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Perinatal Mental Health Network Scotland
National Managed Clinical Network

Delivering Effective Services:

Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services

- Working in Partnership
- Developing Professional Expertise
- Ensuring Equity of Care
- Delivering Best Outcomes

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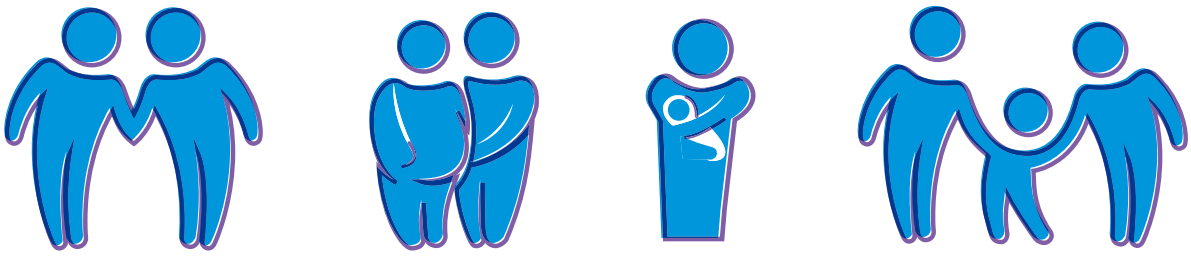

1. Executive summary

This report draws on the findings of the Perinatal Mental Health Network's NHS board visits, professionals' workshops and online survey of women's views, conducted in 2017-18, and the existing evidence base on service provision, to make recommendations on what services Scotland should develop to meet the needs of mothers with mental ill health, their infants, partners and families. It specifically addresses the Scottish Government's commitment that:

- *For those 11,000 women a year who would benefit from help such as counselling we will support the third sector to provide this*
- *For those 5,500 women in need of more specialist help we will ensure rapid access to psychological assessment and treatment*
- *For those 2,250 women with the most severe illness, we will develop more specialist services and consider the need for a small number of additional inpatient beds or enhanced community provision*

Programme for Government, 2018

The report makes recommendations across all tiers of service delivery, with the aim of ensuring that Scotland has the best services for women with, or at risk of, mental ill health in pregnancy or the postnatal period, their infants, partners and families. It places particular emphasis on the development of expertise by all professionals involved in maternal and infant mental health care and the importance of close working links between different services that women encounter. It aims to ensure that women receive the right level of clinical expertise and seamless care, wherever they live in Scotland. It recognises the need not only to care for the woman experiencing ill health, but also to promote best outcomes for her infant and support for fathers, and others who are parents, in their own right.

The report should also be seen as complementing the work of the Best Start 5-Year Plan for Maternity and Neonatal Services and the Children and Young People's Mental Health Task Force.

We would like to thank the professionals and the women with lived experience, and their families, who contributed to our needs assessment exercise. Our visits, workshops and survey were met with enthusiasm, a real drive to see things improve, and a refreshing honesty about what is not yet right. We take sole responsibility for our conclusions but could not have completed this work without their help and support.

Roch Cantwell
Lead Clinician, Perinatal Mental Health Network Scotland

2. Introduction

Mental distress and illness are common in pregnancy and the first postnatal year, affecting up to one in 5 women, and the period after childbirth is a uniquely vulnerable time for development of severe mental illness for certain groups of women (Jones et al, 2014). The consequences of perinatal mental illness may be severe. Mental health related deaths are now the leading cause of maternal death in the first postnatal year (Cantwell et al, 2018). Men may also be more vulnerable to illness at this time and there is evidence that untreated maternal mental illness may adversely affect the mother-infant relationship and infant development (Stein et al, 2014).

The way in which services are traditionally organised is not responsive to the needs of pregnant and postnatal women. Where women require inpatient care, they should be admitted with their infants to facilities that can ensure the baby is safely cared for, avoiding disruption to the developing mother-infant relationship. This is a legal requirement in Scotland (Mental Health (Scotland) Act, 2015). In community services, there is a need to respond rapidly to the timescales imposed by pregnancy and critical developmental stages in early infancy. Services require altered thresholds for referral, taking into account the particular demands brought about by pregnancy and caring for an infant.

The recognition that Adverse Childhood Experiences (ACEs) have a lasting impact on both mental and physical health has led to the development of prevention and early intervention services in at-risk populations, and trauma-informed therapeutic interventions for children and adults. ACEs are stressful or traumatic experiences occurring in childhood. They include abuse and neglect, and the experience of growing up in households experiencing adversity or where a parent is mentally unwell. Childhood adversity can create harmful levels of stress which impact on brain development and result in learning and behavioural difficulties. In perinatal mental health services attention should be paid to women and other family members who may have a history of ACEs, and infants whose risk of experiencing ACEs is high.

Those working with pregnant and postnatal women have a unique opportunity to prevent the development of illness in some women at highest risk and to improve outcomes for children growing up. There is good evidence that early intervention has better, and more cost-effective outcomes than later attempts to address child mental health problems.

In addition to maternal mental illness and the importance of promoting good infant mental health, there is an increasing understanding of the vulnerability of partners at this time. Five to 10% of fathers may develop mental health problems in the perinatal period (Cameron et al, 2016) and they require support in their own right and as parents.

Knowledge and skills required by those working with pregnant and postnatal women extend to an understanding, not just of adult mental health, but also of infant development and parent-infant relationships. Particular knowledge is required in relation to prescribing in pregnancy and breastfeeding and the timely provision of psychological therapies (SIGN, 2012; NICE, 2014).

The perinatal period is perhaps one of the most important in parents' lives. Those working with women and their families at this time have a duty to work in partnership with the woman and to respect her need to have information and care which allows her to make the best decisions for herself, her pregnancy, her infant and family.

3. The needs assessment exercise

3.1 NHS board visits

Beginning in October 2017, the Network visited all NHS boards in Scotland to meet with professionals from mental health, maternity, health visiting, primary care and the third sector, and with women with lived experience and their families. All others with an interest in perinatal mental health were also welcome to attend. Each meeting had three broad aims:

- to assess the need for, availability and uptake of education and training in perinatal mental health
- to explore local pathways to assessment and care for women experiencing perinatal mental health problems
- to identify any specialist service provision, including links to regional inpatient specialist care

In general, requests to visit were met with enthusiasm and excellent attendance, and staff universally welcomed the opportunity to hear about each other's services and to have shared learning.

All boards had made efforts to address perinatal mental health issues. Larger boards had developed specialist teams and smaller boards had identified staff within existing community mental health teams (CMHTs) who had a special interest in perinatal mental health. The island boards, with very low birth numbers, had identified the importance of joint working between mental health, maternity and primary care, and of additional education and training in perinatal mental health. In most instances, special interest posts had been developed by individuals with enthusiasm and drive, but these were rarely supported by matched resources. In almost all board areas services were vulnerable to loss of staff members critical to effective functioning, leading, in a number of instances, to discontinuities or suspension of specialist care.

3.2 Professionals' workshops

Half-day workshops were conducted with individual specialist groups, including midwives, health visitors, perinatal mental health nurses, mother and baby unit staff, clinical psychologists from perinatal mental health specialist services and from maternity and neonatology services, perinatal mental health occupational therapists, social workers and the third sector.

3.3 Online survey

An online survey of women's experiences of services for perinatal mental health was undertaken in collaboration with the Maternal Mental Health Scotland Change Agents, a group of women (and, in some instances, other family members) with lived experience who campaign for improved services. It provided evidence that women most value consistency of care during their antenatal and postnatal period, that they want to have information on which to make decisions about mental health treatments in the perinatal period and that they wish to feel comfortable about discussing emotional issues with professionals who have an understanding of mental health.

If it wasn't for a self-referral to [the counselling] service in Glasgow I wouldn't be here. I'm still recovering but I'm stronger because of 3rd sector support.

The … MBU was fantastic but getting access to it was hard.

My life has completely changed for the better after using these services. It has saved my mental wellbeing and the happiness of myself and my family.

The biggest single factor in my becoming unwell in pregnancy was the GP insisting that I had to come off my antidepressants, not replacing it with a more suitable one, not consulting a psychiatrist.

4. What does Scotland have now?

4.1 Mother and baby units

4.1.1 Current provision

There are two regional 6-bed mother and baby units (MBUs), at St John's Hospital, Livingston and Leverndale Hospital, Glasgow, giving a total of 12 beds for Scotland. They provide care for women with severe mental ill health, alongside their infants. There are different arrangements for the commissioning and oversight of each MBU. All but two NHS boards have formal arrangements for admitting to one or other MBU. NHS Grampian and NHS Forth Valley access beds on an ad hoc arrangement. The two MBUs work closely together to ensure that women in need are admitted to a unit irrespective of area of residence, though there are no underpinning formal arrangements.

Staffing levels varied significantly between the two MBUs. Neither unit is resourced across all disciplines to provide fully comprehensive care.

Current MBU staffing		
Discipline	**WTE St John's Hospital, Livingston**	**WTE Leverndale Hospital, Glasgow**
Consultant Psychiatrist	0.8	0.5
Junior Psychiatrist	0.5	0.5
Nurse Consultant	-	0.2
Senior Charge Nurse (Band 7)	1.0	1.0
Charge Nurse (Band 6)	2.0	1.0
Clinical Psychologist (Band 8C)	0.48	0.5
Occupational Therapist (Band 6)	0.13	0.5
Social Worker	0.4	0.5
Mental Health Nurse (Band 5)	8.6	6.8
Nursery Nurse (Band 4)	3.72	3.7
Health Care Assistant (Band 3)	3.28	1.0
Health Visitor (Band 6)	0.2	0.2
Administrative staff (Band 4/3)	0.4	0.5
Total WTE	21.51	16.9

Together, the two MBUs had 115 admissions per year (averaged over 3 years). Activity levels were similar for each unit (54 admissions to St John's; 62 admissions to Leverndale). The average lengths of stay were 27.0 days (St John's) and 29.25 days (Leverndale). There was clear evidence that MBUs were often full and unable to take admissions. For example, the St John's MBU was fully occupied for 49% of the time between January 2016 and November 2017. The Leverndale MBU had 44 patients who could not be immediately admitted in 2018.

