

# NHS GG&C Mental Health Service

## Perinatal Mental Health Service

### Operational Policy

**Important Note:**

**The Intranet version of this document is the only version that is maintained.**

Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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# MHS 49 - Perinatal Mental Health Service Operational Policy

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

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# Contents

IMPORTANT NOTE: .....	1
<b><u>MHS 49 - PERINATAL MENTAL HEALTH SERVICE OPERATIONAL POLICY.....</u></b>	<b>2</b>
<b><u>1. PRINCIPLES VALUES &amp; SERVICE CONTEXT.....</u></b>	<b>5</b>
1.1 INTRODUCTION .....	5
1.2 SERVICE PRINCIPLES.....	5
1.3 STAFF PRACTICE PRINCIPLES .....	7
1.4 CONFIDENTIALITY.....	8
1.5 ENGAGEMENT AND PARTICIPATION WITH SERVICE USERS AND CARERS.....	8
1.6 PERSON CENTRED CARE.....	8
<b><u>2. CAPACITY, CONSENT &amp; SAFEGUARDING .....</u></b>	<b>9</b>
2.1 CAPACITY, DECISIONS, ADVANCED STATEMENTS AND SAFEGUARDING.....	9
<b><u>3. PMHS STRUCTURE AND FUNCTION.....</u></b>	<b>10</b>
3.1 PMHS CORE ELEMENTS OF SERVICE .....	10
<b><u>4. WEST OF SCOTLAND MBU.....</u></b>	<b>11</b>
4.1 ACCESS & REFERRAL PROCESS.....	11
4.2 CARE PLANNING .....	12
4.3 INFANT CARE .....	12
4.4 INVOLVING FAMILIES AND CARERS .....	13
4.5 PERINATAL MENTAL HEALTH RISK.....	14
4.6 RECORD KEEPING.....	14
4.7 MULTIDISCIPLINARY TEAM (MDT) REVIEWS.....	14
4.8 DISCHARGE PROCESS .....	15
<b><u>5. COMMUNITY PERINATAL MENTAL HEALTH TEAM (CPMHT).....</u></b>	<b>16</b>
5.1 COMMUNITY FUNCTION INCLUDES: .....	16
5.2 MATERNITY LIAISON SERVICE:.....	16
5.3 ROLE AND RESPONSIBILITIES OF TEAM MEMBERS.....	17
5.4 ACCESS AND REFERRAL SYSTEM .....	17
5.5 ELIGIBILITY .....	17
5.6 PROCESSING REFERRALS (INCLUDING RESPONSE TIMES) .....	18
5.7 PATIENTS IN CRISIS AND/OR PRESENTATION OUT OF HOURS .....	20
5.8 DID NOT ATTENDS (DNAs) AND COULD NOT ATTENDS (CNAs).....	20
5.9 SCREENING.....	20
5.10 BEFORE THE ASSESSMENT .....	20
5.11 INITIAL ASSESSMENT.....	21

