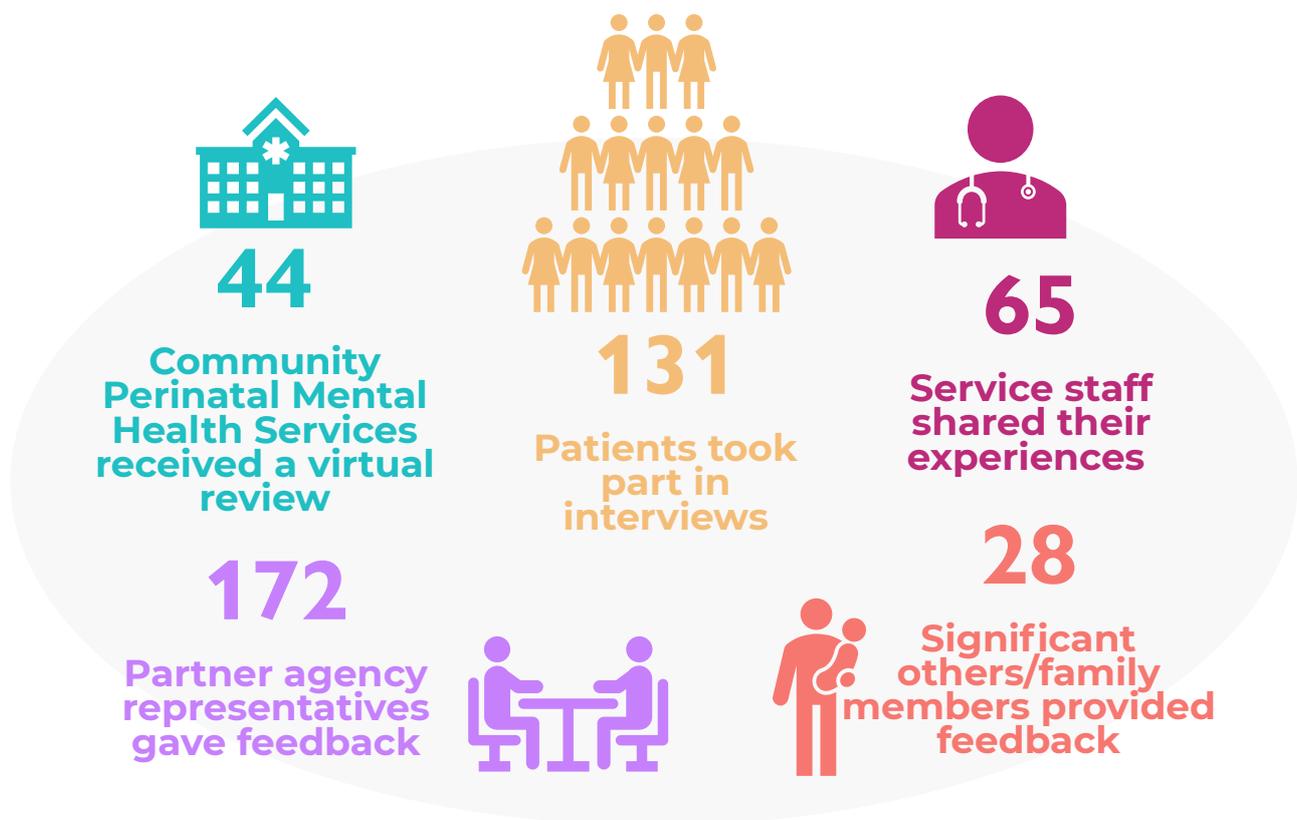
1. Access and referral
2. Assessment
3. Discharge and transfer of care
4. Care and treatment
5. Rights, infant welfare and safeguarding
6. Staffing and training
7. Recording and audit



'Babies do well, with well mums'  
by Emma, South West Yorkshire  
Perinatal Team

# Data collection

In order to get a comprehensive overview of the service being provided by each service, teams were asked to provide contact details of patients who were either currently under the care of the team or had been discharged within three months prior to the review, as well as for significant others/family members, service staff, and partner agency representatives. These groups were either spoken to on the phone prior to the review or during the review using Microsoft Teams, or they provided feedback via MS Forms. The feedback enabled the review team to get a fuller picture of the care being provided.



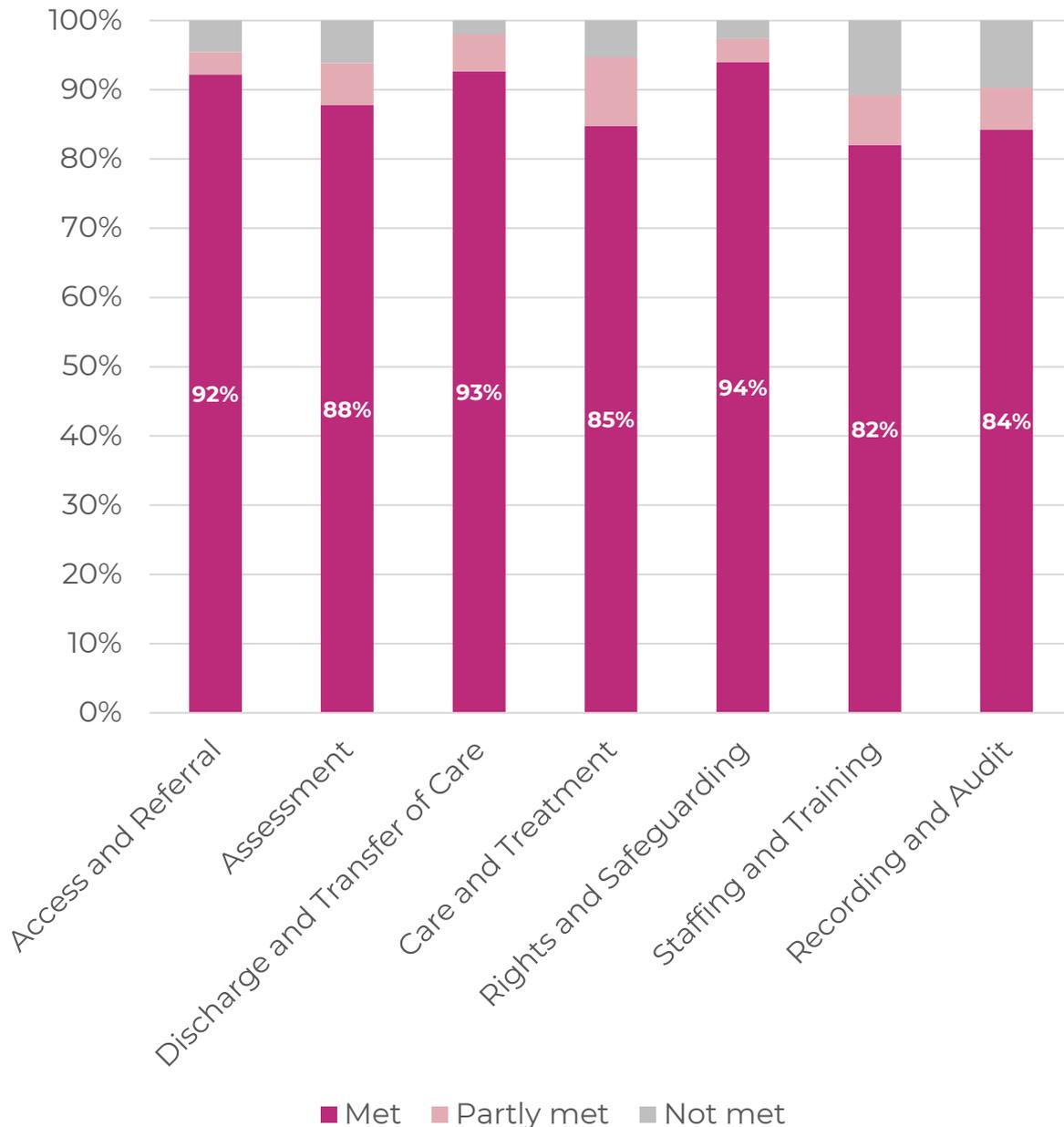
**Figure 1: Overview of qualitative data collected during Cycle 8**

For teams undergoing accreditation we also gathered quantitative data using online questionnaires, which services were asked to distribute to patients, significant others/family members, staff, and referrers. Services were also asked to complete a case note audit using patient notes. Questionnaires were completed via the College online review system, CARS, using Snap Surveys. This data was used during reviews to inform discussion of standards services were not meeting.