NHS board source and rate of admissions is given below. There are higher rates of admission for boards which host an MBU, which may be a reflection of improved detection, local awareness of the service or ease of access for women and families.

MBU admissions by board of residence				
NHS board	Total admissions 2016-2018	Average admissions per year	Births numbers (2017)	Rate of admissions per 1,000 births per year
Ayrshire & Arran	10	3.3	3,281	1.0
Borders	7	2.3	989	2.3
Dumfries & Galloway	1	0.3	1,248	0.2
Fife	20	6.7	3,465	1.9
Forth Valley	7	2.3	2,907	0.8
Grampian	19	6.3	5,917	1.1
Greater Glasgow & Clyde	138	46	12,126	3.8
Highland	4	1.3	2,754	0.5
Lanarkshire	29	9.7	6,763	1.4
Lothian	87	29	9,037	3.2
Orkney	0	0	184	0
Shetland	0	0	218	0
Tayside	19	6.3	3,757	1.7
Western Isles	0	0	215	0
Other UK and unknown	4	1.3	-	-
Total	345	115	52,861	2.2*

*Calculated excluding other ‘UK and unknown’ admissions

Overall, there was a high level of satisfaction across partner NHS boards with the care provided by the regional MBUs, and good liaison between MBUs and local clinicians in the management and discharge planning of women admitted with their infants. Both MBUs have accreditation from the Royal College of Psychiatrists’ Perinatal Quality Network.

4.1.2 Common themes

Boards hosting a regional MBU	• There was very limited, or no, specialist infant mental health input to the MBUs. • There was limited capacity to provide a range of mother-infant psychological interventions.
Boards with formal MBU access	• Beds were not always immediately available. There was a perception in some board areas that lack of availability could be due to MBUs accepting admissions from boards without a service level agreement. • For some boards, distance from an MBU was a disincentive for women and their families to take up offer of admission. • For boards with very limited community provision, ensuring timely support for periods of leave from hospital and for discharge could be a problem.
Boards without formal MBU access	• There was a recognition of lack of equity of access given that MBUs would prioritise admissions from boards with whom they have a contract. MBUs may also not give a 'last bed' to a board without a service level agreement.

4.2 Specialist community perinatal mental health services

4.2.1 Current provision

Four NHS boards currently provide multidisciplinary specialist stand-alone teams for perinatal mental health. However, none is resourced across all disciplines to provide fully comprehensive care. Two of the 4 fall significantly short of recommended provision both in terms of staffing and function. All other boards, with the exception of those with very low birth numbers, have some provision, though this is not always ring-fenced or specifically funded.

Description	Boards	Birth numbers (2017)
Boards with multidisciplinary specialist community teams	Greater Glasgow & Clyde	12,126
	Lothian	9,037
	Lanarkshire	6,763
	Grampian	5,917
Boards with protected multidisciplinary sessions and a core team	Forth Valley	2,907

Boards with one or more members of mental health staff identified as having a special interest in perinatal mental health	Tayside	3,757
	Fife	3,465
	Ayrshire & Arran	3,281
	Highland	2,754
	Dumfries & Galloway	1,248
	Borders	989
Boards without special interest provision for perinatal mental health	Shetland	218
	Western Isles	215
	Orkney	184

4.2.2 Common themes

Boards with multidisciplinary specialist community teams	• No service was resourced across all disciplines to provide comprehensive care. This was particularly (though not exclusively) the case for psychological therapy provision.
Boards with protected multidisciplinary sessions and a core team	• Provision of a core dedicated team with protected time for workers in CMHTs provided a robust service model
Boards with one or more members of mental health staff identified as having a special interest in perinatal mental health	• Most special interest posts in perinatal mental health, with notable exceptions, were not ringfenced either for clinical time or clinical supervision. • Staff had very limited or no opportunity to meet for peer supervision and learning. • There was often a lack of clinical leadership for perinatal mental health.
Boards without special interest provision for perinatal mental health	• Community mental health staff had very limited or no access to specialist advice or supervision. • There was enthusiasm for improved regional links and use of telemedicine.
Other themes	• There was very limited, or no, infant mental health provision in most NHS board areas.

4.3 Infant mental health

Health visitors and family nurses (Family Nurse Partnership, FNP) attended a number of the board visits. Health visiting provides a universal service and has a central role in addressing the mother-infant relationship and infant development. A universal pathway was launched in 2015 to ensure continuity of care from the antenatal period to pre-school age for all families, with an emphasis on prevention and early detection of difficulties (Scottish Government, 2015). This work is underpinned by the Getting It Right For Every Child (GIRFEC) model of practice, which should inform all professionals in their care of infants and children.

Family Nurses have a supervision structure which allows them to support women and infants with complex needs, with a focus on the mother-infant relationship and infant development. However, the role is currently restricted to engagement with first-time mothers aged 19 years and under.

There is a range of provision focussing on the mother-infant relationship, and on infant development, within existing perinatal mental health services. Team members have additional training in infant mental health, including undertaking the NES e-learning module, Solihull Approach training and, in some areas, providing infant massage, video interactive guidance and other interventions.

It is clear however, that the lack of appropriately skilled practitioners within teams prevents access to parent-infant interventions for more complex difficulties and to address preparation for parenthood and parenting in women with significant mental disorder.

Outwith perinatal mental health teams, child and adolescent mental health services (CAMHS) rarely, if ever, had the capacity to assess and manage children under one year. A small number of NHS boards had developed parent-infant mental health services, often driven by enthusiastic and skilled individuals, but these services remain vulnerable and, in some cases, unsustainable.

4.4 Specialist midwives

Three NHS boards have appointed specialist midwives in perinatal mental health (NHS Grampian, Lanarkshire and Tayside). There was a lack of clarity about the role in two areas. Only NHS Grampian provided the specialist midwife with a formal link into the local perinatal mental health service and supervision for their mental health role. However, at the time of visiting, this link was vulnerable given lack of sustainability of the specialist team.

Other board areas had made provision for midwives with a special interest in vulnerable pregnancy, particularly (though not exclusively) with regard to substance misuse (e.g., Special Needs in Pregnancy Service (SNIPS) in Greater Glasgow and Clyde, Vulnerable in Pregnancy (VIP) Project in Fife and PrePare Service in Lothian). These services are multidisciplinary in nature and respond to the needs of women who will often have significant social disadvantage and comorbid mental illness.

There are a number of midwives throughout Scotland who have developed a special interest in perinatal mental health, often driven by individual enthusiasm but not provided for in a sustainable way by boards.

4.5 Maternity and neonatal psychological services

Maternity and neonatal psychological services provide interventions which address psychological need for parents with previous or current pregnancy and neonatal complications, or who have mental health problems which directly affect maternity care. Where these services currently exist, they are provided by a single professional discipline, clinical psychology. Most board areas make no specific provision for psychological interventions within maternity or neonatal services and only NHS Greater Glasgow and Clyde has dedicated provision for maternity services.

Current maternity and neonatal psychological therapies provision		
NHS board	**Service**	**Staffing (WTE)**
NHS Ayrshire & Arran	Neonatal Psychology	0.5 Band 8B
NHS Greater Glasgow & Clyde	Maternity and Neonatal Psychology	3.3 (1.3 Band 8C; 1.0 Band 8A; 1.0 Band 7)
NHS Grampian	Neonatal Psychology	0.2 Band 8A
NHS Lanarkshire	Neonatal Psychology	0.4 Band 8A
NHS Lothian	Neonatal Psychology	0.1 Band 8A

4.6 Primary care mental health

General practitioners will provide expert management of mild to moderate psychological distress and disorder and should usually be the initial source of advice and assessment where such difficulties arise in the perinatal period. There was clear feedback from visits however, that GPs would benefit from additional education and training in prescribing during pregnancy and breastfeeding.

NHS provision of evidence-based interventions for mild to moderate mental distress and disorder at universal/primary care level is very variable throughout Scotland. Board responses include the provision of dedicated primary care mental health teams, integration of mental health nurses within GP services, and development of third sector links.

Where specific services exist, they do not always make adjustments for the distinctive presentations in the perinatal period or the timescales imposed by pregnancy and critical periods in child development. Few NHS boards ensured rapid access to appropriate interventions for pregnant or postnatal women.

4.7 Third sector and peer support

There is a range of service provision within the third sector in Scotland directed at providing practical and emotional support, counselling and psychological interventions to women and their families, where there is parental mental distress or disorder. They may also provide interventions to enhance the parent-infant relationship and improve infant outcomes. There are examples of excellent practice, both from Scottish and UK wide organisations, and from local third sector providers.

The main issues arising from the Network's consultation were 'short-termism' in funding structures which can lead to the withdrawal of existing well-functioning services, and the need for improved links between the third sector and perinatal mental health services within the NHS. It was also evident that the sector could benefit from a co-ordinated structure which would strengthen its voice in helping plan equity of counselling provision and development of women led and peer support worker roles in Scotland.

Peer support workers provide help to others based on their shared lived experiences. They can be volunteers or paid employees and can be supported through third sector or NHS structures. Peer support and women led initiatives are an underdeveloped resource in mental health services generally and in perinatal mental health provision in particular. What was evident from those we spoke to during the visits,

is that those providing peer support may require support themselves at times. They also need to know what other resources are available when peer support alone is not sufficient, and how to access them. Properly provided, peer support may be an invaluable resource for women and their families.

