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PQN
PERINATAL
QUALITY NETWORK

The Perinatal Quality Network: Standards for Community Perinatal Mental Health Services

7th Edition | 2026-2028

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Foreword

We are delighted to publish the 7th edition of the PQN community standards. These standards are the fruits of the relentless efforts of many professionals across the country.

The new edition has taken into consideration the current expansion of the services as well as the challenges within the NHS. It has always been a difficult equation but through our journey, we have seen an amazing level of dedication among professionals to ensure that we will always have great aspiration to continue to refine and improve our expectations from ourselves.

The standards emphasize the patients' rights and dignity. The standards also recognise the need to provide a comprehensive biopsychosocial care for all patients and stresses that this would involve joint working with other non-perinatal services to ensure collaborative and mutual understanding between different teams. This is fundamental to ensure that the isolated patients and patients living in deprived areas will still be able to access the service they need. This approach also reflects evident learning from previous incidents where poor communication among teams led to detrimental effects on the patients' care.

The standards have been developed in accordance with the sustainability principles developed by the Royal College of Psychiatrists. This is a major step in taking a preventative and prophylactic approach to target mental health disorders during the perinatal period. It also highlights the necessity to support different teams especially within the context of the current challenges with recruitment and staffing.

Finally, I would like to express my deepest gratitude to everyone who contribute to the development of these standards.

Sarah Abdelsayed
Consultant Perinatal Psychiatrist
PQN Advisory Group Chair
July 2026

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- The patient and carer representatives that contributed their views and opinions;
- Individuals who attended the standards consultation workshop;
- Individuals who contributed feedback via the e-consultation process.
- NHS England

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Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patients & carers, and email forums with professional groups involved in the provision of community perinatal mental health services. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to community perinatal mental health services.

Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

Who are these standards for?

These standards are designed to be applicable to community perinatal mental health services and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

Categorisation of standards

Each standard has been categorised as follows:

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

- Type 1: Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;
- Type 2: Criteria that a service would be expected to meet;
- Type 3: Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The full set of standards is aspirational and it is unlikely that any service would meet them all. To achieve accreditation, an organisation must meet 100% of type 1 standards, at least 80% of type 2 standards and at least 60% of type 3 standards. The Network facilitates quality improvement and will support teams to achieve accreditation.

Notation

College Centre for Quality Improvement (CCQI) Core Community Standards are marked with the core standard number throughout the document. Those that are not marked with a core number are specialist standards relating to child and adolescent mental health services that are not included in the core set.

Terms used in this document

In this document, the perinatal mental health service is referred to as 'the team' or 'the service'. Patient's partners and family members are referred to as 'partner/chosen other'.

Sustainability Principles

The seventh edition of the PQN quality standards for community perinatal mental health services has been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee (**www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx**).

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this

process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years, the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure, and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamwork facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will not affect the accreditation status of the service.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care. Please see below for further information:

- Guidance for commissioners of financially, environmentally, and socially sustainable mental health services

  https://www.jcpmh.info/good-services/sustainable-services/

- Choosing Wisely – shared decision making

  http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx

- Centre for Sustainable Healthcare

  https://sustainablehealthcare.org.uk/

- Psych Susnet

  https://networks.sustainablehealthcare.org.uk/network/psych-susnet

- Sustainability in Psychiatry

  https://www.rcpsych.ac.uk/improving-care/working-sustainably

Glossary of terms

Term	Definition
Advocacy services	A service which seeks to ensure that patients are able to speak out, to express their views and defend their rights.
Clinical outcome measurement data	Clinical outcomes are measurable changes in health, function or quality of life that result from our care. Clinical outcomes can be measured by activity data such as re-admissions, or by agreed scales and others forms of measurement.
Clinical supervision	A regular meeting between a staff member and their clinical supervisor. A clinical supervisor's key duties are to monitor employees' work with patients and to maintain ethical and professional standards in clinical practice.
Co-produced	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of their care plan to ensure that support is person-centred.
Crisis plan	A crisis plan outlines key information to be considered during a mental health crisis, such as contact details, history of mental and physical illnesses, previous anti-depressants and psychotherapies, signs predicting relapse, and instructions for care if a future relapse occurs.

European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Line management supervision	Supervision involving issues relating to the job description or the workplace. A managerial supervisor's key duties are prioritising workloads, monitoring work and work performance, sharing information relevant to work, clarifying task boundaries and identifying training and development needs.
Mental Capacity Act	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Personal development plan	An action plan that helps to identify learning and development needs to help an individual in their job role or progress in their career.
Reflective practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Risk assessment	A systematic way of looking at the potential risks that may be associated with a particular activity or situation.
Safeguarding	Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect.
Statutory carers' assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.