# Report data

## Overall performance of member services

The graph below shows the average percentage of met, partly met and not met standards in each standard domain.



**Figure 2: Percentage of met standards in each domain**

As can be seen in Figure 2 above, on average the highest proportion of standards were met by services in the rights, infant welfare and safeguarding domain (94%). On average, the lowest proportion of standards met were in the staffing and training domain (82%), with almost one fifth of standards being either partly met or not met at all.

## Contextual data

All services were asked to provide up-to-date contextual data, including number of births within the local population and total active caseload. Other contextual data collected are detailed throughout the report.



The average number of births in the local population is 10,291. Ranging from 1,100 to 37,000.

The average total caseload per team is 295\*. Ranging from 53 to 774 cases.



Of the 44 services represented in this report, 37 are based in England, 5 in Wales and 2 in Scotland

## Open discussion topics

A key part of the peer review is an open discussion during which the team being reviewed can seek advice and guidance on a topic of their choice. In total there were 40 discussion topics which were grouped into ten main themes, see below. For further breakdown of open discussion topics see Appendix 3.



Figure 3: Overview of Cycle 8 open discussion topics

## Feedback from partner agencies

Representatives from partner agencies are invited to give feedback as part of a service's peer or accreditation review. Partner agencies include referrers, community mental health services, mother and baby units, children's services, charities, midwifery, and obstetrics, among others.

In Cycle 8 feedback from partner agencies was collected via Microsoft Forms and representatives were asked to provide feedback about achievements, challenges, and suggestions to meet challenges with perinatal mental health services. The infographic below shows the most frequent successes and challenges identified by 172 partner agency representatives. A full thematic breakdown is available in Appendix 2.

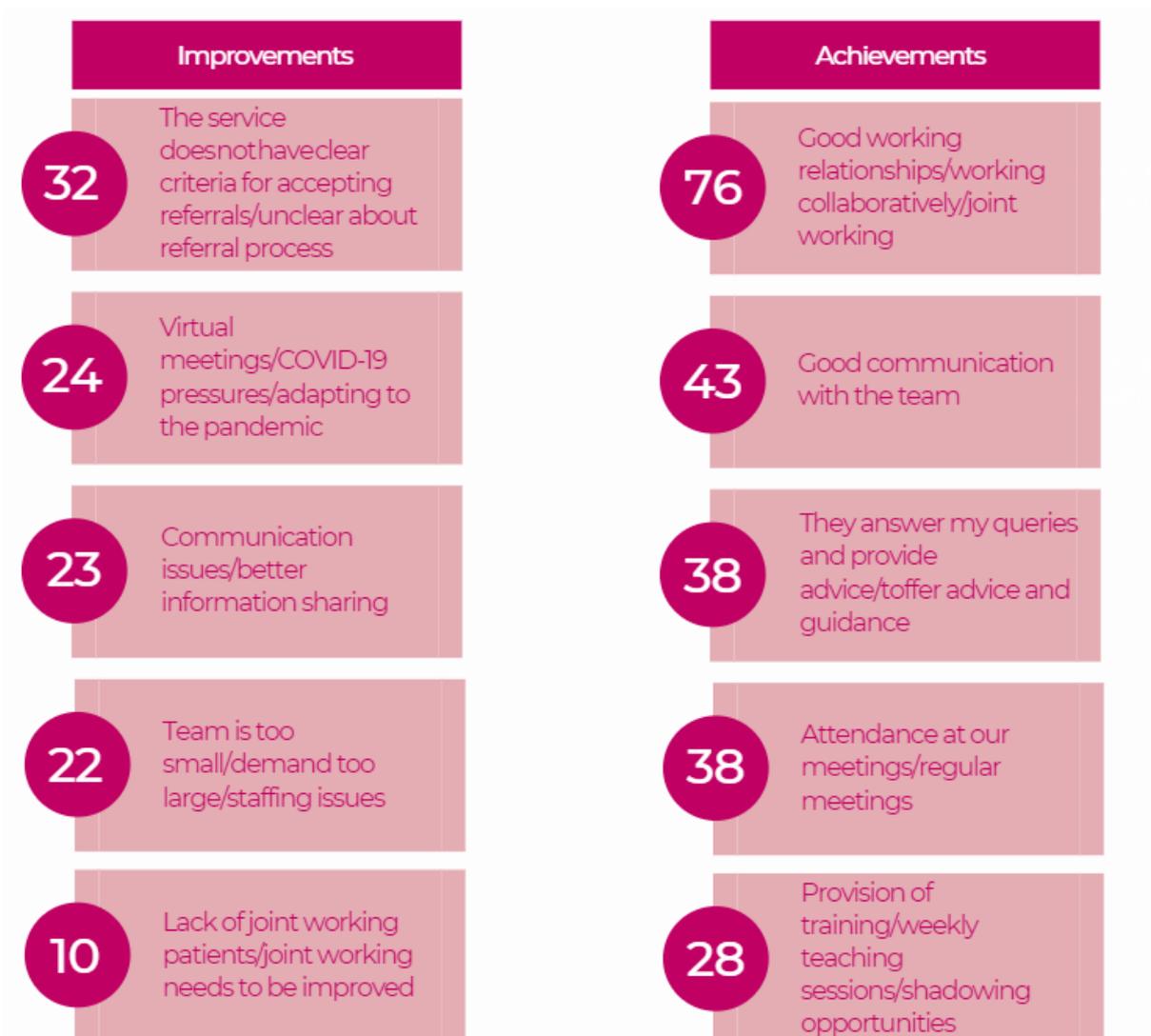


Figure 4: Overview of Cycle 8 multi-agency feedback

# Access and referral

This section looks at the procedures in place to ensure care is available to those who need it, the referral process, and equity of access.



**Over the last 12 months, the average number of referrals was 760<sup>\*\*</sup>. Ranging from 92 to 2,063. The total number of referrals was 33,457**

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**The average number of referrals accepted was 497<sup>\*\*\*</sup>. Ranging from 170 to 1,671. The total number of accepted referrals was 21,887; 65% of referrals made.**



<sup>\*\*</sup>Based on data from 39 services.  
<sup>\*\*\*</sup>Based on data from 36 services.

## Key achievements



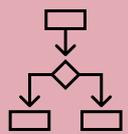
All services have a timetabled meeting at least once a week to discuss the allocation of referrals, current assessments and reviews.



98% of services accepted referrals from any health professionals working with women in the perinatal period and informed the patient's GP/referrer.



In 98% of services, urgent requests for telephone advice from other professionals are responded to within one working day.



In 98% of services, when the team are unable to conduct an emergency assessment, there is an agreed approach in place.

## Areas for improvement



43% of services do not have clear joint working protocols for one or more of the following:

- Working with patients with disordered eating;
- Substance misuse problems;
- A severe, diagnosed personality disorder;
- A learning disability.



19% of services cannot be accessed using public transport or with transport provided by the service.



### Example of good practice

The Leeds Perinatal Mental Health Team works to address gaps in their service provision, particularly with hard-to-reach groups and partners. The team has a partner peer support worker who leads partner peer support groups and publishes a newsletter of resources for partners. The service set up the diverse mums group which was established with patient input. It involves various professionals, such as dietitians and the head of midwifery. The team also work with the local faith communities, talking about culture, stigma and shame around mental health. They have been on local south Asian radio stations which caters to these communities.

“ I received information about my referral in the post but also had a phone call with a perinatal mental health midwife.

**Patient**

I knew what to expect at my first appointment as it was all explained over the phone with the community perinatal nurse.