The Network worked closely with the Maternal Mental Health Scotland Change Agents, a group of women (and, in some instances, their partners and other family members) who campaign for service development and provide a network of informal peer support. We observed a number of examples where individual members engaged in innovative peer to peer initiatives.

5. What should Scotland have in the future?

5.1 Mother and baby units

5.1.1 MBU functions

There is a legal duty under the Mental Health (Scotland) Act (2015) to provide for joint admission of a mother and baby to suitable facilities, where the infant is under 12 months, and it is in the best interests of both mother and infant.

Standards for MBU care are provided by the Royal College of Psychiatrists' Perinatal Quality Network (2018) and the core functions outlined in the College's Report on Recommendations for the Provision of Services for Childbearing Women (2015).

MBUs should be staffed by a multidisciplinary team which has the skills and capacity to safely assess and manage all women requiring inpatient care, accompanied by their babies up to 12 months of age. They should also be able to admit women in later pregnancy.

Core functions of an MBU team

- Assess and care for women in late pregnancy and postnatal women (to 12 months) with mental disorder who require inpatient care, accompanied by their infants
- Provide care across the range of conditions, complexity and severity usually managed on a general adult mental health inpatient unit
- Be able to respond in a timely manner which takes into account the maternity context, needs of the developing infant, and alterations to presentations brought about by the perinatal period
- Ensure that the infant's health, care and developmental needs are fully met
- Assess the mother-infant relationship and infant development in the context of maternal mental disorder
- Provide a range of biopsychosocial interventions to prevent development of illness in women at high risk and to treat current ill health
- Provide a range of biopsychosocial interventions to support the mother-infant relationship and promote best outcomes for infant development
- Provide advice, support and signposting to partners of women under the care of the service, who may themselves have mental health difficulties, and support the development of the father/partner-infant relationship
- Provide clinical advice and guidance to other mental health, maternity, health visiting, primary care and social care colleagues on the assessment and management of maternal mental disorder
- Provide a leadership role for perinatal mental health service development, pathways into care and education through regional network structures

5.1.2 MBU staffing

The MBU team should include psychiatry, mental health nursing, clinical psychology, parent-infant therapist, nursery nursing, occupational therapist, social work and administrative staffing. The team should have sessional commitment from a health visitor and should have close links with maternity services.

Recommended MBU staffing (based on a 6-bed unit)		
Discipline	**WTE**	**Notes**
Consultant psychiatrist	0.5	
Junior psychiatrist	0.5	Core trainee or non-training grade
Senior charge nurse (Band 7)	1.0	
Charge nurse (Band 6)	2.0	
Consultant clinical psychologist (Band 8C)	0.5	
Occupational therapist (Band 6)	0.5	
Social Worker	0.5	
Parent-infant therapist (Band 7-8C)	0.5	Grading may vary depending on overall provision across the MBU and community team
Mental health nurse (Band 5) - to provide three Band 5 nurses on each day shift and two Band 5 nurses on night shift	14.0	
Nursery nurse (Band 4) - to provide one Band 4 nursery nurse on each day and night shift	5.3	
Health visitor (Band 7)	0.2	
Administrative staff (Band 3-4)	0.5	

In addition, there should be a linked midwife/maternity team who will accept responsibility for the care of patients whose admission to the MBU results in lack of continuity of local maternity care.

There may be some variation in discipline allocation, e.g., use of unregistered mental health nursing staff in certain circumstances or in the banding of psychological therapists, but this should not be to the detriment of breadth of care provided and the overall WTE staffing equivalents should be maintained.

RECOMMENDATION 1. The Scottish Government and NHS boards should ensure that MBUs are staffed at the recommended level to provide a comprehensive clinical service.

There are a number of examples of peer support linking with specialist mental health services to the benefit of the women and families who use them (e.g., that provided by Action on Postpartum Psychosis). While there are excellent examples of peer support in Scotland, links with specialist inpatient and community services could be improved. The Network aims to promote the role of peer support within specialist teams and will explore models of provision in selected services, as they develop.

RECOMMENDATION 2. Specialist perinatal mental health services (MBUs and community teams) should include peer support workers as part of their provision. The Scottish Government should work with NHS boards and third sector funders to review models of peer support to specialist services and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.

5.1.3 Bed requirements and equity of access

In addition to the Network's findings from board visits which suggest that distance and bed capacity acted as barriers to admission, the Mental Welfare Commission (MWC) undertook a national review of admissions of women within 12 months of childbirth. Just over one third of women were cared for in a general adult ward setting, rather than in an MBU (Mental Welfare Commission, 2016). Themes emerging on why women were not admitted to MBU care included (i) distance and family commitments; (ii) women's preferences to be treated without their babies; (iii) women not being the main carers of their babies; and (iv) staff awareness and knowledge of MBUs.

Although distance from an MBU may be a barrier to admission, the particular geographical challenges of remote, rural and island areas mean that siting beds in the north of Scotland may still result in significant distances to travel. Additionally, there is a minimum number of beds per MBU which ensures viability, typically accepted as six or, at an absolute minimum, four.

Based on UK norms and the MWC survey, Scotland remains under-resourced for MBU beds. This is also suggested by the Network's needs assessment exercise. At the lower level of estimation, it is recommended that there is a minimum of 0.25 beds per 1,000 deliveries. For Scotland, this equates to between 13 and 14 beds nationally, meaning that Scotland requires, at minimum, an additional two beds to meet demand. However, NICE recommendations on bed numbers in England (2014) also point to the need to revise estimations upwards to consider issues of distance and population distribution. At best estimates, this would suggest a further 1-2 beds, giving a total requirement for Scotland of 15-16 beds.

To meet this level of need, beds may be provided either within existing MBU(s) or through provision of a third MBU, located in the north of Scotland.

RECOMMENDATION 3. An additional two to four MBU beds should be provided on one or other existing MBU site, divided between both, or in a third MBU located in the north of Scotland. To be viable, a third MBU should have a minimum of four beds. The Scottish Government and NHS boards should conduct an option appraisal to meet this additional need as part of a national implementation plan.

There is an inherent inequity of access brought about by all boards not having service level agreements with one or other MBU. Given the scarce resource and need to base admission decisions solely on clinical need, beds in both MBUs (and any newly developed MBU) should be regarded as provided at national level and available to all who require them based on clinical need. Funding structures should move to a format which recognises MBUs as a national resource. This is in line with provision of other inpatient resources for rare conditions and with MBU provision in other areas of the UK.

RECOMMENDATION 4. All NHS boards should have equity of access to a regional MBU for those women who require inpatient care. The Scottish Government should ensure that MBU beds are provided as a national resource and decisions on admission made exclusively on clinical need.

There remains a need to address issues of distance and family commitments. Partners and families should have access to appropriate accommodation and support so that they can be near the woman and infant, while she receives treatment. Options include providing access to existing family accommodation in children's services and/or adjusting an existing MBU to provide semi-independent accommodation which could be used for family accommodation and for 'step-down' in preparation for discharge.

RECOMMENDATION 5. NHS boards should ensure provision for accommodating partners or other family members near to each MBU where they have to travel long distances.

5.2 Community specialist perinatal mental health services

While existing templates for community service structure and function are well-defined for areas with high birth numbers, these need adjustment to take into account the core functions appropriate to a Scottish setting, including the delivery of training to generic workers, leadership for regional multi-professional networks, and ensuring comprehensiveness and timeliness of psychological interventions for the woman and for the parent-infant relationship.

There are no existing templates for areas with low birth numbers or very dispersed populations, which might struggle to sustain a stand-alone community specialist perinatal mental health team. In these circumstances, a dispersed model has evolved in many board areas. Currently, these models are very vulnerable to loss of staff and require greater sustainability. They also need formal links to neighbouring services for education, training and peer supervision, through a system of regional networks.

In the smallest board areas, and particularly for the island boards, the provision of specialist services should be through the development of additional skills within existing community mental health teams, alongside formal access to specialist advice and clinical supervision with the regional network. This is likely to require some joint funding of specialist posts within a regional multidisciplinary structure, to provide dedicated sessional time.

5.2.1 Specialist team functions

The team should have the skills and capacity to case manage all referrals and to accept referrals directly from primary care, maternity and other mental health services. The team should have additional skills and capacity to lead training and education for maternity, primary care, social work and other mental health staff.

Core functions of a specialist community team

- Assess and care for pregnant and postnatal (to 12 months) women with moderate to severe mental disorder who require secondary care mental health services, adjusting referral thresholds for distinctive perinatal need
- Assess the mother-infant relationship and infant development in the context of maternal mental disorder
- Provide pre-pregnancy advice to women who are at high risk of early postpartum major mental illness
- Prioritise the management of women on leave, or recently discharged, from MBU care
- Provide a liaison service to local maternity units
- Be able to respond in a timely manner which takes into account the maternity context, needs of the developing infant, and alterations to presentations brought about by the perinatal period
- Provide a range of biopsychosocial interventions to prevent development of illness in women at high risk and to treat current ill health
- Provide a range of biopsychosocial interventions to promote the mother-infant relationship and promote best outcomes for infant development
- Provide advice, support and signposting to partners of women under the care of the service, who may themselves have mental health difficulties, and support the development of the father/partner-infant relationship
- Provide clinical advice and guidance to other mental health, maternity, health visiting, primary care and social care colleagues on the assessment and management of maternal mental disorder
- Provide education and training to mental health, maternity, health visiting, primary care and social care colleagues on perinatal mental health
- Provide a leadership role for perinatal mental health service development, pathways into care and education through regional network structures

RECOMMENDATION 6. All NHS boards should have community specialist perinatal mental health provision. The specific model will be dependent on birth numbers, socio-demographic and geographical needs and, for smaller boards, may be provided in part by boards collaborating together through regional structures. Sessional time for some highly specialised staff may also be provided through regional collaboration. The Scottish Government should ensure that implementation of this work and longer-term roll-out is included in a national delivery plan as soon as practicable.