Section 1: Access and Referral

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
1.1	**1**	**The service is provided for the following groups in a defined catchment area:**	
1.1a	**1**	Patients following discharge from an inpatient mental health unit.	
1.1b	**1**	Patients experiencing Bipolar Disorder/ Postpartum Psychosis, other psychoses and Serious Affective Disorder, who can be safely managed in the community.	
1.1c	**1**	Patients with moderate to severe non-psychotic conditions.	
1.1d	**1**	Patients identified in pregnancy who are at risk of a recurrence/relapse of a psychotic or serious/complex non-psychotic condition. *Guidance: This includes patients who are currently unwell and those who are well but at risk of becoming unwell.*	
1.1e	**1**	Patients requiring pre-conception counselling.	
1.1f	**1**	Patients with alcohol/substance misuse problems if there is also moderate to severe mental illness. *Guidance: The team should liaise and work jointly with community addiction/substance misuse services to facilitate care/treatment options.*	**10.3**
1.2	**1**	The team provides information about how to make a referral and the waiting times for assessment and treatment. This is available in the public domain for patients, partners/chosen others and referrers.	
1.3	**1**	A care pathway, including recommended antenatal screening questions, is agreed with maternity services, GPs and adult mental health services to identify both those at risk of developing a serious mental illness following delivery and those who are currently unwell. *Guidance: These might need to be separate pathways for each service.*	
1.4	**1**	The team has a system to manage and respond to referrals in a safe and timely way. This includes: • A clinical member of staff being available to discuss urgent referrals during working hours;	**1.3**

		• Where referrals are made through a single point of access, these are passed on to the community team within one working day. Emergency referrals are passed across immediately.	
1.5	**1**	When the team are unable to conduct an emergency assessment, there is an agreed approach in place. *Guidance: This may include having arrangements in place with another service to cover this, e.g. crisis; liaison. If possible, perinatal teams should try to attend, otherwise this should be done by crisis, liaison, home treatment teams, or an equivalent service.*	
1.6	**1**	There is a procedure agreed with out of hours teams that, following assessment, patients requiring perinatal specialist care are referred the next working day.	
1.7	**2**	Services have a mechanism to offer proactive advice and guidance to professionals. *Guidance: This can include a telephone advice line, emails or advice guidance app. This should include the service offering leadership for complex cases or patients with serious risk, even if they don't meet referral criteria.*	
1.8	**1**	Outcomes of referrals are fed back to the referrer and patient. If a referral is not accepted, the team advises the referrer and patient on why it was not accepted and signposts to alternative options. *Guidance: The service manages and responds to referrals in a way that prevents repeated rejected referrals at both patient and referrer level, e.g. thorough direct liaison with the referrer.*	**1.5**
1.9	**1**	The service has a clear joint working protocol or pathway for patients who require the input of other specialist services in order to meet their individual needs adequately in the perinatal period. These should include: • Patients with disordered eating; • Patients with substance misuse problems; • Patients with a learning disability and/or neurodivergence; • Children and young people • Unscheduled care teams/home treatment/crisis/liaison teams.	

1.10	**2**	People who are waiting for assessment and/or treatment are given information and signposted to resources on support available whilst they are waiting. They are made aware of who to contact if their needs change and how and when to access crisis services. *Guidance: Information given could include crisis lines, guided self-help techniques, resources relevant to the patient's treatment pathway, and voluntary organisations.*	**1.6**
1.11	**2**	The team offers appointments both in person and virtually. How appointments are delivered (e.g. in person, phone, online) is determined by clinical need and patient preference rather than clinical space and staffing pressures. Conducting first assessments in-person should be standard practice. *Guidance: The service has clinical guidance and/or a policy regarding the use of different modalities to deliver patient appointments. Data are collected on the use of different appointment modalities and reviewed in team governance meetings in the context of service safety and quality.*	**1.7**

Section 2: Assessment

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
2.1	**1**	Teams assess patients who are experiencing an episode of moderate to severe and complex mental illness in pregnancy and up until 12 months postpartum (if the patients' needs are best met by the perinatal service and clinically indicated).	
2.2	**2**	Teams assess patients who are experiencing an episode of moderate to severe and complex mental illness in pregnancy and up until 24 months postpartum (if the patients' needs are best met by the perinatal service and clinically indicated).	
2.3	**1**	The team assesses patients, who are referred to the service, within an agreed timeframe. *Guidance: There should be a process to ensure urgent referrals are seen within the team or by another team following an agreed protocol. This should include an understanding of perinatal risks and the need for joint working.*	**1.4**
2.4	**1**	For non-urgent assessments, the team makes written communication in advance to patients that includes: • A description of the service; • How to get there and building accessibility; • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them and how this can help; • How to contact the team if they have any queries, require support (e.g. an interpreter, childcare, breast feeding facilities), need to change the appointment or have difficulty in attending appointments	**2.1**
2.5	**1**	If the service receives a referral for a patient who has been prescribed Sodium Valproate or Semi-Sodium Valproate, it is the responsibility of the service to ensure MHRA guidance is followed. An urgent discussion is had (within two working days) with the patient, referrer and other appropriate clinical services. *Guidance: This discussion should include a rigorous assessment of the indications for using Sodium Valproate or Semi-Sodium Valproate. If it has been prescribed as a mood stabiliser by mental health*	

		services, this should be escalated to the relevant authority e.g. the clinical or medical director.	
2.6	**1**	Patients have a comprehensive mental health assessment. The process involves the patient, their partner/chosen other, and other health/care providers as relevant and includes consideration of the patient's: • Strengths, goals and areas for development; • Mental health and medication; • Psychosocial and psychological needs; • Religious traditions and spiritual beliefs; • Advance choices; • Reasonable adjustments. *Guidance: Where appropriate, the assessment should draw on information from a range of sources, including the patient, partner/chosen others, other involved services and agencies and past assessments or relevant information held by services.* **Sustainability Principle: Improving Value**	**2.2** 
2.7	**1**	A physical health review takes place as part of the initial assessment, or as soon as possible, which takes into consideration the patients pregnant or postnatal status. *Guidance: This may comprise of gathering information about recent health checks and treatment already undertaken and offering or facilitating access to further health checks or treatment if necessary.* **Sustainability Principle: Prioritise Prevention**	**2.3** 
2.8	**1**	Patients have a safety assessment, formulation and plan which is co-produced (where the patient is able to participate). This draws on the patient's strengths, involves partners and chosen others (where appropriate), is reviewed regularly and is shared with relevant agencies (where appropriate). *Guidance: The assessment and plan consider risk to self, risk to others, risk from others, risk to the baby/pregnancy, the types of harm that could occur, when they are likely to occur and how they may be mitigated. Online safety is considered as part of the assessment.* **Sustainability Principle: Prioritise Prevention**	**2.4** 
2.9	**1**	For patients assessed in pregnancy, there is a coproduced mental health birth plan formulated and recorded in the handheld records (or equivalent) by 32	

