Service Standards: Third Edition

Perinatal Community Mental Health Services

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Standard No.	Current Standard Type	Current Standard
		Access and Referral
1.1	1	Clear information is made available, in paper and/or electronic format, to patients, partner/significant others and healthcare practitioners on: • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the service, including emergency and out of hours details
1.2		*The service is provided for the following groups in a defined catchment area:*
1.2a	1	Women following discharge from an inpatient stay
1.2b	1	Women suffering from bipolar illness / puerperal psychosis, other psychoses and serious affective disorder, who can be safely managed in the community
1.2c	1	Women with other serious non-psychotic conditions
1.2d	1	Women identified in pregnancy who are at risk of a recurrence / relapse of a psychotic or serious / complex non-psychotic condition *Guidance: This includes women who are currently unwell and those who are at risk of becoming unwell*
1.2e	1	Women requiring pre-conception counselling
1.3	2	The service only works with women who cannot be effectively managed by primary care services
1.4	2	The service only works with women with alcohol/substance misuse problems if there is also (or suspected) moderate to severe mental illness
1.5	1	Patients under age 18 can be referred if perinatal psychiatric disorder dominates the clinical picture
1.6	1	The perinatal service works with the local CAMHS service to provide care to patients under the age of 18
1.7	2	Referrals are accepted from any health professionals working with women in the perinatal period and the patient's GP is informed.
1.8	2	Referrals from Children’s Social Services can only be accepted if they meet the usual clinical criteria
1.9	1	The referral criteria ensure that personality disorder is not a barrier to appropriate service response

1.10	1	Referrals can be made directly to the service during working hours *Guidance: Services may have a single point of access system in addition to this*
1.11	2	The service responds to urgent requests for telephone advice from other professionals within one working day
1.12	1	A clinical member of staff is available to discuss emergency referrals during working hours.
1.13	1	When the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this
1.14	1	There is a procedure agreed with out of hours teams to ensure patients requiring Perinatal specialist care are referred the next working day
1.15	2	Where referrals are made through a single point of access, e.g. triage, these are passed on to the community team within one working day.
1.16	1	Outcomes of accepted referrals are fed back to the referrer, patient and partner/significant other (with the patient's consent) within two working weeks of the referral. If a referral is not accepted, the team advises the referrer, patient and partner/significant other on alternative options.
1.17	2	There are systems in place to monitor waiting times and ensure adherence to local and national waiting times standards. *Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment.*
1.18	2	The team provides patients with information about expected waiting times for appointments, assessment and treatment. Guidance: patients on a waiting list are provided with updates of any changes to their appointment, as well as details of how they can access further support while waiting.
1.19	1	For planned assessments the team sends letters in advance to patients that include: • The name and designation of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries, require support (e.g. an interpreter, child care, breast feeding facilities), need to change the appointment or have difficulty in getting there.
1.20	3	The assessing professional can easily access notes (past and current) about the patient from primary and secondary care.

1.21	1	patients are asked if they and their partner/significant others wish to have copies of letters about their health and treatment.
1.22	1	Information provided to patients and partner/significant others is accessible and easy to understand Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.
1.23	1	When talking to patients and partner/significant others, health professionals communicate clearly, avoiding the use of jargon so that people understand them.
1.24	1	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, patient records, clinical outcome and service performance measurements
1.25	2	The team is able to access IT resources to enable them to make contemporaneous records at meetings.
1.26	3	The service should be easily accessible using public transport or transport provided by the service
2		**Assessment**
2.1	1	Teams assess all women who are suffering from a new episode of serious or complex mental illness (in pregnancy and until 6 months postpartum with follow up to 12 months)
2.2	1	An integrated care pathway including screening questions is agreed with maternity services to detect those at risk of a serious mental illness following delivery
2.3	3	Women are offered a choice of where they would like their assessment to take place, taking into consideration clinical need
2.4	1	The service is able to conduct assessments in a variety of settings, which have been appropriately risk assessed
2.5	1	New onset conditions arising after 28 weeks and before 6 weeks postpartum have the potential to be serious. Contact with the referrer and/or patient should take place within 2 working days to establish the urgency of assessment. *Guidance: When the Consultant Psychiatrist is not available another appropriate member of the team may have these discussions*