5.2.2 Provision in areas with birth numbers over 5,000/year

There should be a dedicated specialist perinatal mental health team, including psychiatry, community mental health nursing, clinical psychology, parent-infant therapist, community nursery nursing, occupational therapist, social work and administrative staffing. Other professions may also form part of the core team, such as specialist midwives and health visitors.

Recommended specialist community team staffing for delivered populations over 5,000/year		
Discipline	**WTE per 10,000 births[1]**	**Notes**
Consultant Psychiatrist	1.0 (+0.1/0.2)	Add 0.1-0.2 WTE to calculated WTE for education/ training responsibilities and regional role[2]
Junior Psychiatrist	1.0	This may be a core trainee or non-training grade
Nurse Consultant (Band 8B)	1.0	Three regional posts in total[3]
Nurse Team Leader (Band 7)	1.0	
Mental Health Nurse (Band 5-6)	5.0	Either all Band 6 or a mix of Bands 6 and 5
Consultant Clinical Psychologist (Band 8C)	0.5 (+0.1/0.2)	Add 0.1-0.2 WTE to calculated WTE for education/ training responsibilities and regional role[2]
Clinical Psychologist (Band 8A-8C) [4]	2.0	
Parent-Infant Therapist/Lead (Band 8A-8C)	0.5 (+0.1/0.2)	These staff may come from a variety of professional backgrounds.[5]
Occupational Therapist (Band 6)	1.0	
Nursery Nurse (Band 4)	2.5	
Social Worker	0.5	
Administrative Staff (Band 3-4)	2.0	

[1] Birth numbers of 10,000 per year would be expected to generate 300-500 new assessments. However, it should be borne in mind that large metropolitan areas will have drift in of births from neighbouring areas and so may require higher overall staffing for their maternity liaison role.

[2] 0.1 or 0.2 WTE dependent on the extent of local or regional education/training roles and leadership of regional networks.

[3] There should be three regional posts, two hosted/co-located with existing MBU services and one within northern regional structures (and hosted/co-located with a third MBU, if provided).

[4] The clinical psychologist provision is within the range recommended in the British Psychological Society report on perinatal provision (2019) and significantly above that recommended by the RCPsych Perinatal Quality Network Standards and College Report 197 (2015).

[5] Parent-infant therapists are likely to have a regional clinical advisory role. Where this is the case, boards should consider providing additional sessional time funded through regional structures.

In addition, Specialist Midwives and Specialist Health Visitors may be appointed by maternity and primary care services. They should have explicit links with, and access to mental health supervision from, the specialist community team.

There may be some variation around these figures to take into account factors such as local geography (e.g., travel times for home assessments), drift in to larger metropolitan maternity units, socio-economic deprivation and number and siting of maternity units. There may also be some variation in discipline allocation, e.g., between mental health nurse and nursery nurse split, using health care assistants in some instances or adjusting the ratio of clinical psychology grades or professional mix of psychological therapists, but this should not be to the detriment of breadth of care provided and the overall WTE staffing equivalents should be maintained.

The Network also recommends that specialist community services should consider including peer support workers, who provide help to others based on their shared lived experiences, as part of the team. They can be volunteers or paid employees and can be supported through third sector or NHS structures. The Network aims to promote the role of peer support within specialist teams and will explore models of provision in selected services, as they develop. (See Recommendation 2)

Appendix 3 provides existing team staffing for boards with birth numbers greater than 5,000/year and what is required to achieve recommended levels.

RECOMMENDATION 7. All NHS boards with birth numbers over 5,000/year should have a multidisciplinary community perinatal mental health team which has the skills and capacity to assess and care for pregnant and postnatal women (to 12 months) who require secondary care mental health services.

5.2.3 Provision in areas with delivered populations under 5,000/year

These areas include the majority of boards in Scotland. Some may find that their birth numbers, geography and existing service provision are best suited to developing a stand-alone community perinatal mental health team as already described. If so, staffing profiles and numbers should follow the guidance given above.

For most however, a dispersed model of care will be more appropriate. This should be provided as follows:

Dispersed model of specialist community team provision

- The core element of the team will consist of a consultant psychiatrist, senior mental health nurse (Band 7) and consultant clinical psychologist (Band 8C) with protected time for specialist perinatal mental health provision. Time allocated should be based on the staffing levels per 10,000 births given in the stand-alone team model above. However, no post should be provided at less than 0.2 WTE.
- Core team members will provide clinical supervision, support and case management to dispersed team members
- The dispersed element will comprise community mental health nursing staff (Band 6), with protected time for perinatal mental health, identified in each adult CMHT. Sessional time will be based on staffing levels for stand-alone teams.
- All team members should have an additional session of protected time at least once weekly for multidisciplinary team meetings (including clinical supervision, case discussion, administrative tasks and learning)
- The team should have access to additional support from occupational therapy, mental health social work and administrative staff. These may be identified within existing CMHT staff but should have additional protected time for specialist provision at a rate in proportion to that specified for the stand-alone team model. They should also have time protected for multidisciplinary team meetings.
- Parent-infant mental health specialist advice and guidance should be available on a regional basis

The team should have the skills and capacity to case manage all (or, at minimum, more complex/high risk) referrals and to accept referrals directly from primary care, maternity and other mental health services. The team should have additional skills and capacity to lead training and education for maternity, primary care, social work and other mental health staff. The core functions are the same as those for a stand-alone specialist team, but there may be greater shared care with the woman's local adult mental health team. Dispersed teams should also consider how peer support workers could contribute to service provision.

Appendix 4 provides existing team staffing for boards with birth numbers under 5,000/year and what is required to achieve recommended levels.

RECOMMENDATION 8. All NHS boards with birth numbers under 5,000/year should have either a stand-alone or dispersed multidisciplinary community perinatal mental health team which has the skills and capacity to assess and care for, at a minimum, pregnant and postnatal women (to 12 months) who have more complex or high-risk presentations.

5.2.4 Provision in island boards and very low birth number areas

Island boards and other remote areas face particular challenges in delivering specialist services. However, women, their infants and families still deserve equity of access to expert advice and care.

Regional model of specialist community provision

- Boards should collaborate with neighbouring larger board(s) to ensure the availability of a consultant psychiatrist and senior mental health nurse (Band 7), with protected time for specialist perinatal mental health, who can provide at least 0.1 WTE for regional specialist advice and supervision for staff working in local adult CMHTs. This may be provided via telemedicine link.
- Boards may consider providing additional resource so that the regional specialist consultant psychiatrist and senior mental health nurse can provide direct clinical assessment via telemedicine link for women under the care of the local service.
- CMHT staff should have regularly updated training in perinatal mental health at a level commensurate with their need to act as the primary specialist professional. Training should be made available through regional network structures.
- Given their relative isolation, boards should also consider collaborating with neighbouring larger boards to provide advice and supervision from specialist perinatal mental health midwifery and parent-infant mental health therapists.

RECOMMENDATION 9. NHS Boards with very low birth numbers should collaborate through regional structures with neighbouring boards to ensure sessional time from core specialist staff to provide advice and supervision for staff in adult community mental health teams. This may be provided via telemedicine link.

5.3 Infant mental health

While existing services have made efforts to address infant mental health need, current service configuration means that it is difficult for MBUs and perinatal mental health teams to meet the developmental and relationship needs of infants where there is maternal mental distress or disorder. Each service should identify a lead professional for parent-infant interventions who can ensure that therapies are evidence-based and provided across all tiers of service delivery. These individuals may come from a range of professional backgrounds, including clinical psychology, parent-infant psychotherapy, appropriately trained nurses, social workers or therapists from other backgrounds.

Clinical care pathways will be needed for onward referral of infants whose presentation is of concern, e.g., when development is delayed, or social relationships are significantly impaired.

For MBUs and specialist community services, interventions should focus on preparation for parenthood and promotion of best infant development in women with existing significant mental disorder. It will also include assessment and management of complex mother-infant relationship problems and support for the developing father/partner-infant relationship.

There is guidance in existence on the evidence base surrounding these interventions e.g., from the Early Interventions Foundation, which will be enhanced further by work currently underway within NHS Education for Scotland.

The lead professional for parent-infant interventions should also link closely into similar provision outside perinatal mental health, for peer support and supervision.

RECOMMENDATION 10. NHS boards should ensure that perinatal mental health services identify a parent-infant mental health lead who will co-ordinate evidence-based interventions and provide clinical expertise to the specialist team. This resource may be provided on a regional basis.

5.4 Specialist midwives

A number of boards have developed specialist roles for midwives in perinatal mental health. These have not always adhered to a clear model of specialist midwife provision and are not always linked into specialist perinatal mental health services or have explicit specialist supervision. Where they exist, there is a real opportunity to enhance the contribution that midwives make to positive mental health promotion, and to the prevention, detection and management of mental illness.

The Royal College of Midwives (RCM) has developed a role description and suite of competencies for specialist perinatal mental health midwives (RCM, 2015). Where boards appoint midwives in a specialist capacity, they should adhere to RCM competencies and those provided within the Curricular Framework for Perinatal Mental Health (2019) for professionals with enhanced roles. In addition, there should be explicit supervision arrangements with both maternity and the local perinatal mental health service (or the maternity and neonatal psychological interventions team). This may be provided regionally if appropriate.