		weeks of pregnancy, that is shared with the patient, their family or chosen others (where appropriate), GP, Midwife, Health Visitor, Obstetrician and any other relevant professionals or organisations. *Guidance: Any exceptions should be documented in the patient's notes along with reasons for this (e.g. if they were a late referral).*	
2.10	**1**	**The mental health birth plan should include:**	
2.10a	**1**	Nature of the risk and condition *Guidance: Including consideration of known triggers, stressors, past history of trauma, and any cultural considerations.*	
2.10b	**1**	Details of current medication and any intended changes in late pregnancy and the early postpartum period.	
2.10c	**1**	Details of infant care, including consideration of the patient's feeding preference.	
2.10d	**1**	Professionals involved. *Guidance: For example, health visitor, GP etc.*	
2.10e	**1**	The patient's chosen emergency contact details.	
2.10f	**1**	Admission to a Mother and Baby Unit if necessary and any plans or special requirements for a maternity admission.	
2.11	**1**	Patients referred in pregnancy who are at high risk of serious illness are assessed by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed.	
2.12	**1**	Patients requiring a formal psychological intervention are offered assessment and treatment within 18 weeks. Where a patient is assessed as not yet ready, this is documented and revisited as part of ongoing care planning.	
2.13	**2**	Patients requiring a formal psychological intervention are offered assessment and treatment within 6 weeks. Where a patient is assessed as not yet ready, this is documented and revisited as part of ongoing care planning.	
2.14	**1**	The team sends correspondence detailing the outcomes of the assessment to the patient, referrer, the GP and other relevant services.	**2.6**

2.15	**1**	Patients are asked if they and their partner/chosen other wish to have copies of correspondence about their health and treatment. *Guidance: Digital as well as written modes of communication may be offered.*	**15.2**
2.16	**1**	Confidentiality and its limits are explained to the patient and partner/chosen other, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	**16.1**
2.17	**1**	The team follows up and proactively engages patients who have not attended an appointment or during periods when engagement is challenging. *Guidance: Different engagement techniques are in place to match the patient's needs. Partners/chosen others, primary care and other services or agencies are involved as appropriate.*	**3.1**
2.18	**1**	If a patient does not attend for an assessment/ appointment, the assessor contacts the referrer. *Guidance: If the patient is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.*	**3.2**
2.19	**1**	If patients are unable to be engaged, a decision is made by the team in collaboration with relevant parties, based on patient need and risk, as to how long to continue to follow up and try to engage the patient. *Guidance: DNA (did not attend) should not be a reason for discharge. If/when discharge from the team occurs, a clear record of the decision-making process, who was involved in it and the safety management plan is included within the patients' electronic record. This is shared with relevant parties.*	**3.3**
2.20	**1**	Patients feel welcomed by staff members when attending their appointments. *Guidance: Staff members introduce themselves to patients, and address patients using their preferred name and pronouns.*	**14.3**
2.21	**2**	The environment is clean, comfortable and welcoming.	**17.1**
2.22	**1**	Clinical rooms are private and conversations cannot be overheard.	**17.2**

2.23	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such handrails, are provided to meet individual needs and to maximise independence.*	**17.3**
2.24	**1**	Patient information is kept and managed in line with relevant information governance guidance and legislation.	**16.3**
2.25	**1**	There is a system by which staff are able to raise an alarm if needed. *Guidance: There should be a protocol in place to ensure staff are safe.*	**17.6**
2.26	**2**	The service has facilities available that are suitable for small babies and siblings. *Guidance: E.g. suitable toys and a room for baby-changing and breastfeeding).*	

Section 3: Discharge and Transfer of Care

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
3.1	**2**	A discharge letter is sent to the patient and all relevant parties within one week of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including relapse indicators, what actions are needed when they occur and details of who to contact; • Medication, including monitoring arrangements and longer-term plans for specific medication, e.g. stop or review dates and recommendations for duration of use; • Details of when, where and with whom the patient's follow-up will take place; • Details of how to re-access the service and/or how to get rapid advice from the team.	**9.1**
3.2	**1**	When patients are transferred between community services, there is a handover process prior to discharge which ensures seamless transfer of care to a new named person and transfer of information including: • Patient preferences for engagement; • Relapse indicators and actions needed in event of them; • Current medication, indication, monitoring arrangements; • An up-to-date care plan, risk assessment and safety plan.	**9.3**
3.3	**1**	The team makes sure that patients who are discharged from mental health inpatient care are followed up within 72 hours.	**9.2**
3.4	**1**	The potential for admission is communicated verbally to the patient and their family where appropriate, and written information provided. This is recorded in the written care plan and communicated to the patient's GP, midwife and health visitor if there has been any potential for admission to inpatient care.	
3.5	**1**	As soon as possible after admission to a Mother and Baby Unit, a perinatal community practitioner is allocated to the patient and attends all appropriate meetings, including the patient's multidisciplinary ward review and pre-discharge meeting. *Guidance: If they are unable to attend in person they should participate by phone or video link.*	