**Patient**

I received information about the service when my partner first started treatment. I found this information very useful.

**Significant other**

“ There needs to be better communication between referrers and the perinatal team so that midwives are more informed about the referral process.

**Patient**

It would have been helpful to receive some information about what the sessions involved and how I could have been involved.

**Significant other**

Whilst patients are on the waiting list, there should be a 'check in' courtesy phone call if this period is to last over 4 weeks.

**Patient**

### Recommendations

1. Teams should ensure they have written joint working protocols in place for working with patients with disordered eating; substance misuse problems; a severe, diagnosed personality disorder; or a learning disability. Examples around this can be sought from accredited services and the PQN team.
2. Services that cannot be easily accessed through public transport should seek accessible clinic spaces for patients, or look into arranging transport.

# Assessment

This section explores standards related to the wait for an assessment, risk assessment and management, the follow up procedure for patients who did not attend their assessment/appointment, and the location of assessments.



Over the last 12 months, the average waiting time for assessment is 3 weeks<sup>†</sup>. Ranging from 1 to 6 weeks.

<sup>†</sup>Based on data from 41 services.

## Key achievements



In all services, 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.



In all services, 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.



In all services, patients felt welcomed by staff members when attending the team base for their appointments.



In all services, patient information is kept in accordance with current legislation.

## Areas for improvement



In 46% of services, facilities are not available that are suitable for small babies and siblings.



In 27% of services, a physical health review does not always take place as part of the initial assessment, or as soon as possible.



In 41% of services, women identified as requiring a psychological intervention are not offered an assessment with a clinical psychologist and any treatment commenced within 28 days of the assessment.



In 18% of services, not all women who are referred to the service are assessed within 28 days for routine cases (or four hours for emergencies).

## Examples of good practice

The Cardiff Community Perinatal Service experienced long waits for psychological interventions, so the team thought about ways to provide support while patients wait for therapy, such as groups and a stabilisation information pack including information on self-help such as grounding, mindfulness, etc.

The Devon Perinatal Mental Health Service has dedicated professionals to oversee women's physical health. The team recognised that physical health is not always considered, and that physical health can be impacted by some treatments.



At my first appointment, the practitioner was amazing. She was really warm, lovely and reassuring. She let me know that perinatal mental health difficulties were common and made me feel really at ease.

**Patient**

My partner/family member's care plan was reviewed weekly. I was consulted at each meeting and in-between if anything changed.

**Significant other**



The perinatal team could have liaised better with others involved in my care. They did not inform my GP about what medication I was on. The GP had no record of my new medication and this caused a real issue.

**Patient**

I would have liked to have been seen in person but this was not an option as it was during lockdown.

**Patient**



## Recommendations

1. Teams should ensure there is a system in place, such as a database, where it is recorded whether a mother has received a physical health review or not as part of the initial assessment.
2. Where teams are low on psychological input and there is longer than a 28 day wait for psychological intervention to commence (after psychological assessment), the team should seek ways to train other staff members in psychological intervention, who can then provide this to patients.
3. Team bases should have facilities such as baby-changing tables and toys available for small babies and siblings.

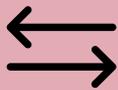
# Discharge and transfer of care

This section focuses on standards related to the discharge process, including the discharge letter, the potential for admission, and involvement of partners/family members.

## Key achievements



All services said that 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.



All services said 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.



In 98% of services, 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.



98% of services are actively involved with their regional perinatal clinical network.

## Areas for improvement



30% of services do not send a discharge letter to the patient and all relevant parties within 10 days of discharge.



In 14% of services, the potential for admission is not communicated verbally to the patient and her family, and written information provided. This is recorded in the written care plan and communicated to the patients, GP, midwife and health visitor if appropriate.



'Always together' by M, North London Partners Specialist Perinatal Mental Health

### Example of good practice

In response to COVID-19, the Aneurin Bevan Perinatal Mental Health Service developed an intensive pathway to reduce the number of admissions to MBUs due to concerns from patients regarding isolation. The service now provides intensive community support to patients on this pathway. Consequently, the service has had no referrals to the MBU since March 2020 up to the point of their review. The review team were very impressed by this pathway, especially for a small team that covers a large geographical area.



My discharge from the service was definitely planned out well. They explained it would be a tailored and gradual end to things. They always kept me aware of how many sessions I had and if those might end. We spoke about how I could continue the work myself after I had left the service. They also spoke about other services I may find helpful after leaving perinatal.

**Patient**



My wife's care has now been transferred to the community mental health team and I am not as confident in the support they are providing. I think it would have been better to stay under perinatal team.

**Significant other**

I think it would be helpful if we could be contacted by the nursery nurse six months after discharge to see how things are going.

**Patient**



### Recommendations

1. Teams could develop discharge letter templates to ensure they consistently include all important information. An audit can be conducted to check if these letters are sent within 10 days of discharge to all relevant parties.
2. Staff should ensure that where appropriate, the potential for admission is communicated verbally to the patient and her family, and written information is provided. This should be kept record of in the patient's notes.

# Care and treatment

This section looks at the provision of written care plans, the provision of written information about the patient’s diagnosis, the range of therapeutic interventions, the provision of information about local organisations for peer support and social engagement, medication reviews, use of clinical outcome data, and information for carers.

**Over the last 12 months, the average waiting time for treatment is 3 weeks<sup>††</sup>. Ranging from 1 to 12.5 weeks. 59% of services reported that patients waited longest for psychological therapy\*.**



††Based on data from 35 services.

## Key achievements



All services feel that patients know who is co-ordinating their care and how to contact them if they have any questions.



All services use 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.



98% of services said patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.

## Areas for improvement



In 27% of services, partners/significant others are not advised on how to access a statutory carers’ assessment, provided by an appropriate agency.



In 39% of services, the team does not actively encourage partners/family members to attend carer support networks or groups.



In 36% of services, postnatal women who are taking mood stabilisers or antipsychotics do not always receive physical health assessments at the start of treatment and at least every three months until the end of care by the team.

### Example of good practice

All of the teams we spoke to during cycle 8 reviews told us about the innovative ways they adapted to the challenges brought about by the pandemic, most notably migrating care and treatment online. Teams told us about offering group therapies online as well as having socially distanced walking groups. Services told us that patients responded really well to the virtual offer and highlighted that there was greater attendance at appointments. Staff members rose to the challenge of meeting the needs of their patients during the pandemic with fantastic results.



The group therapy I received was therapeutic and it was helpful to be with others in the same situation. It gave me something to look forward to and I liked that it was a small intimate group.

**Patient**

Staff spoke to me about how I could involve my partner and my partner was able to come with me to appointments. My practitioner would ask my partner in home visits how he was feeling and getting along too which was really appreciated.

**Patient**



It would be nice to be offered a parenting course to learn how to work as a team and help you learn to take care of your baby and your toddler. I could have benefitted from a mum and dad group. I've really struggled because there's no baby groups.

**Patient**

During the pandemic it would have been better to increase contact for my wife, most things seemed to stop. My wife felt a bit lost; we do understand it is hard though.

**Significant other**



### Recommendations

1. A system should be set up where the team are aware of which postnatal women are taking mood stabilisers or antipsychotics, and where they can also ensure that they receive physical health assessments at the start of treatment and at least every three months.
2. All teams should aim to have readily available written information for partners/chosen others. This should be in an accessible format and available in different languages as required.

# Rights, infant welfare and safeguarding

This section explores patient and families' access to information, confidentiality of patient information, assessment of the emotional and physical needs of the baby, and use of risk assessments.

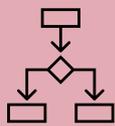
## Key achievements



All services said when prescribing psychotropic medication for breastfeeding mothers, it is tailored to their needs.



All services said assessments of patients' capacity to consent to care and treatment are performed in line with current legislation.



All services said there is a mechanism for recognising areas of concern and identifying an appropriate course of action.



Staff are very good at encouraging my involvement. They consider my opinion and invite me to be part of every stage of the treatment.