The Network will work with multidisciplinary colleagues to agree a template job description for perinatal mental health specialist midwives to assist boards who wish to make appointments.

RECOMMENDATION 11. NHS boards should ensure that, where they are provided, specialist perinatal mental health midwives have a clear job description outlining their roles, competencies and arrangements for clinical supervision from maternity and mental health and should have explicit links with the specialist perinatal mental health team and with maternity and neonatal psychological interventions services.

5.5 Maternity and neonatal psychological services

A large number of women and their partners may require additional counselling and support in relation to pregnancy and delivery complications or loss. In most circumstances, this need will be addressed through enhanced education and training for professionals routinely in contact with women and their families at this time, such as midwives, health visitors and neonatal care staff, and through contact with third sector services. The Network endorses recommendations in The Best Start (Scottish Government, 2017) on ensuring support for bereaved parents prior to discharge, access to staff trained in bereavement care, and appropriate signposting to third sector services who provide bereavement and other mental health support.

Women with more complex difficulties in relation to previous or current pregnancy and neonatal complications, or who have mental health problems which directly affect maternity care, may require additional, or more specialist, interventions. This may include women whose own experiences of being parented may adversely affect their adjustment to pregnancy and infant care.

Core functions of a maternity and neonatal psychological interventions service

Psychological interventions provision for parents with:

- Pregnancy and birth complications or loss
- Previous pregnancy complications, loss or birth trauma affecting mental health in the current pregnancy
- Infants whose health is significantly compromised and who require NICU or SCBU care
- Mental disorders, amenable to psychological therapies, which directly affect maternity care, e.g., needle phobia, tokophobia
- Support for maternity and neonatal staff who care for parents with difficulties in adjustment to pregnancy and infant care.

Maternity and neonatal psychological interventions services may be provided by independent teams but there should be close working arrangements with local perinatal mental health services and agreed referral criteria and pathways into care.

Most board areas make no specific provision for psychological therapies within within maternity or neonatal services. There is a clear need to improve current provision. The British Psychological Society provides the only existing recommendations on staffing and remits for such services (BPS, 2019). However, this model is restricted to a single profession and there is a need to explore models which fit with multidisciplinary team practice. This could be achieved by developing a more multidisciplinary structure within maternity services, which could include midwifery, or other mental health staff, with additional psychological therapies training.

The Network recommends that, as a starting point, the Scottish Government and NHS boards should explore models of service provision in larger maternity units (over 3,000 deliveries) which could be multidisciplinary in nature and which would include clinical psychology and other mental health workers or midwives with additional psychological therapies training. Suggested WTE provision is given below. Smaller units should have clear pathways for access to psychological therapies, which could be via local primary care mental health services, adult mental health clinical psychology or perinatal mental health clinical psychology.

Maternity and neonatal psychological interventions team staffing		
	WTE Consultant Clinical Psychologist per 3,000 deliveries	WTE Psychological Therapist per 3,000 deliveries
Maternity hospitals with 3,000 or more deliveries/ year[1]	0.6 Band 8C	1.0 Band 6-8A
Maternity hospitals with fewer than 3,000 deliveries/year	Clear pathways into local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology	

[1] In large board areas with more than one maternity hospital, these services may be provided by a single maternity and neonatal psychological interventions team.

RECOMMENDATION 12. The Scottish Government should work with NHS boards to review models for multidisciplinary psychological interventions provision to maternity and neonatal services, beginning in larger maternity units. These should be led by clinical psychology, with additional staffing from psychological therapists or midwives with additional psychological training. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.

RECOMMENDATION 13. NHS boards should ensure that maternity hospitals with fewer than 3,000 deliveries per year have access to psychological therapies in local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology. Services should have sufficient psychological therapist provision to meet this need.

5.6 Primary care

As with other professionals providing care to pregnant and postnatal women, and their infants, general practitioners should be included in the provision of additional training in perinatal mental health. For GPs, there is a particular need to ensure that they have confidence in issues regarding prescribing during pregnancy and breastfeeding.

Psychological interventions may be delivered in a number of ways, including through individual, group and online resources. The Scottish Government has committed to improving the provision of self-help and digital services to meet psychological need, including computerised cognitive behavioural therapy and video-conferencing (Scottish Government, 2018). As part of this programme, online resources should be adapted where required to meet the particular needs of pregnant women and parents.

RECOMMENDATION 14. The Scottish Government should ensure that self-help and digital resources are adapted to meet the distinctive needs of pregnant and postnatal women, and their families.

Guidance for how psychological interventions should be structured and delivered is provided by NHS Education for Scotland (NES, 2015). It is widely accepted that a matched or stepped care model of service delivery is most appropriate, ensuring that care is provided at the level appropriate to need. Delivery is underpinned by the Government's HEAT target of 18 weeks from referral to treatment.

Mild to moderate mental health problems not only affect the woman herself but may also impede her access to appropriate maternity care and disrupt the development of the mother-infant relationship.

There is an increasing recognition that timely access to psychological interventions is particularly important in the perinatal period, both for the above reasons, and also because there may be an understandable caution regarding the use of medication for mild to moderate problems in pregnancy, breastfeeding and childcare.

For this reason, and where face to face therapies are required, a number of recommendations provide for shorter wait times from referral to treatment for women accessing services in the perinatal period (RCPsych, 2018; NICE, 2016). In order to respond appropriately to the needs of women, their infants and families, we recommend that the waiting time from referral to initiation of treatment, for primary care psychological therapies, should be no more than six weeks for pregnant and postnatal women.

There is no process in place to measure this at a national level at present. In the first instance, the Network recommends that systems are put in place to ensure national data collection of waiting times, and that a maximum waiting time from referral to initiation of treatment of no more than six weeks is included in the suite of Mental Health Quality Indicators. A useful way of ensuring accurate recording would be to include pregnancy and postnatal status (within 12 months of delivery) as part of the core mental health data set collected nationally.

RECOMMENDATION 15. At the next revision of Mental Health Quality Indicators, the Scottish Government should introduce a Quality Indicator to measure how many women are seen for primary care psychological interventions in pregnancy, and the first postnatal year, within 6 weeks of referral. Systems should be put in place to record this at national level and the data used to drive service improvements. This should be included in a national improvement and delivery plan as soon as practicable.

Of the one in 10 women who experience mental health problems at and above the level of mild to moderate mental disorder, up to half will have a level of severity which warrants referral into secondary care mental health services. This equates to approximately 2,250 women per year, leaving the same number who may benefit from psychological interventions at primary care level. A similar number of men may also be affected by mild to moderate mental health problems in the perinatal period and should have access to appropriate services.

Psychological interventions, provided at this level, will usually be delivered by mental health workers at Band 6 level and require 6-8 treatment sessions. Based on approximately 5% of women and men who might benefit from intervention, and the requirement to reduce waiting times to initiation of treatment, we estimate that an additional 60-80 psychological therapists are required to meet this need. NHS boards differ greatly in the extent and manner of current general provision for primary care psychological interventions. Some may be able to develop capacity within existing provision while others may require more extensive service development. Additional psychological interventions for mild to moderate disorders should be developed in collaboration with NHS boards, with evaluation of local need conducted in parallel.

RECOMMENDATION 16. The Scottish Government and NHS boards should develop additional workforce capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men. This should be developed incrementally, with evaluation of local need conducted in parallel.

5.7 Third sector counselling and support, including peer support

Of the one in 5 women who have emotional difficulties co-occurring during the perinatal period, or in relation to adjustment to parenthood and the developing parent-infant relationship, around half will benefit from primary or secondary care mental health interventions as described above. This equates to approximately 5,500 women per year, leaving the same number who could be helped through counselling and support.

Men are also more vulnerable to anxiety and depression in the perinatal period, and challenges in adjustment to parenthood. In addition, it is estimated that one in 5 couples, who have young children, will have relationship difficulties (Sserwanja & Marjoribanks, 2016). Counselling and practical support is already available, through a range of third sector provision, to those individuals and couples who could benefit, and primary care, maternity and health visiting staff should be aware of the pathways into counselling services for those parents who require it.

A range of third sector organisations provide professional, innovative responses to this need, in a manner which also takes into account the need for childcare and the timescales, and potential challenges to access, imposed by pregnancy and the early postnatal period. However, there would be benefit from co-ordinating the views of the third sector on priorities for psychological therapies, counselling and peer support provision, including testing and evaluating models for future service development.

RECOMMENDATION 17. NHS boards should ensure that all parents, and parents to be, are made aware of third sector counselling and support services which exist in their area and how to access them, including individual and couple counselling and support for the parent-infant relationship.

RECOMMENDATION 18. The third sector should be included in regional networks, with a specific remit to advise on the provision of counselling services and peer support worker development.

RECOMMENDATION 19. The Scottish Government should work with NHS boards and third sector funders to review peer support models and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.

5.8 Staff competencies, education and training

All staff working within specialist perinatal mental health services (including all models of community service provision) should have the skills and training to identify, assess and manage perinatal mental health difficulties at a level in keeping with their professional background and role within the team. They should also have the knowledge and skills to advise and support colleagues in other services who do not have specialist expertise.

All professionals working with women, their infants and families, in the perinatal period, should have the appropriate skills to recognise ill health and to refer on, or manage, as appropriate to their professional background and role.

Competencies are set out in the Curricular Framework for Perinatal Mental Health (2019). There is a need for a linked suite of training materials to enable professionals to achieve competency at the appropriate level. Specifically, there is also a need to develop an induction programme for all staff who are new to specialist services.

RECOMMENDATION 20. NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.

RECOMMENDATION 21. The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services. Implementation and roll-out of education and training should be included in a national delivery plan as soon as practicable.