3.6	**1**	Partners and/or chosen others (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. This includes attendance at review meetings where the patient consents.	**13.1**
3.7	**3**	The service is actively involved with their regional perinatal clinical network.	
3.8	**1**	The team follows a protocol to manage patients who discharge themselves against medical advice. This includes: • Recording the patient's capacity to understand the risks of self-discharge; • Exploring the reasons why a patient may want to discharge themselves and actively try and address these issues, where possible; • Contacting relevant parties (e.g. other agencies, primary care) to notify them of the discharge.	**9.5**

Section 4: Care and Treatment

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
4.1	**1**	Every patient has a written care plan, reflecting their individual needs and goals. Staff members collaborate with patient and their partners/chosen others to develop the care plan, and they are offered a copy. *Guidance: Care planning and outcome measurement tools may be used to support this process, e.g. DIALOG+. Care plans can be written and shared electronically.*	**4.2**
4.2	**2**	Care plans are routinely reviewed as part of an ongoing process to support assessment of response to treatment/interventions and changes in goals and needs. *Guidance: Additional reviews may be initiated when requested by the patient, partner/chosen other or other involved agency, when there is a significant change in circumstances impacting the patient's mental health and/or a change in their presenting problems or needs.*	**4.3**
4.3	**1**	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised. *Guidance: Clinical formulations are coproduced where possible. A working diagnosis can be devised by any suitable clinician.*	**2.5**
4.4	**1**	Patients (and partners and/or chosen others with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.* **Sustainability Principle: Empowering Individuals**	**5.7** 
4.5	**1**	The teams provide a range of evidence-based therapeutic interventions for the patients, the baby, and the partners/chosen others, based on clinical need.	
4.6	**1**	The team supports patients to undertake structured activities such as work, education and volunteering.	**5.5**

		Guidance: This might include: • *Activities that promote enjoyment and interaction with the baby and social engagement (such as swimming lessons, sensory activities, music groups);* • *Voluntary organisations;* • *Community centres;* • *Local religious/cultural groups;* • *Peer support networks;* • *Recovery colleges.*	
4.7	**3**	The team supports patients to access local green and blue spaces on a regular basis. *Guidance: This could include signposting to local walking groups or arranging regular group activities to visit green spaces. Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot- or rainwear. Examples of blue spaces include rivers, lakes, and coastal waters.* **Sustainability Principle: Consider Carbon**	**5.6** 
4.8	**1**	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services; • Domestic abuse services; • Immigration services; • Drug and alcohol services. *Guidance: The team should have joint working protocols with relevant organisations. Staff should know how to access policies and protocols around joint working.*	**10.2**
4.9	**1**	When medication is prescribed, the risks and benefits are discussed with the patient and partner/chosen other (with patient consent). The following are discussed and recorded: • The intended outcome of the intervention; • Timescale for response; • Monitoring requirements; • Patient consent and capacity to consent. *Guidance: This should involve joint decision making between patient and prescriber.*	**6.1**
4.10	**1**	Patients have their medications reviewed regularly, if these medications are prescribed by perinatal	**6.2**

		services. Medication reviews include an assessment of therapeutic response, adherence, safety and management of side effects, including during medication changes and when medications are being stopped/ withdrawn. *Guidance: Side effect monitoring tools can be used to support reviews. There should be particular emphasis on the potential effects of the medication on the pregnancy and changes in the bioavailability of medication as the pregnancy progresses.* **Sustainability Principle: Consider Carbon**	
4.11	**1**	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon. Ongoing monitoring and prescribing plans are developed collaboratively with primary care in order to best meet the patient's needs.	**6.4**
4.12	**2**	Patients and partners/chosen others are able to discuss medications with a specialist pharmacist. *Guidance: This role should be provided by a clinical pharmacist with perinatal mental health expertise. The pharmacist contributes to prescribing decisions, patient and carer counselling, staff education, complex risk–benefit assessments, and safeguarding of medication use.*	**6.3**
4.13	**1**	Clinical outcome measurement is used collaboratively with the patient to inform care planning and monitor progress. *Guidance: This includes patient-reported outcome measurements where possible. How often they are used is determined by the patient's care plan, but they should be collected at minimum at two time points (at assessment and discharge).*	**23.1**
4.14	**2**	Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.	**23.2**
4.15	**1**	Staff members arrange for patients to access screening (including national screening programmes), monitoring and treatment for physical health problems through primary/secondary care services. *Guidance: Where there are potential barriers to engagement, reasonable adjustments (e.g. support*	**7.1**

		to attend an appointment or home visits) are put in place to support patients to engage with this care.	
4.16	**1**	Staff proactively promote the importance of physical health and healthy behaviours for families. Patients are offered evidence-based, personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. *Guidance: This includes providing signposting and advice for children/babies where appropriate.* **Sustainability Principle: Prioritise Prevention**	**7.2** 
4.17	**2**	There are systems in place to ensure that patients with serious mental illness (SMI) receive annual physical health checks. *Guidance: This could be done within the team or through another community service and reasonable adjustments to support attendance are put in place.*	**7.3**
4.18	**1**	The team, including bank and agency staff, is able to identify and manage an acute physical health emergency. *Guidance: This includes escalating physical health concerns as appropriate.* **Sustainability Principle: Empowering Staff**	**22.2** 
4.19	**1**	Patients know who the key people are in their team, who is co-ordinating their care and how to contact them.	**4.1**
4.20	**1**	Patients can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis lines / crisis resolution and home treatment teams, or psychiatric liaison teams.*	**10.1**
4.21	**1**	The team provides each partner and/or chosen other with accessible carer's information. *Guidance: Information is provided verbally and in writing and/or digitally (e.g. carer's pack). It includes:* • *The names and contact details of key staff members in the team and who to contact in an emergency;* • *Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	**13.4**