5.12	INVOLVING FAMILIES AND CARERS.....	22
5.13	ASSESSMENT FEEDBACK AT MDT MEETING/ALLOCATION .....	22
5.14	INTERFACE WITH SPECIALIST MENTAL HEALTH & SOCIAL SERVICES.....	23
5.15	INTERVENTIONS .....	23
5.16	MANAGEMENT OF PERINATAL RISK .....	24
5.17	CARE PLANNING .....	24
5.18	RECORD KEEPING .....	25
5.19	MULTIDISCIPLINARY TEAM (MDT) REVIEWS.....	25
5.20	DISCHARGE/ TRANSFERS.....	26
5.21	TRANSFER- CPMHT TO INPATIENT CARE AND VICE VERSA .....	27
5.22	SERVICE INTERFACES/TRANSITIONS .....	27
<b>6.</b>	<b><u>CO-ORDINATION OF CARE.....</u></b>	<b>28</b>
6.1	CO-ORDINATION OF CARE.....	28
6.2	THE SCOPE OF CO-ORDINATION OF CARE WITHIN THE PMHS.....	28
6.3	NAMED PRACTITIONERS: ROLE AND RESPONSIBILITIES.....	29
6.4	WORKING IN PARTNERSHIP AND INTERFACE WITH SPECIALIST MENTAL HEALTH & SOCIAL SERVICES .....	29
6.5	EQUALITY, RECOVERY AND SOCIAL INCLUSION.....	30
<b>7.</b>	<b><u>QUALITY IMPROVEMENT, KEY PERFORMANCE INDICATORS (KPI) AND OUTCOMES.....</u></b>	<b>31</b>
7.1	QUALITY IMPROVEMENT.....	31
7.2	KEY PERFORMANCE INDICATORS.....	32
7.3	OUTCOME MEASURES.....	32
<b>8.</b>	<b><u>MANAGEMENT ARRANGEMENTS .....</u></b>	<b>33</b>
8.1	CLINICAL AND OPERATIONAL LEADERSHIP .....	33
8.2	CLINICAL AND LINE MANAGEMENT SUPERVISION .....	33
8.3	HEALTH AND SAFETY.....	33
<b>9.</b>	<b><u>WORKFORCE .....</u></b>	<b>34</b>
9.1	STAFFING AND RESOURCES.....	34
9.2	WORKLOAD MANAGEMENT .....	34
<b>10.</b>	<b><u>FURTHER INFORMATION ON PERINATAL MENTAL HEALTH SERVICE.....</u></b>	<b>36</b>

# **1. Principles Values & Service Context**

## **1.1 Introduction**

The NHSGGC Perinatal Mental Health Service (PMHS) aims to provide assessment and treatment of women who are at risk of, or who experience, significant mental disorder while pregnant or within the first postnatal year. The service also prioritises the needs of the infant, other children, and partners of mothers with mental illness.

The community and maternity liaison services are board-wide. The inpatient mother and baby unit (MBU) has a regional remit for the West of Scotland. The service is based at Leverndale Hospital but provides outreach to a number of sites throughout GGC.

The Perinatal Mental Health Service forms part of a whole system approach to mental health services for the population of NHSGGC. The service is delivered in conjunction with Community Mental Health Teams (CMHT), Primary Care Mental Health Teams (PCMHT), other acute services (Crisis/Home Treatment Services & out of hours (OOH) Services); other specialist mental health services (including Child and Adolescent Mental Health Services (CAMHS), Esteem First Episode Psychosis Service, Eating Disorders Service, Addictions Service, Mental Health Assessment Centre), and a range of statutory and non-statutory services that support the delivery of care. There is close partnership working with primary care, maternity and social work services.

This operational policy aims to promote a prevention and recovery-based model of person-centred care that takes into account the woman's needs, preferences and strengths. The operational policy describes the pathway of care through the PMHS, covering all aspects of service delivery from the principles, ethos and values base for practice, through to quality assurance and clinical and care governance processes.

Further guidance is included in the *Perinatal SOP* guidance document.

## **1.2 Service Principles**

The Scottish Government launch of the 10 year Mental Health Strategy 2017-2027 included the provision of a National Managed Clinical Network for Perinatal Mental Health. The NMCN was established in February 2017 and was tasked with reviewing Perinatal Mental Health service provision in all 14 NHS boards in Scotland. The NHS Greater Glasgow & Clyde review took place in Oct 2017.

Scotland's First Minister Nicola Sturgeon launched the *Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services* in March 2019. The 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. Subsequently the National Implementation Board for Perinatal & Infant Mental Health have established an Infant Mental Health Advisory group which has produced a delivery plan.

As outlined in the *Service Specification for Mental Health Services in the Community* (NHSGGC, 2016), the following key principles underpin service delivery:

- Women will receive the right treatment with a minimum of fuss and delay with “easy in - easy out” access to and from the service.
- The early and accurate characterisation and understanding of the woman's problems formulation is critical for an effective system.
- Quality care depends not only on the overt, measurable aspects of service delivery (medicines prescribed, psychological interventions, visits completed), but also on less tangible qualities such as “engagement” and “containment”, good “customer care” and meaningful therapeutic relationships.
- Staff development, satisfaction and fulfilment at work are explicit service goals.