RECOMMENDATION 22. The Scottish Government should ensure that education and training is underpinned by a one-stop digital resource providing a hub for online training for professionals, and perinatal and infant mental health information for professionals, women and their families. This resource should be included in a national delivery plan as soon as practicable.

5.9 Local and regional networks

In each board area, there is a need to co-ordinate service development and to ensure clear pathways into care and across care groups (e.g., maternity, primary care, health visiting, mental health, the third sector and women and families led groups). Multi-professional groups should also provide ongoing monitoring and service evaluation.

It is clear that, for some highly specialist clinical and supervision roles, there is a need for provision at a regional level. This is particularly true, but not only the case, for those boards with very low delivered populations. Particular roles requiring regional provision across Scotland include parent-infant mental health and perinatal nurse consultant specialist provision, but the range of regional provision will be more extensive for remote, rural and island areas. It may also be most appropriate that training and continuing education for specialist services spans board areas. MBU provision is, by necessity, a regional/national function and, with drift of patients accessing maternity services across board boundaries, there is a requirement for neighbouring community specialist services to work closely together. In addition, there is a need to translate national guidance into service provision which is tailored to local and regional requirements.

For all of these reasons, and to ensure that the development of services recommended in this and future reports is done in a co-ordinated way, there is a need to develop regional multi-professional networks in the north, east and west of Scotland. Each of the three regions currently has some regional co-ordination in place, with varying levels of senior managerial support.

Perinatal mental health regional networks, based within existing regional planning structures, will link professionals and service developers/providers across NHS/integrated joint board areas. They will have a strategic role in (i) assisting the co-ordinated development of perinatal mental health services and the workforce to provide them, (ii) ensuring that pathways in and out of care and across geographical, professional and service boundaries are as seamless as possible, and (iii) ensuring the delivery of cross-discipline training and education. Third sector organisations have an important role in maternal and infant mental health service provision and must be represented in regional structures. Representation from women and families must also be part of regional structures, with practical and emotional support put in place to ensure their participation.

Given the scale of change required, the Scottish Government and boards should aim for perinatal mental health service development to be included in regional delivery plans.

RECOMMENDATION 23. Each NHS board should establish a multi-professional group to co-ordinate and lead service development and ongoing monitoring and evaluation. Perinatal mental health regional networks should be established in the north, east and west of Scotland, under existing regional planning structures and governance. The Scottish Government and NHS boards should ensure that perinatal mental health service development is included in regional delivery plans.

RECOMMENDATION 24. The Scottish Government and NHS boards should develop a workforce plan to ensure that there are sufficient numbers of appropriately trained staff to support service development. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.

Local, regional and national structures should be underpinned by clear pathways in and out of care, and between different elements of service. The Network will undertake further work with colleagues to develop care pathway guidance which can be adapted to local and regional needs.

RECOMMENDATION 25. NHS boards should ensure that there are clear care pathways for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services. Information should be easily accessible to women and their families.

5.10 Quality indicators and outcomes

Specialist service development and provision should be evidence-based, standards-led and underpinned by ongoing evaluation.

5.10.1 Standards of care and service provision

For MBUs and stand-alone specialist perinatal mental health teams (recommended for boards with birth numbers greater than 5,000/year), services should adhere to the Royal College of Psychiatrists' Perinatal Quality Network Standards (Inpatient and Community). There is no equivalent set of standards for a dispersed or regional model of specialist community provision and the Network, in collaboration with clinical colleagues, will develop an appropriate suite of resources.

RECOMMENDATION 26. NHS boards should ensure that MBUs, and community specialist perinatal mental health teams providing care for delivered populations greater than 5,000 births/year, are members of the Royal College of Psychiatrists' Perinatal Quality Accreditation Network.

5.10.2 Quality and outcome indicators for perinatal mental health services

A range of core indicators is provided in Appendix 5. These include indicators which can be collected nationally, such as the number of women who receive specialist perinatal mental health community assessment and the number of women requiring inpatient care (and who retain custody of their infant) who are not admitted to an MBU. The Network is developing tools to capture these data centrally and to have a core data set to which all services will contribute.

Other local indicators include:

- Process indicators such as wait times to assessment or treatment
- Clinician rated outcome measures
- Patient rated outcome measures
- Patient/Relative rated experience measures

Nationally accepted measures have been identified in the Royal College of Psychiatrists' Framework for Routine Outcome Measures in Perinatal Psychiatry (2018). Further work will be done by the Network, in collaboration with clinical colleagues, to identify a final suite of outcome indicators.

RECOMMENDATION 27. NHS boards should ensure that all services contribute to a core perinatal mental health data set, identified by the Network, which is collected nationally, and should measure agreed quality indicators for clinical care.

5.11 Services for women with substance misuse

While not part of the Needs Assessment Exercise conducted by the Network, there was wide recognition among contributors that services for this group of women remain patchy, with discontinuities in their mental health care. Information from the Confidential Enquiries into Maternal Deaths repeatedly demonstrates that these women have complex needs and are very vulnerable. They make a significant contribution to deaths in the perinatal period. The Network's workplan includes an undertaking to review need and make recommendations in this area.

RECOMMENDATION 28. The Scottish Government and the Perinatal Mental Health Network should conduct a review of services and assessment of need for pregnant and postnatal women with substance misuse.

6. Summary of recommendations

RECOMMENDATION 1. **The Scottish Government and NHS boards should ensure that MBUs are staffed at the recommended level to provide a comprehensive clinical service.**

RECOMMENDATION 2. **Specialist perinatal mental health services (MBUs and community teams) should include peer support workers as part of their provision. The Scottish Government should work with NHS boards and third sector funders to review models of peer support to specialist services and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 3. **An additional two to four MBU beds should be provided on one or other existing MBU site, divided between both, or in a third MBU located in the north of Scotland. To be viable, a third MBU should have a minimum of four beds. The Scottish Government and NHS boards should conduct an option appraisal to meet this additional need as part of a national implementation plan.**

RECOMMENDATION 4. **All NHS boards should have equity of access to a regional MBU for those women who require inpatient care. The Scottish Government should ensure that MBU beds are provided as a national resource and decisions on admission made exclusively on clinical need.**

RECOMMENDATION 5. **NHS boards should ensure provision for accommodating partners or other family members near to each MBU where they have to travel long distances.**

RECOMMENDATION 6. **All NHS boards should have community specialist perinatal mental health provision. The specific model will be dependent on birth numbers, socio-demographic and geographical needs and, for smaller boards, may be provided in part by boards collaborating together through regional structures. Sessional time for some highly specialised staff may also be provided through regional collaboration. The Scottish Government should ensure that implementation of this work and longer-term roll-out is included in a national delivery plan as soon as practicable.**

RECOMMENDATION 7. **All NHS boards with birth numbers over 5,000/year should have a multidisciplinary community perinatal mental health team which has the skills and capacity to assess and care for pregnant and postnatal women (to 12 months) who require secondary care mental health services.**

RECOMMENDATION 8. **All NHS boards with birth numbers under 5,000/year should have either a stand-alone or dispersed multidisciplinary community perinatal mental health team which has the skills and capacity to assess and care for, at a minimum, pregnant and postnatal women (to 12 months) who have more complex or high-risk presentations.**

RECOMMENDATION 9. **NHS Boards with very low birth numbers should collaborate through regional structures with neighbouring boards to ensure sessional time from core specialist staff to provide advice and supervision for staff in adult community mental health teams. This may be provided via telemedicine link.**

RECOMMENDATION 10. **NHS boards should ensure that perinatal mental health services identify a parent-infant mental health lead who will co-ordinate evidence-based interventions and provide clinical expertise to the specialist team. This resource may be provided on a regional basis.**

RECOMMENDATION 11. **NHS boards should ensure that, where they are provided, specialist perinatal mental health midwives have a clear job description outlining their roles, competencies and arrangements for clinical supervision from maternity and mental health and should have explicit links with the specialist perinatal mental health team and with maternity and neonatal psychological interventions services.**

RECOMMENDATION 12. **The Scottish Government should work with NHS boards to review models for multidisciplinary psychological interventions provision to maternity and neonatal services, beginning in larger maternity units. These should be led by clinical psychology, with additional staffing from psychological therapists or midwives with additional psychological training. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 13. **NHS boards should ensure that maternity hospitals with fewer than 3,000 deliveries per year have access to psychological therapies in local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology. Services should have sufficient psychological therapist provision to meet this need.**

RECOMMENDATION 14. **The Scottish Government should ensure that self-help and digital resources are adapted to meet the distinctive needs of pregnant and postnatal women, and their families.**

RECOMMENDATION 15. **At the next revision of Mental Health Quality Indicators, the Scottish Government should introduce a Quality Indicator to measure how many women are seen for primary care psychological interventions in pregnancy, and the first postnatal year, within 6 weeks of referral. Systems should be put in place to record this at national level and the data used to drive service improvements. This should be included in a national improvement and delivery plan as soon as practicable.**

RECOMMENDATION 16. **The Scottish Government and NHS boards should develop additional workforce capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men. This should be developed incrementally, with evaluation of local need conducted in parallel.**

RECOMMENDATION 17. **NHS boards should ensure that all parents, and parents to be, are made aware of third sector counselling and support services which exist in their area and how to access them, including individual and couple counselling and support for the parent-infant relationship.**

RECOMMENDATION 18. **The third sector should be included in regional networks, with a specific remit to advise on the provision of counselling services and peer support worker development.**

RECOMMENDATION 19. **The Scottish Government should work with NHS boards and third sector funders to review peer support models and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 20. **NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.**