### Significant other

The waiting area was a suitable environment for older children, I feel it was secure and safe and had 2/3 toys.

### Significant other



## Areas for improvement



In 36% of services, patients are not given accessible written information which staff members talk through with them as soon as is practically possible.



In 62% of services, if a patient and infant or older child are seen in an outpatient clinic or other mental health facility, the waiting area is not exclusively for the use of the perinatal and/or maternity services during that session.

## Recommendations

1. Services should have a pack of information that is shared with patients when they first access the service or alongside their assessment letter.
2. Where patients are seen in an outpatient clinic or other mental health facility, efforts should be made to have a waiting area space exclusively for the use of the Perinatal and/or maternity services during that session.
3. Services should use Knowledge Hub to share resources.

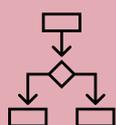
# Staffing and training

This section examines standards relating to the make-up of the multidisciplinary team, staffing levels, the induction programme, training, and supervision.

Profession	Average Whole Time Equivalent (WTE)	Average WTE per 0-5,000 births	Average WTE per 5,001-10,000 births	Average WTE per 10,001-15,000 births	Average WTE per 15,001-20,000 births
Consultant Psychiatrist	1.6	0.9	1.1	2.1	2.7
Non-Consultant Medical Input	0.6	0.5	0.4	1.1	0.8
Clinical Psychologist	2	1.2	1.5	2.5	3.3
Occupational Therapist	1.3	0.7	1	1.3	3.3
Social Worker	0.7	0.3	0.7	1	1
Service Manager	1	0.8	1	1.1	1.2
Community Psychiatric Nurse	6.7	4.1	4.9	7.4	11.8
Nursery Nurse	1.8	1.4	1.6	2	5.2
Midwifery Input	0.4	0.4	0.4	0.2	1.7
Health Visitor Input	0.1	0	0.02	0.1	1.3
Administration/Secretarial	3	1.8	2	3.8	5.2

**Table 1: Average staffing complement in community perinatal mental health services**

## Key achievements



All services said 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.



All services stated all staff members receive an annual appraisal and personal development planning (or equivalent).



All services stated that staff members feel able to challenge decisions and to raise any concerns they may have about standards of care.

## Areas for improvement



In 43% of services, all staff requiring training are not trained in physical health assessment.



In 23% of services appropriately experienced patient or partner/family member representatives are not involved in the interview process for recruiting staff members.



38% of services do not involve experts by experience in delivering and developing staff training face-to-face.

### Example of good practice

The Hertfordshire Community Perinatal Team created a WhatsApp group during the pandemic as an easy and fun way for staff to keep in touch with each other. They also set up virtual tea breaks during lockdown, which were beneficial for staff morale and team bonding. There were also virtual working circles for the team to complete administrative work together demonstrate a creative approach to problem solving which promotes efficiency and supports staff's needs.

“ The team were amazing. They had the right experience, skills, and knowledge. They really helped me feel like I wasn't the only person going through it.

#### Patient

The support and care I received was personalised, person-led and organic. I had such an incredible, positive and cathartic experience which ultimately led to a successful and sustainable recovery, and gave me a steady platform to be and feel well.

#### Patient

“

The person who assessed my loved one was brilliant. She always got back to her really quickly and tried to solve problems. Even when she was busy, she made the time to speak with my wife.

#### Significant other

One of the people I saw might benefit from some training about her approach to patients. They were very personal with me and quite negative about things.

#### Patient

”

### Recommendations

1. Services should ensure that all staff requiring it are trained in physical health assessment.
2. Teams should seek additional funding where needed to employ at least 2.5 WTE Nursery Nurses per 10,000 births.
3. Teams should seek additional funding where needed to employ at least 1 WTE non-consultant Psychiatrist input per 10,000 births.
4. Teams are encouraged to share their PQN reports with commissioners and use them as tools to demonstrate the need for additional staffing posts.

# Recording and audit

This section looks at standards related to how available information is used to evaluate the performance of the service, involvement of staff in clinical audit, and the use of quality improvement methodology.

## Key achievements



In all services, systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.



In 98% of services, 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.

## Example of good practice

The Cheshire and Mersey Specialist Perinatal Team, collect feedback through POEM as well a Clinical Development Oversight Group. The team has used feedback from these forums to develop a physical health pathway, a specialist perinatal induction package for new starters, online training resources for external professionals, and a newsletter for staff.

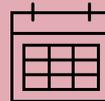
## Areas for improvement



25% of services do not annually evaluate women involved in Care Proceedings / Child Safeguarding Protection Plans.



34% of teams do not actively encourage patients and carers to be involved in QI initiatives.



32% of services do not have 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.

## Recommendations

1. All services should keep a record of which patients are involved in Care Proceedings/Child Safeguarding Protection Plans. This should be evaluated annually, so the team are aware of any key findings.
2. Services should set dates for and host a meeting at least annually, whereby key stakeholders are invited and important discussions can be had, such as around service developments.

# Full list of recommendations

## Access and referral

1

Teams should ensure they have written joint working protocols in place for working with patients with disordered eating; Substance misuse problems; a severe, diagnosed personality disorder; or a learning disability. Examples around this can be sought from accredited services and the PQN team.

2

Services that cannot be easily accessed through public transport should seek easier to access clinic spaces for patients, or look into arranging transport.

## Assessment

1

Teams should ensure there is a system in place, such as a database, where they are aware of whether a mother has received a physical health review or not as part of the initial assessment.

2

Where teams are low on psychological input and there is longer than a 28 day wait for psychological intervention to commence (after psychological assessment), the team should seek ways to train other staff members in psychological intervention, who can then provide this to patients.

3

Team bases should have facilities such as baby-changing tables and toys available for small babies and siblings.

## Discharge and transfer of care

1

Teams may develop discharge letter templates which include all important information. An audit can be conducted to check if these letters are sent within 10 days of discharge to all relevant parties.

2

Staff should ensure that where appropriate, the potential for admission is communicated verbally to the patient and her family, and written information is provided. This should be kept record of in the patient's notes.

## Care and treatment

1

A system should be set up where the team are aware of which postnatal women are taking mood stabilisers or antipsychotics, and where they can also ensure that they receive physical

2

health assessments at the start of treatment and at least every three months.

All teams should aim to have readily available written information for partners/chosen others. This should be in an accessible format and available in different languages as required.

### **Rights, infant welfare and safeguarding**

1

Services should have a pack of information that is shared with patients around the start of them accessing the service, such as alongside their assessment letter.

2

Where patients are seen in an outpatient clinic or other mental health facility, efforts should be made to have a waiting area space exclusively for the use of the Perinatal and/or maternity services during that session.

3

Services should use Knowledge Hub to share resources.

### **Staffing and training**

1

Services should ensure that all staff requiring it are trained in physical health assessment.

2

Teams should seek additional funding where needed in order to employ at least 2.5 WTE Nursery Nurses per 10,000 births.

3

Teams should seek additional funding where needed in order to employ at least 1 WTE non-consultant Psychiatrist input per 10,000 births.

### **Recording and audit**

1

All services should keep a record of which patients are involved in Care Proceedings/Child Safeguarding Protection Plans. This should be evaluated annually, so the team are aware of any key findings.

2

Services should set a date for and host a meeting at least annually, whereby key stakeholders are invited and important discussions can be had, such as around service developments.