4.22	**1**	Partners/chosen others are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.*	**13.2**
4.23	**2**	Where a patient or patient's family member is identified as a young carer, the service is able to signpost to specific young carer support.	
4.24	**1**	Partners/chosen others are offered individual time with staff members to discuss concerns, family history and their own needs. **Sustainability Principle: Empowering Individuals**	**13.3**
4.25	**2**	The team actively encourages partners and/or chosen others to attend carer support networks or groups. There is a designated staff member to support carers.	**13.5**
4.26	**1**	The team knows how to respond to partners/chosen others when the patient does not consent to their involvement. *Guidance: The team may receive information from the partner/chosen other in confidence.*	**16.2**
4.27	**3**	The service ensures that older children and other dependants are supported appropriately. *Guidance: This may be achieved through referral or signposting to other services, e.g. social services, health visitor. Any materials should be age appropriate.*	
4.28	**1**	Staff members treat patients and partners/chosen others with compassion, dignity and respect.	**14.1**
4.29	**1**	Patients feel listened to and understood by staff members.	**14.2**
4.30	**1**	When talking to patients and partners/chosen others, health professionals communicate clearly, avoiding the use of jargon.	
4.31	**1**	Reasonable adjustments are made to how care is delivered, if required, for patients with disability, including those with autism and/or learning disability. Any reasonable adjustments are recorded in the patient's notes and in line with any relevant legal or regulatory recording requirements. **Sustainability Principle: Empowering Individuals**	**14.4**

4.32	**2**	The team works with interpreters to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. *Guidance: If the patient's first language is not English, an assessment is made as to whether they can accurately describe their symptoms, difficulties and needs. If not, an interpreter is booked for subsequent reviews.*	**15.3**
4.33	**2**	Information for patients and partners/chosen others is available in accessible formats for neurodiverse people and people with sight/hearing/cognitive difficulties or learning disabilities. It can be provided in languages other than English (ensuring cultural relevance, if necessary). *Guidance: In Wales, services and communication (written and spoken) comply with the relevant Welsh Language legislation.*	**15.1**

Section 5: Rights, Infant Welfare and Safeguarding

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
5.1	**1**	Patients are given accessible information about the service, their rights as patients and the supports available to them to use the service. *Guidance: The information includes, where relevant:* • *Their rights in relation to relevant mental health, human rights and mental capacity legal frameworks, including confidentiality and consent to treatment;* • *How to access advocacy services;* • *How to access a second opinion;* • *How to access interpreting services;* • *How to view their health records;* • *How to raise concerns, complaints and give compliments.* *This may be on a website but also available in other formats that can be discussed together with a staff member.*	**2.7**
5.2	**1**	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation.	**11.1**
5.3	**1**	When patients lack capacity to consent to interventions, decisions are made in their best interests and that of the family (with consideration of safeguarding and appropriate use of the Mental Health Act).	
5.4	**1**	There are systems in place to ensure that the service takes account of any advance directives or statements that the patient has made. *Guidance: An advance directive is a legally binding instruction regarding treatment and is not the responsibility of the perinatal mental health team to create or oversee; however, where one exists, it should be clearly flagged within the person's health record so that staff are aware of its contents and legal status.* *In contrast, an advance statement (e.g., statement of wishes) is not legally binding, is focused on the person's preferences and values, and should form part of routine care planning within perinatal services.*	

		These are accessible and staff members know where to find them.	
5.5	**1**	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary. *Guidance: In collaboration with social care where appropriate.*	
5.6	**1**	**During the initial assessment process for the patient, the emotional and physical care needs of the infant are assessed. This assessment should include:**	
5.6a	**1**	The baby's age and date of birth or due date.	
5.6b	**1**	Parental responsibility for the infant.	
5.6c	**1**	Name and contact numbers of GP, Health Visitor, Midwife, Obstetrician, any Social Worker or Paediatrician involved and any other relevant professionals or agencies.	
5.6d	**1**	If the child is the subject of a Child in Need Plan/ Looked After Child Plan/Child Protection Plan/Care Proceedings. *Guidance: Pertinent negatives must also be recorded, i.e. that the child is not the subject of a Child Protection Plan.*	
5.6e	**1**	Mode of delivery and obstetric complications during birth.	
5.6f	**1**	Current or planned mode of feeding and any previous or current problems with feeding.	
5.6g	**1**	A brief assessment of mother-infant interaction, care and relationship.	
5.6h	**1**	The occupants of the household.	
5.7	**1**	The team has a mechanism for recognising areas of concern and identifying an appropriate course of action. *Guidance: E.g. discussion at a safeguarding meeting or supervision.*	
5.8	**1**	Parent-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.	