Consistent with the 6 quality dimensions; *Efficient, Timely, Safe, Person Centred, Effective and Equitable*, the PMHS will deploy “data rich” open systems able to negotiate and resolve women's/families' expectations and service capability; encourage innovation, creativity and quality improvement in service development; manage inappropriate variation; generalise improvements; learn from mistakes and adapt to changing needs and emerging evidence.

The PMHS will provide the level of care tailored to the individual's needs. In particular:

- Clinical outcomes will be monitored routinely using agreed clinical outcome measures, and efforts made to “match” individuals to the right level of care.
- Women and, where appropriate, their partners and families, will be active participants in care decisions and care delivery.
- The system will seek and make use of feedback from women, their partners and families about their satisfaction with services.
- The PMHS will act as a ‘one stop shop’, to triage all referrals of women in pregnancy or the postnatal period, ensuring easy access to the service for a diverse range of referrers.

### **1.3 Staff Practice Principles**

In common with all mental health services delivered within NHSGGC, PMHS staff will adhere to their professional Codes of Practice and when exercising any function in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003, Adults with Incapacity, Adult Support and Protection Acts and relevant child protection legislation – Protection of Children (Scotland) Act 2003, National Guidance for Child Protection in Scotland 2014, will have regard to the principles of these Acts. Lessons from the Confidential Enquiry into Maternal Deaths 2019, and subsequent reports, will be considered.

Staff will take into account patients' rights to advocacy services as laid out within the Charter of Patients' Rights and Responsibilities, with particular reference to the general Health Care principles within the Patient Rights (Scotland) Act 2011.

Staff will adhere to Duty of Candour Procedure (Scotland) regulations 2018.

Staff will use GIRFEC (Getting It Right for Every Child) 2006 principles and framework to aid assessment of child health and welfare with reference to the Children's and Young Persons Act (Scotland) 2014.

In keeping with the specific remit of the service, staff will use evidence-based practice, taking into account guidance from SIGN, NICE and standards set through relevant professional bodies.

In addition, staff will be required to ensure that joint and individual service governance, standards and accountability frameworks underpin their day-to-day practice, and be mindful of their role in delivery of equalities sensitive practice.

## **1.4 Confidentiality**

The collecting and sharing of information is essential to provide safe and effective healthcare. Patients entrust the NHS in Scotland with their personal information, and all staff working within the PMHS have a legal and ethical duty to keep patient information confidential. All PMHS staff will comply with,

- NHS Scotland Code of Practice on Protecting Patient Confidentiality
- Data Protection Act
- Caldicott guidance
- NHSGGC Information Sharing Policy
- Mental Welfare Commission Guidance.

## **1.5 Engagement and Participation with Service Users and Carers**

The PMHS will work flexibly to engage women, partners and family in delivery of services which are user focused and seek to include women, their partners, families or representatives in the planning and review of care plans, offering choice wherever possible. Families include relatives, friends, non-professional advocates and significant others who play a supporting role for the person using mental health services. If the woman agrees, partners and families should have the opportunity to be involved in decisions about treatment and care. Partners and families should also be given the information and support they need, including access to a carer's assessment.

## **1.6 Person Centred Care**

The PMHS will work as flexibly as possible in the time and location of appointments (home, clinic, maternity or base) and choice of worker, offering second opinions where required. Additional guidance has been developed since the outbreak of COVID 19 in March 2020. The service has embraced technology and offer Attend Anywhere and remote video consultations, in addition to pursuing additional methods of delivering care and treatment.

The views of women, their partners and families are central not only to making decisions affecting their own lives but in more general policy development and monitoring of services and this should be seen as an important function of engaging service users/carers. The PMHS will continue to improve services by listening and responding to concerns, complaints, suggestions and queries through various feedback including 'patient conversations'.