2.6	1	Pregnant women referred with a past history of serious affective disorder / psychosis / anxiety disorder / eating disorder / obsessive compulsive disorder, even if currently well, should be offered an assessment to take place in their pregnancy.
2.7.2	1	All women who are referred with a known or suspected mental health problem are provided with psychological interventions within 1 month of the initial assessment
2.8.1	1	Pregnant women receiving Sodium Valproate should be discussed with the current prescriber within 2 working days of referral and appropriate advice given. *Guidance: When the Consultant Psychiatrist is not available another appropriate member of the team may have these discussions*
2.9	1	Women currently in the care of psychiatric services may be managed by the perinatal team or collaboratively with their usual psychiatric care team, depending on clinical need and the patient's wishes.
2.10	1	Patients have a comprehensive assessment in accordance with NICE guidance which includes their: • Mental health and medication; • Psychosocial needs; • Strengths and weaknesses.
2.11	1	Staff members address patients using the name and title they prefer.
2.12	1	Patients have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of: • Risk to self; • Risk to others; • Risk from others.
2.13	1	The team discusses the purpose and outcome of the risk assessment with each patient (where clinically appropriate) and a management plan is formulated jointly.
2.14		A physical health review takes place as part of the initial assessment. The review includes but is not limited to: • Details of past medical history, including obstetric history; • Current physical health medication, including side effects and compliance with medication regime; Mode of infant feeding • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual health, drug and alcohol use.
2.15	1	All women have a named mental healthcare professional. They are told how and who to contact if this person is not available and in an emergency

2.16	1	Every patient has a written care plan, reflecting their individual needs. Guidance: This clearly outlines: • Agreed intervention strategies for physical and mental health; • Measurable goals and outcomes; • Strategies for self-management; • Any advance directives or stated wishes that the patient has made; • Crisis and contingency plans; • Review dates and discharge framework.
2.17	1	Care plans are reviewed at least every 3 months *Guidance: For patients with complex needs on CPA (or local equivalent) this should be a formal review involving members of the multi-disciplinary team and other relevant professionals. For patients not on a CPA (or local equivalent) the review may be conducted by the professional(s) from the service directly involved with the patient's care.*
2.18	1	The practitioner develops the care plan collaboratively with the patient and their partner/significant other (with patient consent).
2.19	1	The patient and their partner/significant other (with patient consent) are offered a copy of the care plan and the opportunity to review this.
2.20		*For women seen in pregnancy, there is a peripartum management plan formulated and recorded in the handheld records by 32 weeks of pregnancy shared with the woman, her family (where appropriate), GP, Midwife, Health Visitor, obstetrician and any other relevant professionals or organisations. This includes:*
2.20a	1	Nature of the risk and condition
2.20b	1	Details of current medication and any intended changes in late pregnancy and the early postpartum.
2.20c	1	Consideration of whether the mother intends to breastfeed.
2.20d	1	Those involved and frequency of contact.
2.20e	1	Emergency contact details.
2.20f	1	Admission to a mother and baby unit if necessary
2.20g	1	Plans for a maternity admission, including notifying the perinatal team once the patient has delivered
2.21	1	Women referred in pregnancy who are at high risk of serious illness are seen by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed
2.22	1	All patients have a documented diagnosis and a clinical formulation. Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.