5.9	**1**	**A risk assessment of patient and infant is undertaken during the initial assessment process and if the patient's condition changes. This should include:**	
5.9a	**1**	Disclosures of harmful or potentially harmful acts.	
5.9b	**1**	Any delusions / overvalued ideas or hallucinations involving the pregnancy, infant or other children.	
5.9c	**1**	Any thoughts, plans or intentions of harming the pregnancy, infant or other children. *Guidance: The assessment should consider that the phenomena could be intrusive obsessional thoughts.*	
5.9d	**1**	Hostility, irritability and/or rejection towards the unborn baby, infant or other children.	
5.9e	**1**	Any involvement with Children's Social Care. *Guidance: For example, an unborn baby, infant or older children subject to Child Protection Plan, childcare proceedings or child protection concerns.*	
5.9f	**1**	Any concern about any other person who may pose a risk to the unborn baby, child or other children. *Guidance: This includes anyone on the Sex Offender's Register, anyone with a drug/alcohol dependency, anyone with supervised access to children or anyone who has been refused access to other children.*	
5.9g	**1**	The patient's thoughts and behaviours about estrangement from the baby and severe maternal inadequacy.	
5.10	**2**	The risk assessment tool is designed or modified for use by perinatal community mental health services.	
5.11	**1**	At each stage of care and risk assessment, consideration is given as to whether it is appropriate to initiate a Common Assessment Framework/Early Help Referral (or local equivalent) to better assess any additional needs the baby or older children of the family may have.	
5.12	**1**	**Case notes include:**	
5.12a	**1**	Any maternal concerns in relation to the pregnancy/childbirth/infant.	
5.12b	**1**	Their care of the pregnancy/infant.	

5.12c	**1**	Their enjoyment of the pregnancy/infant.	
5.12d	**1**	If the infant is absent from an appointment, the reason why is recorded.	
5.13	**1**	Where the service is prescribing psychotropic medication for breastfeeding patients, it is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration.	
5.14	**2**	If a patient and infant or older children are seen in an outpatient clinic or other mental health facility, the waiting area is appropriate for the use of the perinatal service during that session.	
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 mental health team is part of the trust-wide safeguarding group.	

Section 6: Staffing and Training

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
6.1		**The multi-disciplinary team comprises, as a minimum (per 10,000 births):** *Guidance: All teams ought to complete 6.1 regardless of offering.*	
6.1a	**1**	1 WTE Consultant Perinatal Psychiatrist input. *Guidance: This should be comprised of no more than two Consultant Perinatal Psychiatrists.*	
6.1b	**2**	1 WTE Non-consultant Psychiatrist input.	
6.1c	**1**	5 WTE Perinatal Community Mental Health Nurses. *Guidance: This ratio should be adjusted based on geographical area.*	
6.1d	**2**	0.5 WTE Social Worker. *Guidance: This should be one Social Worker.*	
6.1e	**1**	1 WTE Consultant Clinical or Counselling Psychologist *Guidance: The psychologist provides the psychological professions team with strategic leadership, professional support and accountability.*	
6.1f	**2**	2 WTE psychological professionals *Guidance: This can include:* • *CBT therapist* • *Systemic psychotherapist* • *Adult psychotherapist*	
6.1g	**1**	2.5 WTE Nursery Nurses.	
6.1h	**1**	1 WTE Occupational Therapist.	
6.1i	**1**	1 WTE Administrator (band 3 or above, or local equivalent).	**19.4**
6.2		**For teams providing a service up to 24 months postpartum, the multi-disciplinary team comprises, as a minimum (per 10,000 births):** *Guidance: Standards 6.2a - 6.2k can be scored as N/A for services not currently providing a service up to 24 months postpartum.*	

6.2a	**2**	2.5 WTE Consultant Perinatal Psychiatrist	
6.2b	**3**	2.5 WTE non-consultant Psychiatrist	
6.2c	**2**	8 WTE Perinatal Community Mental Health Nurses *Guidance: This ratio should be adjusted based on geographical area.*	
6.2d	**3**	2 WTE Social Worker *Guidance: This should be comprised of no more than two Social Workers*	
6.2e	**3**	5 WTE additional psychological professionals. *Guidance: This could include counselling psychology, CBT therapist, systemic psychotherapist and adult psychotherapist. This would be in line with the objectives set out in the NHS Long Term Plan.*	
6.2f	**3**	2 WTE Team Manager. *Guidance: This could include 1 WTE Band 8a managerial, 0.5 WTE Band 7 deputy and 0.5 WTE clinical/managerial.*	
6.2g	**2**	4 WTE Nursery Nurses	
6.2h	**2**	2 WTE Occupational Therapists	
6.2i	**3**	4 Peer support workers (band 4 or above or local equivalent) *Guidance: This should include a peer support lead.*	
6.2j	**2**	5 WTE Administrator (band 3 or above or local equivalent)	
6.2k	**2**	1.0 WTE Specialist Pharmacist *Guidance: This role should be provided by a clinical pharmacist with perinatal mental health expertise. The pharmacist contributes to prescribing decisions, patient and carer counselling, staff education, complex risk–benefit assessments, and safeguarding of medication use.*	
6.3	**1**	The team has a dedicated specialist team manager.	
6.4	**2**	The team have dedicated staff who deliver parent-infant therapy.	