## **2. Capacity, Consent & Safeguarding**

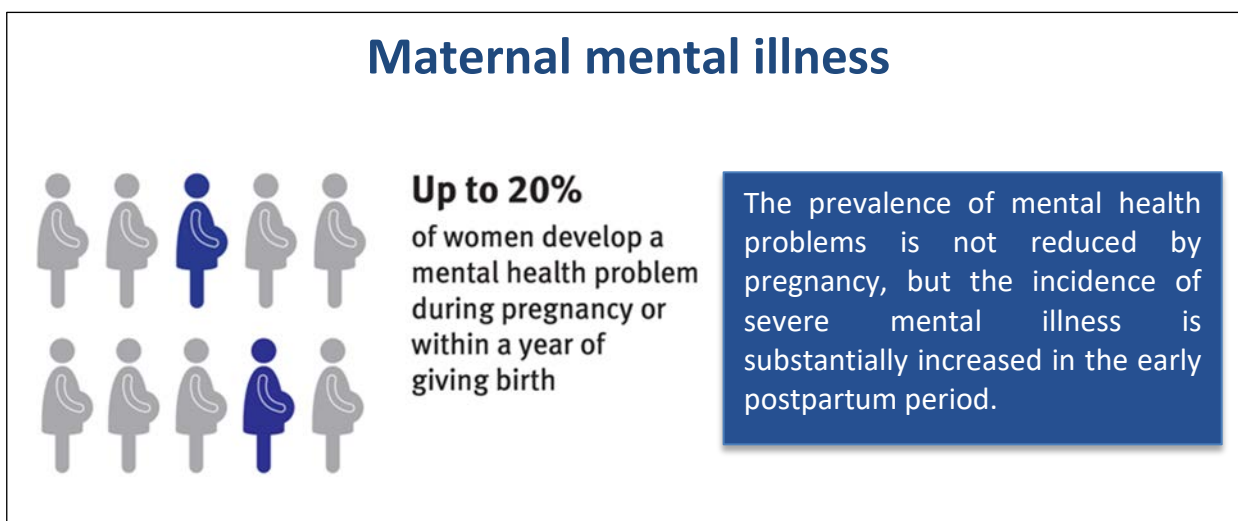
People who use mental health services should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners. If women do not have the capacity to make decisions, healthcare professionals should ensure that legal, organisational and professional requirements for obtaining consent to treatment are followed.

### **2.1 Capacity, Decisions, Advanced Statements and Safeguarding**

PMHS practitioners must ensure that they:

- Understand and can apply the principles of the Adults with Incapacity Act 2000(AWI) appropriately.
- Can assess mental capacity and understand how the Mental Health (Care & Treatment) (Scotland) 2003 Act and AWI relate to each other in practice.
- Inform women of their right to make an advance statement and support them to do so if they wish.
- Document the Advance Statement / decision to decline in their care plans and ensure copies are held by the woman and in primary and secondary care records.
- Check their care record for advance statements and advance decisions before offering or starting treatment when a woman has impaired capacity
- Consider women for assessment according to local safeguarding procedures for vulnerable adults
- Establish if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system.
- Inform women of their right to advocacy
- Understand how to act on any Child Protection issues/concerns

### 3. PMHS Structure and Function



Core functions of the service are:

- Assessment and treatment of women at risk of, or suffering from, mental illness in pregnancy and the postpartum period
- Assessment and facilitation of the mother-infant relationship in the context of maternal mental illness.

#### 3.1 PMHS Core Elements of Service

Service component	Function	Area covered
<b>West of Scotland Mother and Baby Unit</b>	6-bed inpatient acute psychiatry unit providing joint admission for mothers and babies. Where appropriate, women in late pregnancy may also be admitted.	<b>West of Scotland</b> <ul style="list-style-type: none"> <li>• NHS GGC</li> <li>• NHS Lanarkshire</li> <li>• NHS Ayrshire and Arran</li> <li>• NHS Dumfries and Galloway</li> <li>• NHS Western Isles</li> <li>• NHS Highland (Argyll region)</li> </ul> <i>Admissions from other areas by agreement.</i>
<b>Community Perinatal Mental Health Team</b>	Multidisciplinary team providing assessment and treatment for women with, or at risk of, significant mental illness in pregnancy or the postnatal period	NHS GGC
<b>Maternity Liaison Service</b>	Assessment and treatment of inpatients and, in emergencies, outpatients of NHSGGC maternity services	Women delivering at any NHS GGC maternity hospital (PRMH, QEUH, RAH)

## 4. West of Scotland MBU

The West of Scotland MBU is situated in purpose-designed facilities at Leverndale Hospital. It allows for the joint admission of mothers accompanied by their babies, where the woman requires acute inpatient mental health care. Women, their families and others can access a virtual tour via website.