2.23	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.
2.24	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.
2.25	1	Confidentiality and its limits are explained to the patient and partner/significant other at the first assessment, both verbally and in writing. Guidance: For partner/significant others this includes confidentiality in relation to third party information
2.26	1	All patient information is kept in accordance with current legislation. Guidance: 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.
2.27	1	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.
2.28	1	If a patient does not attend for assessment, the team contacts the referrer. Guidance: If the patient is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan.
2.29	1	The team follows up patients who have not attended an appointment/ assessment or who are difficult to engage.
3		**Discharge**
3.1	2	Discharge or onward care planning is discussed at the very first and every subsequent care plan review.
3.2	1	patients and their partner/significant others (with patient consent) are involved in decisions about discharge plans. Guidance: This could be through a formal discharge meeting
3.3	1	The team follows a protocol to manage patients who disengage from community care. This includes: • Recording the patient's capacity to understand the risks of self-discharge; • Putting a crisis plan in place; • Contacting relevant agencies to notify them of the discharge.
3.4	2	When a patient is admitted to hospital, a community team representative contributes and attends (where possible) ward rounds and discharge planning.

3.5	1	Patients who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk. Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.
3.6	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.
3.7	3	When patients are transferred between community services there is a meeting in which members of the two teams meet with the patient and partner/significant other to discuss transfer of care.
3.8	2	There is active collaboration between Child and Adolescent Mental Health Services and Working Age Adult Services for patients who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer.
3.9	1	A letter setting out a clear discharge plan is sent to the patient and all relevant parties within 10 days of discharge. The plan includes details of: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication; • Details of when, where and who will follow up with the patient as appropriate • Assessment of the quality of mother-infant interaction • Risk assessment (mother and child)
4		**Care and Treatment**
4.1		*All teams have access to a range of therapeutic interventions focusing on mother, baby, and family including:*
4.1a	1	Evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes. Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.
4.1b	2	Mother and baby interventions
4.1c	3	Family and couples interventions
4.1d	3	Creative therapies
4.1e	3	Occupational therapy
4.2	2	The team provides information, signposting and encouragement to patients to access local organisations for peer support and social engagement.

4.3	2	Psychological assessment takes place within 2 weeks of referral and intervention within one month of assessment
4.4	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.
4.5	1	The team signposts patients to structured activities such as antenatal classes, baby yoga
4.6	1	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.
4.7	1	Patients and their partner/significant others (with patient consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.
4.8	1	Patients have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. Guidance: Side effect monitoring tools can be used to support reviews. Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum.
4.9	1	When patients experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this.
4.10	1	Where concerns about a patient's physical health are identified, the team arranges or signposts the patient to further assessment, investigations and management from primary or secondary healthcare services
4.11	1	The team gives targeted lifestyle advice to patients. This includes: • Smoking cessation advice; • Healthy eating advice; • Physical exercise advice; • Alcohol advice
4.12	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor*

4.13	1	The service has a policy or protocol for the care of patients with dual diagnosis that includes: • Liaison and shared protocols between mental health and substance misuse services to enable joint working; • Drug/alcohol screening to support decisions about care/treatment options; • Liaison between mental health, statutory and voluntary agencies; • Staff training; • Access to evidence based treatments.
4.14	1	Patients who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: • A personal/family history (at baseline and annual review); • Lifestyle review (at every review); • Weight (at every review); • Blood pressure (at every review); • Fasting plasma glucose/ HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review). Guidance: patients are advised to monitor their own weight every week for the first 6 weeks and to contact the service if they have concerns about weight gain.
4.15	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency *Guidance: This includes guidance about when to call 999*
4.16		*The clinical members of the team are able to advise (working with other professionals) the patient, partner and family on:*
4.16a	1	Early mother-infant care and attachment
4.16b	2	Infant development
4.16c	1	Promoting involvement of partner / family members
4.17	2	Partners and designated family members are involved in decisions about care, where the patient consents
4.18	1	Partners/significant others are advised on how to access a statutory carers assessment, provided by an appropriate agency Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.