RECOMMENDATION 21. **The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services. Implementation and roll-out of education and training should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 22. **The Scottish Government should ensure that education and training is underpinned by a one-stop digital resource providing a hub for online training for professionals, and perinatal and infant mental health information for professionals, women and their families. This resource should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 23. **Each NHS board should establish a multi-professional group to co-ordinate and lead service development and ongoing monitoring and evaluation. Perinatal mental health regional networks should be established in the north, east and west of Scotland, under existing regional planning structures and governance. The Scottish Government and NHS boards should ensure that perinatal mental health service development is included in regional delivery plans.**

RECOMMENDATION 24. **The Scottish Government and NHS boards should develop a workforce plan to ensure that there are sufficient numbers of appropriately trained staff to support service development. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.**

RECOMMENDATION 25. **NHS boards should ensure that there are clear care pathways for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services. Information should be easily accessible to women and their families.**

RECOMMENDATION 26. **NHS boards should ensure that MBUs, and community specialist perinatal mental health teams providing care for delivered populations greater than 5,000 births/year, are members of the Royal College of Psychiatrists' Perinatal Quality Accreditation Network.**

RECOMMENDATION 27. **NHS boards should ensure that all services contribute to a core perinatal mental health data set, identified by the Network, which is collected nationally, and should measure agreed quality indicators for clinical care.**

RECOMMENDATION 28. **The Scottish Government and the Perinatal Mental Health Network should conduct a review of services and assessment of need for pregnant and postnatal women with substance misuse.**

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Appendix 1

Perinatal Mental Health Network Scotland

The Scottish Perinatal Mental Health National Managed Clinical Network was established in 2017 following a commitment by the Scottish Government in the 10-year Mental Health Strategy (2017) to deliver improvements in the provision of mental health services to pregnant and postnatal women, their infants and families.

The Network is commissioned and governed through the National Network Management Service (NNMS) of NHS Scotland National Services Division (NSD). Oversight of the work of the Network is also provided by the Mental Health Strategy Implementation Group.

The Network's overarching aim is to bring statutory (NHS and Integrated Joint Boards, including social services) and third sector professionals together, alongside women, their infants and families, to ensure equity of access to high quality services across Scotland for women experiencing, or at risk of, mental health problems in the perinatal period. It is also responsible for ensuring access to appropriate infant mental services for children who require them, up to the age of 12 months.

The Network has identified four broad roles through which these aims can be achieved:

- **Working in Partnership** with professionals, women and their families to ensure broad consultation and a primary role in the Network for those with lived experience
- **Developing Professional Expertise** across all professional and third sector groups to ensure that those who come in contact with women, and their families, in the perinatal period have the knowledge and skills to deliver high quality care
- **Ensuring Equity of Care** through recommendations on service provision across all tiers of service delivery, taking into account the distinctive needs brought about by geography and birth numbers
- **Delivering Best Outcomes** by working with professionals and those with lived experience to establish standards for excellence in care and outcome measures

The Network team

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Appendix 2

Scottish Government commitments to perinatal mental health provision

Mental Health Strategy 2017-2027

The 10-year Scottish Government Mental Health Strategy (2017) recognised that improving perinatal mental health care was good, not only for mothers, but also for the health and wellbeing of their children and could contribute to breaking the cycle of poor outcomes from early mental health adversity. Action 16 of the Strategy committed the Government to

"Fund the introduction of a Managed Clinical Network to improve the recognition and treatment of perinatal mental health problems"

Programme for Government 2018-19

'Delivering for Today, Investing for Tomorrow', the Government's Programme for Scotland, published in 2018, detailed the Government's commitment to developing perinatal mental health services. The programme identified three tiers of service delivery

"We will provide three tiers of support across Scotland, in line with the needs of individuals:

- *For those 11,000 women a year who would benefit from help such as counselling we will support the third sector to provide this*
- *For those 5,500 women in need of more specialist help we will ensure rapid access to psychological assessment and treatment*
- *For those 2,250 women with the most severe illness we will develop more specialist services and consider the need for a small number of additional inpatient beds or enhanced community provision"*

Programme for Government Delivery Plan 2018

'Better Mental Health in Scotland', the delivery plan for the Government's programme, further detailed the commitment to perinatal mental health.

To assist parents in being well equipped to support their children it stated that:

"We will ensure there is sufficient investment in service provision for equitable access to perinatal counselling services, perinatal and infant mental health promotion, and preparation for parenthood for those who need it, including in the third sector. All mental health staff should have the knowledge and skills necessary to promote good maternal and infant mental health, and recognise and manage, to their level of competency, mental distress and disorder.

To do this, by March 2020, we will:

- *publish a refreshed Perinatal Mental Health Curricular Framework;*
- *develop a suite of educational tools to meet workforce needs across all tiers of service provision; and*
- *develop high quality digital resources for both workers (such as e-learning) and women and families (such as information about perinatal mental health)."*

In addition, for those women who need more specialist help, the Delivery Plan stated that:

"We will ensure rapid access to psychological assessment and psychological treatment (PT). There should be sufficient primary care PT services across Scotland so that all women experiencing mild-to-moderate mental health problems in the perinatal period can be assessed and treated in a timely way, in line with maternal and infant mental health needs. Peer support – through group or individual help, and through digital, online or tele-health resources – should be available to all women with mild-to-moderate mental distress or issues.

From the start of 2019 onwards, we will:

- *recruit and train primary care psychological therapists; and*
- *invest in community capacity-building, where individuals who have experienced perinatal mental health problems have an opportunity to support others with similar needs and concerns."*

For those women with the most severe illness, it stated that:

"All women with, or at risk of, moderate-to-severe perinatal mental difficulties, and their families, will have access to specialist mental health community services wherever they live in Scotland. There will be sufficient inpatient mother and baby unit beds in Scotland to ensure that women are admitted with their infants, in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003.

To achieve this, from the start of next year and over the next five years we will:

- *publish the Perinatal Mental Health National Scottish Service Standards and Recommendations Report;*
- *recruit Specialist Perinatal Mental Health teams in high birth number areas as well as low/ dispersed birth number areas and island Boards;*
- *develop and implement a model of maternity and neonatology psychological services provision;*
- *develop a national induction programme for new workers in specialist services;*
- *review inpatient bed provision; and*
- *recruit multi-disciplinary staff to provide additional inpatient care or intensive home treatment to serve remote and rural areas."*

Appendix 3

Current and recommended community staffing for NHS boards with more than 5,000 births per year

NHS Grampian		Birth numbers: 5,917 (2017)	
Staff	**Recommended wte (per 5,917 deliveries)**	**Current provision**	**Additional requirement**
Consultant psychiatrist*	0.6	0.4	0.2
Junior psychiatrist	0.6	-	0.6
Nurse consultant † (Band 8B)	1.0	-	1.0
Nurse team leader (Band 7)	0.6	0.1	0.5
Mental health nurse (Band 6/5)	3.0	-	3.0
Consultant clinical psychologist (Band 8C)*	0.3	-	0.3
Clinical psychologist (Band 8A)	1.2	-	1.2
Occupational therapist (Band 6)	0.6	-	0.6
Nursery nurse (Band 4)	1.5	-	1.5
Social worker	0.3	-	0.3
Parent-infant therapist/ lead (Band 8C)*	0.3	-	0.3
Administrative staff (Band 4/3)	1.2	-	1.2

Note: Grampian has a specialist midwife (0.8WTE) who is a core member of the perinatal team.

NHS Greater Glasgow & Clyde		Birth numbers: 12,126 (2017)	
Staff	**Recommended WTE (per 12,126 deliveries)**	**Current provision**	**Additional requirement**
Consultant psychiatrist*	1.2	1.0	0.2
Junior psychiatrist	1.0	0.5	0.5
Nurse consultant † (Band 8B)	1.0	1.0	-
Nurse team leader (Band 7)	1.0	1.0	-
Mental health nurse (Band 6/5)	6.0	6.5	-
Consultant clinical psychologist (Band 8C)*	0.6	0.3	0.3
Clinical psychologist (Band 8A)	2.4	-	2.4
Occupational therapist (Band 6)	1.2	-	1.2
Nursery nurse (Band 4)	3.0	1.0	2.0
Social worker	0.6	0.5	0.1
Parent-Infant therapist/lead (Band 8C)*	0.6	-	0.6
Administrative staff (Band 4/3)	2.4	2.0	0.4

NHS Lanarkshire		Birth numbers: 6,763 (2017)	
Staff	**Recommended WTE (per 6,763 deliveries)**	**Current provision**	**Additional requirement**
Consultant psychiatrist	0.7	0.4	0.3
Junior psychiatrist	0.7	-	0.7
Nurse consultant † (Band 8B)	-	-	-
Nurse team leader (Band 7)	1.0	1.0	-
Mental health nurse (Band 6/5)	3.5	3.6	-
Consultant clinical psychologist (Band 8C)	0.4	-	0.4
Clinical psychologist (Band 8A)	1.4	-	1.4
Occupational therapist (Band 6)	0.7	-	0.7
Nursery nurse (Band 4)	2.0	-	2.0
Social worker	0.5	-	0.5
Parent-infant therapist/lead (Band 8C)	0.35	-	0.35
Administrative staff (Band 4/3)	1.4	-	1.4

NHS Lothian		Birth numbers: 9,037 (2017)	
Staff	**Recommended WTE (per 9,037 deliveries)**	**Current provision**	**Additional requirement**
Consultant psychiatrist*	0.9	0.9	-
Junior psychiatrist	1.0	-	1.0
Nurse consultant † (Band 8B)	1.0	-	1.0
Nurse team leader (Band 7)	1.0	1.0	-
Mental health nurse (Band 6/5)	5.0	2.5	2.5
Consultant clinical psychologist (Band 8C)*	0.5	0.08	0.42
Clinical psychologist (Band 8A)	1.8	-	1.8
Occupational therapist (Band 6)	0.9	0.48	0.42
Nursery nurse (Band 4)	2.3	-	2.3
Social worker	0.5	0.4	0.1
Parent-infant therapist/ lead (Band 8C)*	0.5	-	0.5
Administrative staff (Band 4/3)	1.8	-	1.8

Note: Lothian also has a clinical nurse manager for the whole service (Band 8A). Any clinical time (or clinical time released for the NTL) by this post should be taken into account in calculating additional need.