The unit is staffed by a multi-disciplinary team of professionals including psychiatrists, mental health nurses, nursery nurses, occupational therapist, social worker, psychologist, health visitor, nursing assistants, pharmacist, administrators and sessions from other health disciplines as required.

The unit offers a wide range of therapies including biological, psychological and psychosocial interventions including interventions to enhance the mother-infant relationship, along with tools and outcome measures.

MBU staff roles include:

- Assessment and treatment of significant mental disorder co-occurring or newly arising in relation to childbearing
- Facilitation and enhancement of the developing mother-infant relationship to optimise infant development
- Assessment and facilitation of parenting skills in the context of acute maternal mental disorder
- Ensuring that the infant's health and care needs are met at all times. Staff responsibilities to the infant are set out in the *Perinatal SOP* guidance document.
- Admission of women in late pregnancy where it is judged clinically that the MBU would provide the most appropriate care environment

The West of Scotland MBU is a member of the Royal College of Psychiatrists Perinatal Mental Health Quality Network and is committed to achieving and maintaining accreditation status.

### 4.1 Access & Referral Process

Arrangements for access and referral are detailed below and in the *Perinatal SOP* guidance document.

The service will also meet the requirements of the NHSGGC Psychiatric Emergency Plan (PEP) and interface protocols with other services.

- 24 hours a day, 7 days a week ability to admit
- Includes detained patients (see MHCTS Act 2003 and 2015)
- Patients admitted will be within one year of childbirth and suffering from major mental illness of a severity requiring inpatient care. In most cases such illness would be associated with psychotic symptoms, severe behavioural disturbance or risk to self/others. Planned admissions may also be appropriate where women with major mental illness have failed to

respond to standard treatments. In general, admissions of women with substance misuse problems or personality disorder would only be appropriate where additional acute mental illness is present.

- Patients in late pregnancy, usually from 32 weeks gestation, with moderate to serious mental illness may be admitted.
- Parenting assessment is an important component of inpatient evaluation but would not be a sole reason for admission in the absence of acute mental illness of a significance requiring inpatient treatment.
- Referrals to the unit are accepted from mental health professionals, general practitioners, health visitors and maternity staff for assessment by our team. For referrals from out with NHS Greater Glasgow & Clyde, the woman should be assessed by a local perinatal mental health service or if not available, a psychiatrist in the first instance. A virtual tour is available online for women and their families to watch if admission is an option being offered to them.
- If the West of Scotland MBU has no available beds, there is a reciprocal agreement with St John's MBU in Livingston (NHS Lothian) that they will admit on our behalf until we have a bed available.
- In circumstances where admission to the MBU may not be appropriate, for example where it may not be in the interests of mother or baby to be admitted together, arrangements will be made to find the most suitable place for mother and baby. This may be temporary and must be reviewed regularly. Perinatal staff will provide advice and support to colleagues, as per established guidance for mothers admitted to adult psychiatric beds. It is envisaged that this would be an infrequent occurrence and only where a joint MBU admission would pose a significant and direct risk to mother, baby or others on the unit.
- Mothers under age 18 will have a named CAMHS clinician available for consultation and advice. The local authority and Mental Welfare Commission will be informed, where appropriate.

## **4.2 Care Planning**

All women and, where appropriate, their partners and families, will be involved in the formulation of their plan of care. Care plans will be formulated and agreed utilising a strength-based and recovery-focused approach to care delivery which optimises the woman's ability to self-manage. Women will be asked to consent to and agree their care plan and this will be recorded in the care plan. Where the woman disagrees/lacks capacity/does not wish to proceed with the care plan, this will be recorded within the care plan. In the MBU, the baby has a care plan devised by the Nursery Nurse and the mother and, where appropriate, the father and families.