4.19	2	The team provides each partner/significant other with a specific information pack Guidance: This includes the names and contact details of key staff members in the service. It also includes other local sources of advice and support such as local partner/significant others' groups, partner/significant others' workshops and relevant charities.
4.20	2	Partners/significant others are offered individual time with staff members to discuss concerns, family history and their own needs
4.21	2	Partners/significant others have access to a support network or group. This could be provided by the service or the team could signpost partner/significant others to an existing network. Guidance: This could be a group/network which meets face-to-face or communicates electronically.
4.22	1	The team follows a protocol for responding to partners/significant others when the patient does not consent to their involvement.
4.23	2	The service has a designated staff member dedicated to providing support to partners/significant other
4.24	2	The service ensures that older children and other dependents are supported appropriately *Guidance: This may be done via other services, e.g. social services, health visitor*
4.25	3	Age appropriate perinatal mental health information is available to older children in the patient's family
4.26	1	The team have established relationships with local mother and baby units
4.26.1	1	The team informs a mother and baby unit of all women at risk of potential admission *Guidance: This includes women with a past history of puerperal psychosis / bipolar disorder / serious affective disorder and women with serious illness currently managed in the community*
4.26.2	1	The potential for admission is communicated verbally to the patient and her family and recorded in the written care plan and communicated to her GP, midwife and health visitor if appropriate
4.26.3	2	Written and verbal information is given to the patient, her partner and family about the mother and baby unit
4.26.4	2	Patients and their partner/significant others are given the opportunity to visit the mother and baby unit if admission is being considered Guidance: This could be facilitated through virtual tours

4.27	1	As soon as possible after admission to a mother and baby unit a perinatal community psychiatric practitioner should be allocated to the patient
4.28	2	The allocated perinatal psychiatric team member attends the patient's multidisciplinary ward rounds as appropriate *Guidance: If they are unable to attend in person they should participate by phone*
4.29	1	A member of the perinatal psychiatric team member attends the patient's pre-discharge meeting *Guidance: If they are unable to attend in person they should participate by phone*
4.30	1	Following discharge from an inpatient stay, the patient is seen in the community by a member of the perinatal team within 7 days
4.31	1	Staff members follow a lone working policy and feel safe when conducting home visits.
4.32	1	Patients are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.
4.33	1	Capacity assessments are performed in accordance with current legislation.
4.34	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)
4.35	1	There are systems in place to ensure that the service takes account of any advance directives that the patient has made.
4.36	1	Patients are treated with compassion, dignity and respect. Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.
4.37	1	Patients and their partner/significant others (where the patient consents) are offered written and verbal information about the patient's mental illness.
4.38	1	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.
4.39	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.

4.40	2	Outcome data is used as part of service management and development, staff supervision and caseload feedback. Guidance: This should be undertaken every 6 months as a minimum.
5		**Infant Welfare and Safeguarding**
5.1		*During the initial assessment process for the patient, the emotional and physical care needs of the infant will be assessed. This assessment will include:*
5.1a	1	The baby's age and date of birth or due date
5.1b	1	Parental responsibility for the infant
5.1c	1	Name and contact numbers of GP, health visitor, midwife, obstetrician, any social worker or paediatrician involved and any other relevant professionals or agencies
5.1d	1	If the child or unborn child is the subject of a Child Protection Plan/Child Protection Register/At Risk Register/Care Proceedings
5.1e	1	Mode of delivery and obstetric complications during birth
5.1f	1	Current or planned mode of feeding and any previous problems with feeding
5.1g	1	A brief assessment of mother-infant interaction, care and attachment
5.1h	1	Responsibility for occupants of the household
5.2	1	If areas of concern are highlighted then the care co-ordinator ensures a full assessment is completed using an instrument that is relevant to the concern, working collaboratively with the health visitor, psychologist or social worker if involved
5.3	1	Mother-infant relationship and care should be observed and recorded in the patients notes every 3 months or more frequently should the patient's mental state and behaviour change
5.4	2	All observations of mother-infant relationship and care are fed back to and discussed with the patient with particular reference to progress and problem areas
		Risk Assessment of the Infant
5.6		*A risk assessment of mother and infant must be undertaken during the initial assessment process by the service. This should include:*
5.6a	1	Disclosures of harmful or potentially harmful acts
5.6b	1	Any delusions / overvalued ideas or hallucinations involving the unborn baby, infant or other children
5.6c	1	Any thoughts, plans or intentions of harming the unborn baby, infant or other children
5.6d	1	Hostility and / or irritability towards the unborn baby, infant or other children
5.6e	1	Any involvement with Children's Social Care *Guidance: e.g. unborn baby, infant or older children subject to child protection plan or child care proceedings*