		Guidance: Staff who deliver parent-infant interventions should have appropriate training and receive regular supervision from a psychological professional.	
6.5	**3**	The team has access to Allied Health Professionals to meet a range of patient needs that may be identified as part of care and treatment planning. There is sufficient sessional time and/or a pathway/shared care arrangements in place to draw on these staff on an as needed basis. *Guidance: As a minimum, this includes dietetics, physiotherapy and speech and language therapy with appropriate experience in mental health.*	**5.4**
6.6	**1**	There are written documents that specify professional, organisational and line management responsibilities.	
6.7	**1**	The service has a mechanism for responding to low/unsafe staffing levels, for example, when they fall below minimum agreed levels and/or waiting times or caseload size rises above agreed thresholds. The mechanism includes: • 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. **Sustainability Principle: Empowering Staff**	**19.1**
6.8	**1**	When a staff member is on leave (planned or unplanned), the MDT provides adequate cover for the patients who are allocated to that staff member to support continuity of care. *Guidance: Services may use systems such as buddy or associate systems to operationalise how caseload cover is provided during leave.*	**19.2**
6.9	**2**	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: These representatives should have experience of the relevant service.* **Sustainability Principle: Empowering Individuals**	**20.1**
6.10	**1**	There is an identified senior clinician available at all times who is available on the phone or at the team base within an hour. Video consultation may be used in exceptional circumstances.	**19.3**

		Guidance: Some services may have an agreement with primary care to provide this cover.	
6.11	**1**	Staff members receive an induction programme specific to the perinatal mental health service, which covers key information including: • The team's mission statement and core identity; • Aims of the service; • Key policies; • Referral and care pathways. *Guidance: This induction should be over and above the mandatory trust or organisation-wide induction programme.*	
6.12	**1**	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes 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.	**20.2**
6.13	**2**	All new staff members are allocated a mentor to oversee their transition into the service. *Guidance: A mentor does not need to be a formal supervisor and may be an established member of the team who has experience in perinatal mental health.*	
6.14		**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:** *Guidance: Teams should review the need for refresher trainings at regular intervals to ensure staff competencies remain current.*	
6.14a	**1**	The use of relevant mental health, human rights and capacity legal frameworks.	**22.1.1**
6.14b	**1**	Physical health assessment. *Guidance: This includes basic life support, understanding physical health problems in pregnancy and the early postnatal period, including common long-term conditions, physical observations and when to refer the patient for specialist input.*	**22.1.2**
6.14c	**1**	Safeguarding vulnerable adults and children (including the unborn child).	**22.1.3**

		Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect and includes identifying and responding to domestic violence. **Sustainability Principle: Prioritise Prevention**	
6.14d	**1**	Risk assessment and risk management. *Guidance: This includes assessing, formulating and managing risk to self, from self-neglect, from others, to others, and from unintended consequences of healthcare and treatment. The training updates staff members on evidence regarding changing patterns and trends in the populations they work with.*	**22.1.4**
6.14e	**1**	The range of perinatal disorders and normal emotional changes in pregnancy and after birth.	
6.14f	**1**	Basic infant development including emotional developmental milestones. *Guidance: This should be refreshed annually.*	
6.14g	**2**	Supporting parents in a culturally sensitive way with particular relevance to the local population.	
6.14h	**1**	Understanding and promoting parent-infant interaction and relationship. *Guidance: This should be refreshed annually.*	
6.14i	**2**	Infant mental health training. *Guidance: This can be accessed locally or from designated providers.*	
6.14j	**1**	Cognitive impairment, learning disability and autism. This includes awareness of neurodiversity, how to interact appropriately with autistic people and people who have a learning disability and clinical differences in these populations, e.g. how symptoms or risk may present differently.	**22.1.5**
6.14k	**2**	Trauma-informed care.	**22.1.6**
6.14l	**2**	Identification of co-occurring substance use with specific focus on alcohol and commonly used drugs. This may include updates on substance misuse trends, awareness of evidence-based brief interventions and harm reduction advice.	**22.1.7**

6.14m	**1**	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (this is updated at least annually).	
6.14n	**2**	Contraception and sexual health.	
6.14o	**2**	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care including cultural competence and awareness of the importance of faith/spirituality. *Guidance: Training should address all nine protected characteristics and their relevance to delivering equitable mental health care.*	**22.1.8**
6.14p	**1**	Carer awareness, family inclusive practice and social systems, including partner/family members' rights in relation to confidentiality.	
6.14q	**1**	Infant feeding (including breastfeeding). *Guidance: This should be refreshed annually.*	
6.14r	**2**	Staff who use clinical outcome measures have received relevant training.	
6.15	**1**	Peer support workers are provided with a bespoke training programme appropriate to their role, which includes: • Listening and facilitation skills; • Negotiating boundaries; • Common issues relating to perinatal mental health.	
6.16	**2**	Patient and carer representatives are involved in delivering and developing staff training.	**22.3**
6.17	**1**	All clinical staff members receive formal individual 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. Clinical supervision should be in addition to managerial supervision. If the two are provided together, there is a clear differentiation between them.*	**20.3**

6.18	**2**	All staff members receive individual line management supervision at least monthly. *Guidance: Managerial supervision should be in addition to clinical supervision. If the two are provided together, there is a clear differentiation between them.*	**20.4**
6.19	**2**	Staff members in training and newly qualified staff members receive weekly supervision, in line with professional requirements. *Guidance: The duration of this will be agreed with supervisor and supervisee at the beginning and be in line with the new starter's needs.*	
6.20	**1**	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs, and should be informed by self-assessment against an agreed competency framework.*	
6.21	**2**	The team holds business meetings at least once a month.	
6.22	**3**	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	
6.23	**2**	Frontline staff members are involved in key decisions about the service provided.	
6.24	**1**	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that frontline staff members find accessible and easy to use.	
6.25	**1**	The team has access to office accommodation and clinical spaces which meets the needs of the service model and patient cohort. *Guidance: This can be split across different bases.*	**17.4**
6.26	**1**	There are sufficient IT resources to provide all practitioners with easy access to key information.	
6.27	**1**	Staff members are easily identifiable to patients (for example, by wearing appropriate identification).	
6.28	**1**	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include:	**17.5**