# Appendix 1: Aggregated results

Standard number	Standard type	Criteria	Percentage of services meeting the standard
<b>Section 1: Access And Referral</b>			
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.	<b>93%</b>
1.1b	1	Women experiencing Bipolar Disorder/Postpartum Psychosis, other psychoses and Serious Affective Disorder, who can be safely managed in the community.	<b>95%</b>
1.1c	1	Women with moderate to severe non-psychotic conditions.	<b>93%</b>
1.1d	1	Women identified in pregnancy who are at risk of a recurrence/relapse of a psychotic or serious/complex non-psychotic condition. <i>This includes women who are currently unwell and those who are well but at risk of becoming unwell.</i>	<b>95%</b>
1.1e	1	Women requiring pre-conception counselling.	<b>95%</b>
1.1f	1	Women with alcohol/substance misuse problems if there is also moderate to severe mental illness.	<b>95%</b>
1.2	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	<b>91%</b>

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.	<b>98%</b>
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.  <i>This might need to be separate pathways for each service.</i>	<b>91%</b>
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.  <i>When a senior team member is not available another appropriate member of the team may be consulted for these discussions.</i>	<b>91%</b>
1.6	1	Referrals can be made directly to the service during working hours.  <i>Direct referrals should be encouraged where possible.</i>	<b>98%</b>
1.7	1	The service responds to urgent requests for telephone advice from other professionals within one working day.	<b>98%</b>
1.8	1	A clinical member of staff is available to discuss emergency referrals during working hours.	<b>98%</b>
1.9	1	When the team are unable to conduct an emergency assessment, there is an agreed approach in place.	<b>98%</b>

		<i>This may include having arrangements in place with another service to cover this, e.g. crisis; liaison.</i>	
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.	<b>93%</b>
1.11	3	The service provides a telephone advice line for professionals (e.g. midwives, GPs) at specific times of the week.	<b>89%</b>
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.	<b>92%</b>
1.13	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.  <i>Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.</i>	<b>100%</b>
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.	<b>91%</b>
1.15	1	The service has clear joint working protocols regarding working with patients with: <ul style="list-style-type: none"> <li>• Disordered eating;</li> <li>• Substance misuse problems;</li> <li>• A severe, diagnosed personality disorder;</li> <li>• A learning disability.</li> </ul>	<b>57%</b>
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.	<b>95%</b>

1.17	3	Everyone can access the service using public transport or transport provided by the service.	<b>81%</b>
<b>Section 2: Assessment</b>			
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).  <i>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.</i>	<b>80%</b>
2.2	1	The team assess women who are referred to the service within 28 days for routine cases (or four hours for emergencies).	<b>82%</b>
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.  <i>In some areas, this will involve collaborative working with other specialist services.</i>	<b>100%</b>
2.4	1	For non-emergency assessments, the team sends letters in advance to patients that include: <ul style="list-style-type: none"> <li>• The name and designation of the professional they will see;</li> <li>• An explanation of the assessment process;</li> <li>• Information on who can accompany them;</li> <li>• 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.</li> </ul>	<b>80%</b>
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	<b>98%</b>

		<p>discussion (within two working days) with the referrer and other appropriate clinical services.</p> <p><i>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.</i></p>	
2.6	1	<p>Patients have a comprehensive evidence-based assessment which includes their:</p> <ul style="list-style-type: none"> <li>• Mental health and medication;</li> <li>• Psychosocial and psychological needs;</li> <li>• Strengths and areas for development;</li> <li>• Risk, including risk to self, the baby and others.</li> </ul>	<b>95%</b>
2.7	1	A physical health review takes place as part of the initial assessment, or as soon as possible.	<b>73%</b>
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.	<b>91%</b>
2.9	1	<p>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.</p> <p><i>Any exceptions should be documented in the patient's notes along with reasons for this (e.g. if they were a late referral).</i></p>	<b>82%</b>
2.10		The peripartum management plan should include:	

2.10a	1	Nature of the risk and condition.	<b>91%</b>
2.10b	1	Details of current medication and any intended changes in late pregnancy and the early postpartum period.	<b>91%</b>
2.10c	1	Consideration of whether the mother intends to breastfeed.	<b>89%</b>
2.10d	1	Professionals involved and frequency of contact. <i>For example, frequency of contact with health visitor, GP etc.</i>	<b>89%</b>
2.10e	1	The patient's chosen emergency contact's details.	<b>89%</b>
2.10f	1	Admission to a Mother and Baby Unit if necessary and any plans or special requirements for a maternity admission.	<b>100%</b>
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.	<b>59%</b>
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. <i>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.</i>	<b>84%</b>
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.	<b>82%</b>
2.14	1	Patients are asked if they and their partner/family member wish to have copies of letters about their health and treatment.	<b>86%</b>

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.	<b>100%</b>
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.	<b>98%</b>
2.17	1	If a patient does not attend for an assessment/ appointment, the assessor contacts the referrer.  <i>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.</i>	<b>100%</b>
2.18	1	Patients feel welcomed by staff members when attending the team base for their appointments.  <i>Staff members introduce themselves to patients and address them using the name and title they prefer.</i>	<b>95%</b>
2.19	2	The service can conduct assessments in a variety of settings and, where possible, patients are offered a choice.	<b>98%</b>
2.20	2	The environment is clean, comfortable and welcoming.	<b>95%</b>
2.21	1	Clinical rooms are private, and conversations cannot be overheard.	<b>91%</b>
2.22	1	The environment complies with current legislation on disabled access.  <i>Relevant assistive technology equipment, such handrails, are provided to meet individual needs and to maximise independence.</i>	<b>98%</b>

2.23	1	All patient information is kept in accordance with current legislation.  <i>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.</i>	<b>73%</b>
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.	<b>54%</b>
2.25	2	The service has facilities available that are suitable for small babies and siblings.  <i>E.g. Suitable toys and a room for baby-changing and breastfeeding.</i>	<b>80%</b>
<b>Section 3: Discharge and transfer of care</b>			
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: <ul style="list-style-type: none"> <li>• On-going care in the community/aftercare arrangements;</li> <li>• Crisis and contingency arrangements including details of who to contact;</li> <li>• Medication, including monitoring arrangements;</li> <li>• Details of when, where and who will follow up with the patient as appropriate;</li> <li>• Assessment of the quality of mother-infant interaction;</li> <li>• Risk assessment (mother and child).</li> </ul>	<b>70%</b>
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.  <i>This should also include a needs assessment and transfer to a general mental health team as well as within perinatal teams.</i>	<b>100%</b>

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.	<b>93%</b>
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.	<b>93%</b>
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.	<b>86%</b>
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.  <i>If they are unable to attend in person they should participate by phone or video link.</i>	<b>100%</b>
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.  <i>If attendance is not possible, the community team should make contact via phone/video-link.</i>	<b>98%</b>
3.8	1	Partners/family members (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	<b>95%</b>
3.9	3	The service is actively involved with their regional perinatal clinical network.	<b>98%</b>
<b>Section 4: Care and Treatment</b>			

4.1	1	<p>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.</p> <p><i>The care plan clearly outlines:</i></p> <ul style="list-style-type: none"> <li>• <i>Agreed intervention strategies for physical and mental health;</i></li> <li>• <i>Measurable goals and outcomes;</i></li> <li>• <i>Strategies for self-management;</i></li> <li>• <i>Any advance directives or statements that the patient has made;</i></li> <li>• <i>Crisis and contingency plans;</i></li> <li>• <i>Review dates and discharge framework.</i></li> </ul>	<b>80%</b>
4.2	1	<p>All patients have a documented diagnosis and a clinical formulation.</p> <p><i>Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.</i></p>	<b>86%</b>
4.3	1	<p>Patients (and partners/family members, with patient consent) are offered written and verbal information about the patient's mental illness and treatment.</p> <p><i>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.</i></p>	<b>86%</b>
4.4	1	<p>Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.</p>	<b>98%</b>
4.5	1	<p>The teams provide a range of therapeutic interventions for the mother, the baby, and the family including:</p> <ul style="list-style-type: none"> <li>• Pharmacological interventions;</li> </ul>	<b>82%</b>