5.6f	1	Any concern about any other person who may pose a risk to the unborn baby, child or other children
5.6g	1	Thoughts about wanting to estrange themselves/inadequacy as a parent
5.7	1	The risk assessment tool is specifically designed for use by perinatal psychiatric services *Guidance: This could include a measure adapted or developed by the service or an existing measure such as Perinatal FACE (http://www.face.eu.com/solutions/assessment-tools/perinatal-psychiatry)*
5.8	1	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.
5.9	1	Risk assessments are completed prior to discharge and a summary is sent to all relevant agencies involved in care
5.10	1	At each stage of Care and Risk Assessment consideration is given as to whether it is appropriate to initiate a CAF (or local equivalent) to better assess any additional needs the baby or older children of the family may have (www.ecm.gov.uk/caf)
		Care and Treatment of the Infant
5.11		*Case notes include:*
5.11a	1	Any maternal concerns in relation to the unborn baby/ infant
5.11b	1	Her care of the unborn baby/ infant
5.11c	1	Her enjoyment of the unborn baby/ infant
5.11d	1	If the infant is absent from the contact the reason why is recorded
5.12	2	Staff encourage the involvement of partners and/or other significant family members in the care of the mother and her infant, unless detrimental to the mother or infant. *Guidance: Record of this should be included in the care plan*
5.13		*Women who choose to breastfeed are supported and encouraged by the following:*
5.13a	1	Where the service is prescribing psychotropic medication for breastfeeding mothers it is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration
5.13b	1	Women and all clinicians have access to up to date and expert information about medication in relation to breastfeeding
5.14	3	If a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility, the waiting area is exclusively for the use of the perinatal and/or maternity services during that session

		Safeguarding of the Infant
5.15	1	Local safeguarding and child protection guidance is available and accessible to all staff members
5.16	1	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details
5.17	3	A member of the perinatal psychiatric team is a member of the local safeguarding or child protection group
5.18	1	Referral to Children and Family Services should be made on the basis of a risk assessment and should not be "routine" (i.e. only because the mother is mentally ill)
5.19		*When the following factors are identified a referral to Children and Family Services should be made:*
5.19a	1	Concern from risk assessment about the immediate safety of the infant from its mother, partner or any other person
5.19b	1	An assessment identifies that the child is at ongoing risk of harm
5.19c	1	Current domestic violence
5.19d	1	Evidence that harm has already occurred
5.20	1	Any safeguarding referral is made in accordance with local NHS Trust (or equivalent body) and county council procedures
5.21	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
5.22	1	The team should inform the relevant local social care team if any other child in the family has been subject to a care order or been on the Child Protection Risk Register *Guidance: This should not automatically be a formal 'referral'*
5.23	1	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team in services that have access to one. Guidance: This includes joint care reviews and jointly organising admissions to hospital for patients in crisis.
5.24	1	Patients are given verbal and written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records