		• Having a lone working policy in place; • Conducting a risk assessment; • Identifying control measures that prevent or reduce any risks identified.	
6.29	**1**	The service actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.* **Sustainability Principle: Empowering Staff**	**21.1**
6.30	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	**21.2**
6.31	**2**	There is regular reflective practice available of sufficient frequency to ensure that all staff can access this at least every six weeks. *Guidance: Reflective practice is facilitated by someone with experience in managing a group process.* **Sustainability Principle: Empowering Staff**	**18.1**
6.32	**2**	Peer support workers have access to group supervision with others in similar roles.	
6.33	**1**	Staff members, patients and carers who are affected by a serious incident are offered post-incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.* **Sustainability Principle: Empowering Staff**	**21.3**
6.34	**1**	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	**18.4**

6.35	**2**	Those in service and team leadership roles are visible and present at the team base and actively role model and promote an open learning culture. They are confident and competent in both listening up and following up in line with Freedom to Speak Up principles. *Guidance: Staff know that incident reporting, learning from incidents and responsiveness to feedback are leadership priorities. If staff raise concerns, they are confident their leadership will address them.*	**18.2**
6.36	**3**	The team has a system for reviewing culture in the team and takes action on findings. *Guidance: This may include reviewing incident data, patient and partner/chosen other feedback, staffing and employee relations data and/or use of a validated staff survey, culture of care or safety culture tool/survey.*	**18.3**
6.37	**3**	In-house multi-disciplinary team education and practice development activities occur in the service at least every three months. *Guidance: This should be available to all staff, including healthcare assistants, nursery nurses and peer support workers.*	
6.38	**2**	The team has protected time for team building and discussing service development at least once a year.	

Section 7: Recording and Audit

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
7.1	**1**	The team reviews demographic data at least annually about the people who use the service. Data are compared with local population statistics and action is taken to address any inequalities of access that are identified.	**1.1**
7.2		**The service evaluates annually:**	
7.2a	**2**	Feedback from referrers.	
7.2b	**2**	Feedback from service staff.	**19.2**
7.2c	**2**	Analysis of complaints.	**19.3**
7.2d	**2**	The findings of audits.	
7.2e	**2**	Key performance data (e.g. number of referrals, reasons for declined referrals and outcome measurement data).	
7.2f	**1**	Patients involved in Care Proceedings / Child Safeguarding Protection Plans.	
7.2g	**3**	Data on the demographic breakdown in their area. *Guidance: Teams should take meaningful action to address inequality and improve access.*	
7.3	**2**	The team has embedded standard operating processes and clinical governance to: • Hold oversight of and manage size and clinical need of caseloads; • Hold oversight of and manage size and safety of waiting lists.	**8.2**
7.4	**2**	Action plans are developed based on the service evaluation and resulting quality improvement is monitored.	
7.5	**2**	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders could include staff member representatives from inpatient, community and*	

		primary care teams as well as patient and partner/chosen other representatives.	
7.6	**1**	The service's clinical outcome data are collated, analysed and reported at least bi-annually (every 6 months). Access, experience and outcomes data are shared with commissioners, the team, patients and partners/chosen others, and used to make improvements to the service.	**23.3**
7.7	**1**	Systems are in place to enable staff members to report incidents quickly and effectively, and managers encourage staff members to do this.	**24.1**
7.8	**1**	When serious mistakes are made in care, this is discussed with the patient and their partner/chosen other, an apology given and actions taken as appropriate to mitigate the outcome of the mistake and/or prevent its recurrence. Any safeguarding concerns that have arisen through the incident are raised and processed in line with policy.	**24.2**
7.9	**1**	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	**24.3**
7.10	**1**	Any serious untoward incident, including those involving a child and any emergency child protection order, is reviewed within six weeks and chaired by a suitably qualified clinician external to the service.	
7.11	**1**	The service asks patients and partners/chosen others for their feedback about their experiences of using the service and this is used to improve the service. **Sustainability Principle: Empowering Individuals**	**12.1** 
7.12	**1**	Feedback received from patients and partners/chosen others is analysed to identify any differences of experiences by protected characteristics. *Guidance: Complaints, compliments and other feedback sources include the option to share demographic information.*	**12.2**
7.13	**2**	Services are developed in partnership with patients and partners/chosen others who have relevant lived experience, and who take an active role in informing decision-making.	**12.3**
7.14	**2**	The team is actively involved in QI activity. *Guidance: This may include audits, developing policies/protocols, activities around development of*	**24.4**

		service and involving patients and partners/chosen others. **Sustainability Principle: Improving Value**	
7.15	**2**	The team actively encourages patients and partners/chosen others to be involved in QI initiatives.	**24.5**
7.16	**2**	The team reviews its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services. Progress against the plan is reviewed at regular time points throughout the year and the plan is refreshed annually. *Guidance: Good practice includes adopting practices in line with recommendations in RCPsych Net Zero Guidance. This may include, for example, assigning a Sustainability Champion role, staff undertaking training in sustainable practice, developing a green transport plan for the team, reviewing practices to improve continuity of care.* **Sustainability Principle: Consider Carbon**	**18.5** 
7.17	**3**	The organisation has a research friendly culture which provides staff with the opportunity to take part in research projects.	
7.18	**3**	The team consistently records the provision of psychological interventions using standardised SNOMED CT codes to support local audit, national reporting and improvements in patient outcomes.	

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