		<ul style="list-style-type: none"> <li>• Evidence-based psychological therapies;</li> <li>• Evidence-based mother and baby interventions;</li> <li>• Occupational therapy.</li> </ul>	
4.6	3	<p>The teams provide a range of therapeutic interventions for the mother, the baby, and the family including:</p> <ul style="list-style-type: none"> <li>• Evidence-based family and couple's interventions;</li> <li>• Recreational and creative activities.</li> </ul> <p><i>If not provided directly by the service, patients are supported to access these within their local area.</i></p>	<b>66%</b>
4.7	2	<p>The team provides information and encouragement to patients to access local organisations for peer support and social engagement.</p> <p><i>This might include:</i></p> <ul style="list-style-type: none"> <li>• <i>Activities that promote enjoyment and interaction with the baby and social engagement (such as swimming lessons, sensory activities, music groups);</i></li> <li>• <i>Voluntary organisations;</i></li> <li>• <i>Community centres;</i></li> <li>• <i>Local religious/cultural groups;</i></li> <li>• <i>Peer support networks;</i></li> <li>• <i>Recovery colleges.</i></li> </ul>	<b>93%</b>
4.8	1	<p>The team supports patients to access organisations which offer:</p> <ul style="list-style-type: none"> <li>• Housing support;</li> <li>• Support with finances, benefits and debt management;</li> <li>• Social services;</li> <li>• Domestic abuse services;</li> </ul>	<b>95%</b>

		<ul style="list-style-type: none"> <li>• Immigration services.</li> </ul> <p><i>The team should have joint working protocols with relevant organisations.</i></p>	
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.	<b>95%</b>
4.10	1	<p>Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.</p> <p><i>Side effect monitoring tools can be used to support reviews.</i></p>	<b>98%</b>
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.	<b>80%</b>
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.	<b>68%</b>
4.13	1	Women in pregnancy or with a newborn 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.	<b>98%</b>

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.	<b>64%</b>
4.15	1	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	<b>82%</b>
4.16	1	Clinical outcome measurement data, including progress against user defined goals, is collected as a minimum at assessment, after 6 months, 12 months and then annually until discharge. Staff can access this data.	<b>70%</b>
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.	<b>91%</b>
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.	<b>84%</b>
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.	<b>86%</b>
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.  <i>This includes guidance about when to call 999 and how and when to arrange transfer to A&amp;E from a mental health or antenatal outpatient clinic on a general hospital site.</i>	<b>84%</b>
4.21	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	<b>100%</b>

4.22	1	<p>Patients can access help from mental health services 24 hours a day, seven days a week.</p> <p><i>Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams and telephone helplines.</i></p>	<b>100%</b>
4.23	2	<p>The team provides each partner/family member with accessible carer's information.</p> <p><i>Information is provided verbally and in writing (e.g. carer's pack). This includes:</i></p> <ul style="list-style-type: none"> <li>• <i>The names and contact details of key staff members in the team and who to contact in an emergency;</i></li> <li>• <i>Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.</i></li> </ul>	<b>61%</b>
4.24	1	<p>Partners/significant others are advised on how to access a statutory carers assessment, provided by an appropriate agency.</p> <p><i>This advice is offered at the time of the patient's initial assessment, or at the first opportunity.</i></p>	<b>73%</b>
4.25	1	<p>Partners/significant others are offered individual time with staff members to discuss concerns, family history and their own needs.</p>	<b>77%</b>
4.26	3	<p>The service actively encourages partners/family members to attend carer support networks or groups. There is a designated staff member to support carers.</p>	<b>61%</b>
4.27	1	<p>The team follows a protocol for responding to partners/significant others when the patient does not consent to their involvement.</p>	<b>82%</b>
4.28	3	<p>The service ensures that older children and other dependants are supported appropriately.</p>	<b>93%</b>

		<i>This may be achieved through referral or signposting to other services, e.g. social services, health visitor. Any materials should be age-appropriate.</i>	
4.29	1	Staff members treat patients and partners/family members with compassion, dignity and respect.	<b>98%</b>
4.30	1	Patients feel listened to and understood by staff members.	<b>100%</b>
4.31	1	When talking to patients and partners/family members, health professionals communicate clearly, avoiding the use of jargon.	<b>98%</b>
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.  <i>Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.</i>	<b>100%</b>
<b>Section 5: Rights, Infant Welfare and Safeguarding</b>			
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: <ul style="list-style-type: none"> <li>• Their rights regarding consent to treatment;</li> <li>• Their rights under the Mental Health Act;</li> <li>• How to access advocacy services;</li> <li>• How to access a second opinion;</li> <li>• Interpreting services;</li> <li>• How to view their records;</li> <li>• How to raise concerns, complaints and give compliments.</li> </ul>	<b>64%</b>

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.	<b>100%</b>
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).	<b>100%</b>
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.  <i>These are accessible and staff members know where to find them.</i>	<b>89%</b>
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.	<b>100%</b>
5.5b	1	Parental responsibility for the infant.	<b>93%</b>
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.	<b>100%</b>
5.5d	1	If the child is the subject of a Child in Need Plan/ Looked After Child Plan/Child Protection Plan/Care Proceedings.  <i>Pertinent negatives must also be recorded, i.e. that the child is not the subject of a Child Protection Plan.</i>	<b>98%</b>
5.5e	1	Mode of delivery and obstetric complications during birth.	<b>100%</b>
5.5f	1	Current or planned mode of feeding and any previous or current problems with feeding.	<b>100%</b>
5.5g	1	A brief assessment of mother-infant interaction, care and relationship.	<b>100%</b>

5.5h	1	The occupants of the household.	<b>98%</b>
5.6	1	The team has a mechanism for recognising areas of concern and identifying an appropriate course of action.  <i>E.g. Discussion at a safeguarding meeting or supervision.</i>	<b>100%</b>
5.7	1	Mother-infant relationship and care are observed and recorded in the patient's notes every three months or more frequently should the patient's mental state and behaviour change.	<b>98%</b>
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.	<b>98%</b>
5.8b	1	Any delusions/overvalued ideas or hallucinations involving the pregnancy, infant or other children.	<b>98%</b>
5.8c	1	Any thoughts, plans or intentions of harming the pregnancy, infant or other children.  <i>The assessment should consider that the phenomena could be intrusive obsessional thoughts.</i>	<b>98%</b>
5.8d	1	Hostility, irritability and/or rejection towards the unborn baby, infant or other children.	<b>100%</b>
5.8e	1	Any involvement with Children's Social Care.  <i>For example an unborn baby, infant or older children subject to Child Protection Plan or child care proceedings.</i>	<b>100%</b>
5.8f	1	Any concern about any other person who may pose a risk to the unborn baby, child or other children.	<b>98%</b>

		<i>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.</i>	
5.8g	1	Thoughts and behaviours about estrangement from the baby and severe maternal inadequacy.	<b>100%</b>
5.9	2	The risk assessment tool is designed or modified for use by perinatal community mental health services.	<b>80%</b>
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.	<b>98%</b>
5.11	Case notes include:		
5.11a	1	Any maternal concerns in relation to the pregnancy/infant.	<b>100%</b>
5.11b	1	Her care of the pregnancy/infant.	<b>100%</b>
5.11c	1	Her enjoyment of the pregnancy/infant.	<b>100%</b>
5.11d	1	If the infant is absent from an appointment the reason why is recorded.	<b>91%</b>
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.	<b>100%</b>
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.	<b>38%</b>

5.14	1	Local safeguarding and child protection guidance is available and accessible to all staff members.	<b>98%</b>
5.15	1	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details.	<b>98%</b>
5.16	3	A member of the perinatal mental health team is part of the Trustwide safeguarding group.	<b>70%</b>
<b>Section 6: Staffing and Training</b>			
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). <i>This should be comprised of no more than two Consultant Perinatal Psychiatrists.</i>	<b>93%</b>
6.1b	2	1 WTE non-consultant Psychiatrist input per 10,000 births.	<b>48%</b>
6.1c	1	5 WTE Perinatal Community Psychiatric nurses per 10,000 births. <i>This ratio should be adjusted based on geographical area.</i>	<b>89%</b>
6.1d	2	0.5 WTE Social Worker per 10,000 births. <i>This should be one Social Worker.</i>	<b>61%</b>
6.1e	1	1 WTE Clinical Psychologist per 10,000 births.	<b>91%</b>
6.1f	2	1 WTE additional Clinical or Counselling Psychologist. <i>This should be a qualified professional and not an assistant or trainee.</i>	<b>57%</b>
6.1g	2	2.5 WTE Nursery Nurses per 10,000 births.	<b>55%</b>
6.1h	1	1 WTE Occupational Therapist per 10,000 births.	<b>77%</b>