6		**Staffing and Training**
6.1	1	specific to the service, which covers: • The purpose of the service; • The team's clinical approach; • The roles and responsibilities of staff members; • The importance of family and partner/significant others; • Care pathways with other services. Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.
6.1a	1	New staff members, including agency staff, receive an induction based on an agreed list of core competencies. Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.
6.1b	1	All newly qualified staff members are allocated a preceptor to oversee their transition into the service. Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body. See http://www.rcn.org.uk/__data/assets/pdf_file/0010/307756/ Preceptorship_framework.pdf for more practical advice.
6.1c	2	All new staff members are allocated a mentor to oversee their transition into the service.
6.1d	2	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.
6.1e	2	Where group work is offered, staff members have an understanding of group dynamics and of what makes a therapeutic environment.
6.1f	3	The organisation's leaders provide opportunities for positive relationships to develop between everyone.
6.2		*Training has been provided in the following:*
6.2a	1	The range of perinatal disorders and normal emotional changes in pregnancy and after birth
6.2b	2	Clinical outcome measures;
6.2c	1	Basic infant development including the main development milestones
6.2d	1	Cultural differences in infant feeding, care / interaction and family relationships

6.2e	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);
6.2f	1	Understanding and promoting mother-infant interaction and attachment
6.2g	1	Physical health assessment; Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.
6.2h	2	Infant mental health training (e.g. Solihull, Watch Wait Wonder or Mellow Babies)
6.2i	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities;
6.2j	1	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist)
6.2k	1	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (updated annually)
6.2l	1	A range of evidence-based psychological therapies delivered by staff with appropriate qualifications, training and supervision. This includes CBT, IPT and mother-infant interaction interventions.
6.2m	2	Contraception and sexual health
6.2o	1	Smoking cessation (suggestion to remove others as not really applicable)
6.2p	2	Family awareness, family inclusive practice and social systems, including partner/significant others' rights in relation to confidentiality.
6.2q	1	Infant feeding (including breastfeeding)
6.2r	2	Staff members can access leadership and management training appropriate to their role and specialty.
6.3	1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: • Safeguarding vulnerable adults (or local equivalent) • Safeguarding children Level 3 (or local equivalent) • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.
6.4	1	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:

6.5	2	Patients, partners/significant others and staff members are involved in devising and delivering training face-to-face.
6.6	3	In-house multi-disciplinary team education and practice development activities occur in the service at least every 3 months.
6.7	2	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.
6.8	2	All clinical staff attend a specialist perinatal training day at a minimum of once every two years
6.9	2	The team provide an annual training plan or strategy about perinatal mental health and its services which is appropriate for and accessible to midwives, health visitors, GPs, obstetricians, social workers and mental health workers
6.10.1	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*
6.10.2	1	All staff members receive monthly line management supervision.
6.10.3	2	Staff members in training and newly qualified staff members are offered weekly supervision.
6.11	2	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs*
6.12	2	The team holds business meetings that are held at least monthly.
6.13	3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.
6.14	2	Front-line staff members are involved in key decisions about the service provided.
6.15	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that front-line staff members find accessible and easy to use.
6.16		*The service consists of:*
6.16a	1	Sessions from a dedicated specialised consultant perinatal psychiatrist
6.16b	3	0.5 WTE consultant psychiatrist input per 5000 births
6.16c	2	Non-consultant medical input
6.16d	3	0.5 WTE non-consultant psychiatrist input per 5000 births
6.16e	1	Dedicated perinatal community psychiatric nurses

6.16f	3	2.5 WTE perinatal community psychiatric nurses per 5000 births
6.16g	2	Dedicated sessions of a social worker
6.16h	3	0.25 WTE social worker per 5000 births
6.16i	1	Dedicated clinical psychologist sessions
6.16j	3	0.5 WTE clinical psychologist per 5000 births
6.16k	2	Dedicated nursery nurse sessions
6.16l	3	1.25 WTE nursery nurses per 5000 births
6.16m	2	Dedicated OT sessions
6.16n	3	0.5 WTE occupational therapist per 5000 births
6.16o	2	Dedicated administrative and data entry support
6.17	1	The service has a mechanism for responding to low staffing levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.
6.18	1	Members of the team have timely access to advice and support from a specialist perinatal psychiatrist during working hours
6.19	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service
6.20	1	The service has access to interpreters and the patient's relatives are not used in this role unless there are exceptional circumstances. Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.
6.21	2	The service uses interpreters who are sufficiently knowledgeable to provide a full and accurate translation.
6.22	1	The team has a base and office accommodation
6.23	2	Staff working in teams covering a large geographical area can hot desk at other locations
6.24	1	Staff members are easily identifiable (for example, by wearing appropriate identification).
6.25	2	All staff access performance and quality data on both their own patients and the team as a whole, including the regular reviewing of outcome measures to inform patient care and team development
6.26	1	There are written documents that specify professional, organisational and line management responsibilities.
6.27	2	Team managers and senior managers promote positive risk-taking in the context of safeguarding issues to encourage patient recovery and personal development.