Total requirements for combined Scottish boards with birth numbers over 5,000 per year		Birth numbers: 33,843 (2017)	
Staff	**Recommended WTE (per 33,843 deliveries)**	**Current provision**	**Additional requirement**
Consultant psychiatrist*	3.4	2.7	0.7
Junior psychiatrist	3.3	0.5	2.8
Nurse consultant † (Band 8B)	3.0	1.0	2.0
Nurse team leader (Band 7)	3.6	3.1	0.5
Mental health nurse (Band 6/5)	17.5	12.6	5.5
Consultant clinical psychologist (Band 8C)*	1.8	0.38	1.42
Clinical psychologist (Band 8A)	6.8	-	6.8
Occupational therapist (Band 6)	3.4	0.48	2.92
Nursery nurse (Band 4)	8.8	1.0	7.8
Social worker	1.9	0.9	1.0
Parent-infant therapist/ lead (Band 8C)*	1.75	-	1.75
Administrative staff (Band 4/3)	6.8	2.0	4.8

*These posts (in Grampian, Greater Glasgow and Clyde, and Lothian) require an additional 0.1-0.2 WTE provision for regional roles. If this is taken into account, then the total additional WTE increases for (i) Consultant psychiatrist (to 1.0-1.3; Consultant clinical psychologist (to 1.72-2.02 and (iii) Parent-infant therapist (to 2.05-2.35).

† The nurse consultant post should be provided regionally.

Appendix 4

Current and recommended community staffing for NHS boards with fewer than 5,000 births per year

NHS Ayrshire & Arran		Birth numbers: 3,281 (2017)	
Staff	Recommended WTE (per 3,281 deliveries)	Current provision	Additional requirement
Consultant psychiatrist	0.3-0.4	0.2	0.1-0.2
Lead nurse	0.3-0.4	-	0.3-0.4
Consultant psychologist	0.2	-	0.2
Link CPN	1.5-2.0	-	1.5-2.0
Occupational therapist	0.3-0.4	-	0.3-0.4
Social worker	0.2	-	0.2
Administrative staff	0.6-0.8	-	0.6-0.8

NHS Borders		Birth numbers: 989 (2017)	
Staff	Recommended WTE (per 989 deliveries)	Current provision	Additional requirement
Consultant Psychiatrist	0.2	0.1	0.1
Lead Nurse	0.2	-	0.2
Consultant Psychologist	0.2	-	0.2
Link CPN	0.5	-	0.5
Occupational therapist	0.1	-	0.1
Social worker	0.1	-	0.1
Administrative staff	0.2	-	0.2

NHS Dumfries & Galloway		Birth numbers: 1,248 (2017)	
Staff	Recommended WTE (per 1,248 deliveries)	Current provision	Additional requirement
Consultant Psychiatrist	0.2	-	0.2
Lead Nurse	0.2	-	0.2
Consultant Psychologist	0.2	-	0.2
Link CPN	0.5	-	0.5
Occupational therapist	0.1	-	0.1
Social worker	0.1	-	0.1
Administrative staff	0.2	-	0.2

NHS Fife		Birth numbers: 3,465 (2017)	
Staff	**Recommended WTE (per 3,465 deliveries)**	**Current provision**	**Additional requirement**
Consultant Psychiatrist	0.3-0.4	0.2	0.1-0.2
Lead Nurse	0.3-0.4	-	0.3-0.4
Consultant Psychologist	0.2	-	0.2
Link CPN	1.5-2.0	-	1.5-2.0
Occupational therapist	0.3-0.4	-	0.3-0.4
Social worker	0.2	-	0.2
Administrative staff	0.6-0.8	-	0.6-0.8

NHS Forth Valley		Birth numbers: 2,907 (2017)	
Staff	**Recommended WTE (per 2,907 deliveries)**	**Current provision**	**Additional requirement**
Consultant Psychiatrist	0.3	0.2	0.1
Lead Nurse	0.3	1.0	-
Consultant Psychologist	0.2	-	0.2
Link CPN	1.5	1.4*	-
Occupational therapist	0.3	-	0.3
Social worker	0.2	-	0.2
Administrative staff	0.6	0.5	0.1

*These posts currently consist of 1 WTE Band 6 nurse based within the hub team, with 2 CPNs dispersed in the CMHTs.

NHS Highland		Birth numbers: 2,754 (2017)	
Staff	**Recommended WTE (per 2,754 deliveries)**	**Current provision**	**Additional requirement**
Consultant Psychiatrist	0.3	-	0.3
Lead Nurse	0.3	0.4	-
Consultant Psychologist	0.2	-	0.2
Link CPN	1.5	-	1.5
Occupational therapist	0.3	-	0.3
Social worker	0.2	-	0.2
Administrative staff	0.6	-	0.6

NHS Orkney*		Birth numbers: 184	
Staff	Recommended WTE (per 184 deliveries)	Current provision	Additional requirement
Consultant Psychiatrist	0.02	-	0.02
Lead Nurse	0.02	-	0.02
Consultant Psychologist	0.01	-	0.01
Link CPN	0.1	-	0.1
Occupational therapist	0.02	-	0.02
Social worker	0.01	-	0.01
Administrative staff	0.04	-	0.04

*Much of this resource is likely to be provided on a regional basis and figures provided are indicative for funding purposes

NHS Tayside		Birth numbers: 3,757	
Staff	Recommended WTE (per 3,757 deliveries)	Current provision	Additional requirement
Consultant Psychiatrist	0.4	-	0.4
Lead Nurse	0.4	-	0.4
Consultant Psychologist	0.2	-	0.2
Link CPN	2.0	-	2.0
Occupational therapist	0.4	-	0.4
Social worker	0.2	-	0.2
Administrative staff	0.8	-	0.8

NHS Shetland*		Birth numbers: 218	
Staff	Recommended WTE (per 218 deliveries)	Current provision	Additional requirement
Consultant Psychiatrist	0.02	-	0.02
Lead Nurse	0.02	-	0.02
Consultant Psychologist	0.01	-	0.01
Link CPN	0.1	-	0.1
Occupational therapist	0.02	-	0.02
Social worker	0.01	-	0.01
Administrative staff	0.04	-	0.04

*Much of this resource is likely to be provided on a regional basis and figures provided are indicative for funding purposes

NHS Western Isles*		Birth numbers: 215	
Staff	**Recommended WTE (per 218 deliveries)**	**Current provision**	**Additional requirement**
Consultant Psychiatrist	0.02	-	0.02
Lead Nurse	0.02	-	0.02
Consultant Psychologist	0.01	-	0.01
Link CPN	0.1	-	0.1
Occupational therapist	0.02	-	0.02
Social worker	0.01	-	0.01
Administrative staff	0.04	-	0.04

*Much of this resource is likely to be provided on a regional basis and figures provided are indicative for funding purposes

Total requirements for combined Scottish boards with birth numbers under 5,000 per year		Birth numbers: 19,018 (2017)	
Staff	**Recommended WTE (per 19,018 deliveries, taking into account regional variation)**	**Current provision**	**Additional national requirement**
Consultant Psychiatrist	2.26	0.7	1.56
Lead Nurse	2.26	1.4	1.66
Consultant Psychologist	1.43	-	1.43
Link CPN	10.3	1.4	8.8
Occupational therapist	2.06	-	2.06
Social worker	1.23	-	1.23
Administrative staff	4.12	0.5	3.62

Appendix 5

Quality indicators for perinatal mental health services

Quality indicators for community services

	National Indicator	Measure	Type
1.	Fidelity to model of service provision in board area	National and local audit	
2.	Number of women receiving specialist assessment	Proportion of total deliveries	
	Service Indicator	**Measure**	**Type**
1.	Time from referral to initial assessment	Proportion outwith standard	Process indicator
2.	Time from referral to psychological therapy commencement, where indicated	Proportion outwith standard	Process indicator
3.	Complaints received	Number of complaints as proportion of caseload	Process indicator
4.	Change in mental health (e.g., HoNOS)	Change from entry to exit from service	Clinician rated outcome measure
5.	Change in symptoms (e.g., CORE-OM)	Change from entry to exit from service	Patient rated outcome measure
6.	Mother-infant relationship (e.g., PBQ)	Change from entry to exit from service	Patient rated outcome measure
7.	Satisfaction with care (e.g., POEM)	Change from entry to exit from service	Patient related experience measure

Quality indicators for MBUs

	National Indicator	Measure	Type
1.	Fidelity to model of service provision in board area	National and local audit	
2.	Number of women, who retain custody of their child, admitted to non-MBU bed	Proportion of total admissions	
	Service Indicator	**Measure**	**Type**
1.	Time from referral to MBU admission	Proportion outwith standard	Process indicator
2.	Time from referral to psychological therapy commencement, where indicated	Proportion outwith standard	Process indicator
3.	Complaints received	Number of complaints as proportion of caseload	Process indicator
4.	Change in mental health (e.g., HoNOS)	Change from entry to exit from service	Clinician rated outcome measure
5.	Change in symptoms (e.g., CORE-OM)	Change from entry to exit from service	Patient rated outcome measure
6.	Mother-infant relationship (e.g., BMIS or Louis-MACRO)	Change from entry to exit from service	Patient rated outcome measure
7.	Satisfaction with care (e.g., POEM)	Change from entry to exit from service	Patient related experience measure