6.1i	3	1 WTE Parent-Infant Therapist.	<b>21%</b>
6.1j	1	1 WTE Administrator (band 3 or above or local equivalent).	<b>100%</b>
6.2	1	The team has a dedicated specialist team manager.	<b>95%</b>
6.3	1	There are written documents that specify professional, organisational and line management responsibilities.	<b>91%</b>
6.4	1	The service has a mechanism for responding to low staffing levels, including: <ul style="list-style-type: none"> <li>• A method for the team to report concerns about staffing levels;</li> <li>• Access to additional staff members;</li> <li>• An agreed contingency plan, such as the minor and temporary reduction of non-essential services.</li> </ul>	<b>80%</b>
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.	<b>100%</b>
6.6	2	Appropriately experienced patient or partner/family member representatives are involved in the interview process for recruiting staff members.  <i>This could include co-producing interview questions or sitting on the interview panel.</i>	<b>77%</b>
6.7	1	There is an identified senior clinician available at all times who can attend the team base within an hour.  <i>Some services may have an agreement with a local GP to provide this medical cover.</i>	<b>93%</b>
6.8	1	Staff members receive an induction programme specific to the perinatal mental health service, which covers key information including: <ul style="list-style-type: none"> <li>• The team's mission statement and core identity;</li> <li>• Aims of the service;</li> </ul>	<b>80%</b>

		<ul style="list-style-type: none"> <li>• Key policies;</li> <li>• Referral and care pathways.</li> </ul> <p><i>This induction should be over and above the mandatory Trust or organisation-wide induction programme.</i></p>	
6.9	1	<p>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).</p> <p><i>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.</i></p> <p><i>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.</i></p>	<b>70%</b>
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.	<b>84%</b>
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.	<b>82%</b>
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:		
6.12a	1	Statutory and mandatory training.	<b>86%</b>

		<i>This includes assessing and managing suicide risk and self-harm and the prevention of aggression and violence.</i>	
6.12b	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	<b>89%</b>
6.12c	1	Physical health assessment.  <i>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.</i>	<b>57%</b>
6.12d	1	Safeguarding vulnerable adults and children.  <i>This includes recognising and responding to the signs of abuse, exploitation or neglect.</i>	<b>91%</b>
6.12e	1	Risk assessment and risk management.  <i>This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.</i>	<b>84%</b>
6.12f	1	The range of perinatal disorders and normal emotional changes in pregnancy and after birth.	<b>77%</b>
6.12g	1	Basic infant development including emotional developmental milestones.	<b>75%</b>
6.12h	2	Supporting parents in a culturally sensitive way with particular relevance to the local population.	<b>68%</b>
6.12i	1	Understanding and promoting mother-infant interaction and relationship.	<b>84%</b>

6.12j	2	Infant mental health training. <i>This can be accessed locally or from designated providers.</i>	<b>79%</b>
6.12k	1	Recognising and communicating with patients with cognitive impairment or learning disabilities.	<b>68%</b>
6.12l	1	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (this is updated at least annually).	<b>77%</b>
6.12m	2	Contraception and sexual health.	<b>66%</b>
6.12n	2	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	<b>75%</b>
6.12o	1	Infant feeding (including breastfeeding).	<b>79%</b>
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.	<b>85%</b>
6.14	1	Peer support workers are provided with a bespoke training programme appropriate to their role, which includes: <ul style="list-style-type: none"> <li>• Listening and facilitation skills;</li> <li>• Negotiating boundaries;</li> <li>• Common issues relating to perinatal mental health, including feeding and birth trauma.</li> </ul>	<b>72%</b>
6.15	2	Staff who use clinical outcome measures have received relevant training.	<b>80%</b>
6.16	2	Experts by experience are involved in delivering and developing staff training face-to-face. <i>This may include training around the role of peer support and its value.</i>	<b>62%</b>

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.  <i>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.</i>	<b>95%</b>
6.18	2	All staff members receive individual line management supervision at least monthly.	<b>93%</b>
6.19	2	Staff members in training and newly qualified staff members receive weekly supervision, in line with professional requirements.	<b>93%</b>
6.20	1	All staff members receive an annual appraisal and personal development planning (or equivalent).  <i>This contains clear objectives and identifies development needs, and should be informed by self-assessment against an agreed competency framework.</i>	<b>100%</b>
6.21	2	The team holds business meetings at least once a month.	<b>100%</b>
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.	<b>89%</b>
6.23	2	Frontline staff members are involved in key decisions about the service provided.	<b>91%</b>
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.	<b>95%</b>
6.25	1	The team has a fixed base and office accommodation, which adequately meets the need of the staffing group.	<b>61%</b>
6.26	1	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information.	<b>91%</b>

6.27	1	Staff members are easily identifiable to patients (for example, by wearing appropriate identification).	<b>98%</b>
6.28	1	Staff members follow a lone working policy and feel safe when conducting home visits.	<b>95%</b>
6.29	1	The service actively supports staff health and well-being.  <i>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.</i>	<b>98%</b>
6.30	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.  <i>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.</i>	<b>100%</b>
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.	<b>86%</b>
6.32	2	Peer support workers have access to group supervision with others in similar roles.	<b>79%</b>
6.33	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	<b>98%</b>
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.  <i>This includes decisions about care, treatment and how the service operates.</i>	<b>100%</b>

6.35	3	In-house multi-disciplinary team education and practice development activities occur in the service at least every three months.  <i>This should be available to all staff, including healthcare assistants, nursery nurses and peer support workers.</i>	<b>86%</b>
6.36	2	The team has protected time for team-building and discussing service development at least once a year.	<b>77%</b>
<b>Section 7: Recording and audit</b>			
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.	<b>77%</b>
7.2	The service evaluates annually:		
7.2a	2	Feedback from referrers.	<b>89%</b>
7.2b	2	Feedback from service staff.	<b>88%</b>
7.2c	2	Analysis of complaints.	<b>86%</b>
7.2d	2	The findings of audits.	<b>84%</b>
7.2e	2	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data).	<b>75%</b>
7.2f	1	Women involved in Care Proceedings/Child Safeguarding Protection Plans.	<b>82%</b>
7.3	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored.	<b>68%</b>
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	<b>66%</b>

		practice.  <i>Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as patient and partner/significant other representatives.</i>	
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.	<b>100%</b>
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.	<b>98%</b>
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.	<b>98%</b>
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.	<b>98%</b>
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.	<b>89%</b>
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.	<b>77%</b>
7.11	2	Services are developed in partnership with appropriately experienced patient and carers and have an active role in decision making.	<b>82%</b>
7.12	2	The team use quality improvement methods to implement service improvements.	<b>66%</b>
7.13	2	The team actively encourage patients and carers to be involved in QI initiatives.	<b>77%</b>

# Appendix 2: Multi-agency feedback

Challenges	No. of partner agency representatives
The service does not have clear criteria for accepting referrals/it is difficult to get referrals accepted/the referral process is unclear	32
Not being able to meet in person due to the pandemic/COVID-19 pressures/adapting to the pandemic	24
Communication issues/information sharing could be better	23
The team is too small/demand is too large/there have been staffing issues	22
There is a lack of joint working/joint working needs to be improved	10
Liaison meetings could be improved/attendance at meetings could be improved	7
More training about perinatal mental health/shadowing opportunities	7
Support for patients post 12 months	6
Having different electronic notes systems can make information sharing challenging	6
Reports about patients are sent quite late so we don't know what is going on	5
Working with parents who have mental health difficulties can pose interagency challenges, particularly in respect of safeguarding/ lack of understanding about safeguarding	5
Treating patients with co-morbidities	5
Lack of suitable space (clinical and non-clinical)	4
There has been an increase in referrals	4
Access to interventions	4
Lack of perinatal mental health midwives	3
Lack of team cohesion/rapid expansion of team	3
There is a lack of understanding of the significant impact of adverse childhood experiences on the long-term wellbeing of children and young people/lack of understanding of domestic abuse	3
Lack of funding	2
Patients can be discharged too soon	2
More input into ward areas to give clarity on case management	2
Increase in patients transitioning from CAMHS/transition from MBU to community service	2
Pathways could be improved	2
We need to be made aware of patients earlier	1
The team does not have a social worker	1
Lack of consultant time	1