6.28	1	Staff members and patients feel confident to contribute to and safely challenge decisions. Guidance: This includes decisions about care, treatment and how the service operates.
6.29	1	Staff members feel able to raise any concerns they may have about standards of care.
6.30	2	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.
6.31	2	The team has protected time for team-building and discussing service development at least once a year.
6.32	2	Patient or partners/significant others are involved in interviewing potential staff members during the recruitment process.
6.33	1	The service actively supports staff health and well-being. Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.
6.34	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.
6.35	2	Staff members have access to reflective practice groups.
6.36	1	The team follows a joint working protocol/care pathway with primary health care teams. Guidance: This includes the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP.
6.38	1	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services.
6.39	1	There are arrangements in place to ensure that patients can access help, from mental health services, 24 hours a day, 7 days a week. Guidance: Joint protocols are agreed, for example, with commissioners, primary healthcare services, emergency medical departments, social services.
6.40	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.

6.41	3	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as patient and partner/significant other representatives.
6.42	2	Patient representatives attend and contribute to local and service level meetings and committees.
7		**Recording and Audit**
7.1		*The service evaluates annually:*
7.1a	2	Feedback from referrers
7.1b	2	Feedback from service staff
7.1c	2	Accident and incident records *GUIDANCE: The service should provide the quality network with information of any SUIs, investigations or complaints in the past 12 months*
7.1d	2	Analysis of complaints
7.1e	2	The findings of audits
7.1f	2	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data)
7.1g	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored
7.1h	1	Women involved in care proceedings / child safeguarding protection plans
7.2	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.
7.3	1	Any serious untoward incident including those involving a child and any emergency child protection order should be audited within 6 weeks and chaired by a suitably qualified clinician external to the service
7.4	1	The service keeps a record of any difficulties / undue delay in transferring the patient to another psychiatric service
7.5	2	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice
7.6	1	Patients and their partner/significant other are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service. Guidance: This might include patient and partner/significant other surveys or focus groups

7.7	2	Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist. *Guidance: This should include monitoring a patient's failure to attend the initial appointment after referral and early disengagement from the service.*
7.8	2	The service reviews data at least annually about the patients who use it. Data are compared with local population statistics and action is taken to address any inequalities of access where identified. G*uidance: This data is used to understand who is accessing the service, identify under-represented groups, promote the service to these groups and improve the accessibility of the service*
7.9	2	The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent).
7.10	1	The safe use of high risk medication is audited, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines*.
7.11	3	The team, patients and partner/significant others are involved in identifying priority audit topics in line with national and local priorities and patient feedback.
7.12	2	When staff members undertake audits they; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.
7.13	2	Key information generated from service evaluations and key measure summary reports (e.g. reports on waiting times) are disseminated in a form that is accessible to all.
7.14	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
7.15	1	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their partner/significant other, in line with the Duty of Candour agreement.
7.16	1	Staff members, patients and partner/significant others who are affected by a serious incident are offered a debrief and post incident support.
7.17	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.

7.18	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.
7.19	2	The service is explicitly commissioned or contracted against agreed standards. Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders.
7.20	3	Commissioners and service managers meet at least 6 monthly.