The perinatal team can't see patients in hospital who are not on the maternity ward	1
Cancellation of sessions	1
Not enough time for non-clinical discussions	1
The team should carry out more audits to find out what is working/not working	1
Capacity to meet long term objectives	1
The team needs to think about the child's needs	1
Out of hours support	1
Perinatal team can be unclear about what support is offered	1
The team could use community centres better	1
Support for fathers could be improved	1

Achievements	No. of partner agency representatives
Good working relationships/working collaboratively/joint working	76
Good communication with the team	43
Attendance at our meetings/regular meetings	38
They answer my queries and provide advice/the team offers advice and guidance	38
Provision of training/weekly teaching sessions/shadowing opportunities	28
Good care and support is provided to patients and their families	22
It is easy to refer into the service/referrals are managed well/the referral criteria is understandable	21
Clients have reported receiving good assessment and treatment from the service	15
The team is dedicated, reliable, approachable and experienced	15
Quick responses from the team	15
Timely contact with referred patients	12
Positive adaptations and innovations made during the pandemic	12
Continual support is provided	7
Attendance at pre-birth planning meetings/involved in care planning meetings/joint birth plans	7
The team provides feedback on our patients	7
The team attends stakeholder meetings focused on developments within the perinatal mental health team and are included in meaningful discussions about changes within the service	6
Offer of a specialist service and interventions	6
Value their expertise	5
The team is good at signposting	5
There is strong, consistent clinical leadership from the team psychiatrist/good leadership from team leader/proactive leadership	5
The team always put the patient and their needs first	5

The team has expanded	4
Development of a specific pathway/improvement of pathways	4
Provide advice about medication while breastfeeding/advice available from medic about medication	4
Good consistency for patients	3
Face to face consultations pre-pandemic	3
Effective handover between teams for women in hospital/effective handover between services	3
Case management of complex cases is good	2
The perinatal mental health midwife is brilliant	2
The team helps us to build relationships with women	2
We are well supported by effective administrative staff	2
The team improve and promote parent-infant relationships	2
Good liaison with local services	1
Safeguarding supervision provision from the safeguarding lead	1
Provide support with running our groups	1
Working with consultant psychiatrist in the antenatal clinic	1
Shared psychologist to ensure continuity of care	1
Peer support pilot	1
Collaboration with maternity transformation programme	1
The team identifies fathers who need support	1

# Appendix 3: Open discussion topics

Theme of open discussion topics	Topics
Care and therapeutic interventions	<ul style="list-style-type: none"> <li>• Psychological work and complex cases</li> <li>• Parent-infant interventions</li> <li>• Medical input</li> <li>• Role of pharmacist</li> <li>• Hosting groups</li> <li>• Care Programme Approach</li> <li>• Nursery-nurse led groups</li> </ul>
Adaptations made to service provision during the pandemic	<ul style="list-style-type: none"> <li>• Achievements and adaptations during the pandemic</li> <li>• The roadmap around changing base and easing COVID-19 restrictions</li> <li>• Virtual working and the roadmap out of lockdown</li> <li>• The impact of COVID-19 on practice</li> </ul>
Support for partners and significant others	<ul style="list-style-type: none"> <li>• Peer support workers for partners</li> <li>• Groups for partners</li> <li>• Interventions and support for partners</li> <li>• Working with and supporting partners</li> <li>• Assessing partners</li> </ul>
Training for staff	<ul style="list-style-type: none"> <li>• Training for nursery nurses</li> <li>• Perinatal education and training</li> <li>• Parent-infant support training</li> <li>• Nurse prescribing</li> </ul>
Miscellaneous	<ul style="list-style-type: none"> <li>• Estates</li> <li>• Setting up a maternal mental health service</li> <li>• The long term plan</li> <li>• Management of MDT meetings</li> </ul>
Referring into the service	<ul style="list-style-type: none"> <li>• Access targets</li> <li>• 'Hard to reach' patients</li> <li>• Ensuring appropriate referrals</li> </ul>
Working with other services	<ul style="list-style-type: none"> <li>• Joint working with other teams</li> <li>• Redesigning the work of care co-ordinators</li> </ul>

	<ul style="list-style-type: none"> <li>• Maternity liaison</li> <li>• Managing crisis and interfaces with the Home Treatment Team and Psychiatric Liaison Team</li> </ul>
Managing safeguarding concerns	<ul style="list-style-type: none"> <li>• Safeguarding</li> <li>• Patients receiving support from children's services</li> </ul>
Career development and support	<ul style="list-style-type: none"> <li>• Peer support for doctors</li> <li>• Career development</li> </ul>
Physical health assessments	<ul style="list-style-type: none"> <li>• Logistics of carrying out physical health assessments</li> <li>• Assessment letters</li> </ul>

# Appendix 4: Cycle 8 participating services

Aneurin Bevan Perinatal Mental Health Service  
Betsi Cadwaladr Perinatal Mental Health Team  
Brent and Harrow Perinatal Mental Health Team  
BSW Specialised Community Perinatal Mental Health Service  
Buckinghamshire Perinatal Team  
Cardiff Perinatal Community Service  
Cheshire and Mersey Specialist Perinatal Service  
Cornwall Specialist Perinatal Team  
CPFT Perinatal Mental Health Team  
Cwm Taf Perinatal Mental Health Team  
Derbyshire Perinatal Mental Health Team  
Devon Perinatal Mental Health Service  
Dorset Perinatal Mental Health Service  
Glasgow and Clyde Perinatal Mental Health Service  
Gloucestershire Perinatal Community Mental Health Service  
Greater Manchester Specialist Perinatal Community Mental Health Team  
Hampshire Perinatal Community Team  
Hertfordshire Community Perinatal Team  
Hillingdon Perinatal Mental Health Service  
Hywel Dda Perinatal Mental Health Service  
Lambeth Perinatal Community Service  
Lancashire Community Perinatal Mental Health Service  
Leeds Perinatal Mental Health Service  
Lewisham Perinatal Team  
Lincoln Perinatal Mental Health Team

Livewell Southwest  
Lothian Perinatal Mental Health Service  
NELFT Perinatal Parent Infant Mental Health Service  
Norfolk and Waveney Community Perinatal Mental Health Service  
North London Partners Specialist Perinatal Mental Health Service  
North Yorkshire and York Perinatal Service  
Northamptonshire Specialist Perinatal Mental Health Service  
Northumberland, Tyne and Wear Perinatal Community Mental Health Team  
Nottingham Perinatal Psychiatric Service  
Oxfordshire Perinatal Team  
Oxleas Perinatal Mental Health Service  
Sandwell and West Birmingham Perinatal Team  
South West Yorkshire Perinatal Team  
Surrey Perinatal Mental Health Service  
SWLSTG Perinatal Mental Health Service  
Tees Specialist Perinatal Community Team  
Walsall, Wolverhampton and Dudley Perinatal Team  
West London Perinatal Mental Health Service  
Worcestershire Community Perinatal Service

# Appendix 5: Acknowledgements

The Perinatal Quality Network is extremely grateful to the following people for their time and expert advice:

- Services which participated in Cycle 8;
- Professionals who attended reviews;
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- Other artists whose artwork is used throughout the report: 'Babies do well, with well mums' by Emma, South West Yorkshire Perinatal team, 'Kindness matters' by Faye, Cardiff Perinatal Mental Health Team, and 'Always together' by M, North London Partners Specialist Perinatal Mental Health Team.



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