## **4.3 Infant Care**

- It is the expectation that babies admitted to the MBU will be healthy and thriving.
- Arrangements are in place for all admitted babies to receive a primary care examination within 2 working days.
- All babies are weighed and body mapped on admission
- Health visitors are informed of all new babies arriving on the unit within 48 hours of admission
- Health visitors are informed of all periods of overnight leave.

- Appropriate infant care plans are developed in co-operation with the parents.
- Well established arrangements are in place if there are concerns for the baby's health and they require assessment or treatment. Doctors working in psychiatry eg. On-call doctor, are not expected to provide care or treatment of the baby.
- The status of the child will be of a 'dependent child' as defined in the relevant guidance document.
- The MBU Health Visitor will provide regular assessment and advice for all babies on the MBU, in co-operation with nursery nurses.
- The baby will be registered temporarily with a local GP practice.
- All aspects of baby's care will be documented in the appropriate care records, as per local guidance, and recorded in the baby's Red Book by the MBU Health Visitor where appropriate.

Additional details and guidance are included in the Perinatal SOP guidance document.

#### **4.4 Involving Families and Carers**

Consistent with the principles of the Triangle of Care, PMHS staff will discuss with the person using mental health services if and how they want their partner or family to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances and should not happen only once. All decisions and discussions will be recorded in the plan of care.

If a woman wants her partner or family to be involved, PMHS staff will facilitate and discuss this involvement between the woman and her partner/family. This will include discussion of:

- Consent for partner/family involvement.
- Confidentiality and sharing of information on an ongoing basis.
- How partners and families can help support the service user and help with treatment plans.
- Ensuring that no services are withdrawn because of the partner's or family's involvement in delivering aspects of care, unless this has been clearly agreed with the woman and her partner or family.
- Verbal and written information about the mental health problem(s) experienced by the woman and the treatments indicated.
- Their right to a formal carer's assessment and how to access this.

If the woman does not want her partner or family to be involved in her care, consistent with the Triangle of Care guidance, PMHS staff can:

- Give the partner/family verbal and written information on the mental health problem(s) experienced by the woman and the indicated treatments.
- Give the partner/family information about statutory and third sector/voluntary, local support groups and services specifically for families or carers, and how to access these.

## **4.5 Perinatal Mental Health Risk**

The assessment and management of perinatal risk is an integral part of the screening and assessment process and is an ongoing process with constant consideration to Adult Support and Protection and Child Protection. All women will have a current completed perinatal risk assessment and associated perinatal risk management plan. This is reviewed at the weekly MDT, or more frequently, as and when required by staff.

On admission, women are given information about various levels of observation that may be applied whilst in the MBU.

Infants in the MBU are continually reviewed and observation levels are applied using the 'Support and Supervision' tool. This is explained in more detail by the Named Nurse and Named Nursery Nurse.

Given the core importance of child protection to the work of the PMHS, staff will prioritise attendance at SW child protection meetings where possible or provide information via the NHS GGC Adult Mental Health Child Protection reporting template.

## **4.6 Record Keeping**

All written/electronic records must adhere to the Health/Local Authority recording policies and in accordance with professional standards to provide an objective overview of all contacts and actions relating to the individual woman.

All records, paper or electronic, are treated as confidential documents. Information is only shared on a 'need to know' basis with the woman's permission and under the scrutiny of the Caldicott principles and in accordance with NHSGGC Information Sharing policy, unless the situation meets necessary risk requirements which would require those rights to be breached.

An entry will be made in the clinical record for each clinical contact. This record will include details on the intervention delivered, be signed, dated and include details of the practitioner's job title and team (or similar equivalent when using electronic patient records). The entry will include details of the next planned session, where this is applicable.

Formal communication with GPs/referrers/Health Visitor/Maternity and any others will be at the point of,

- Admission (telephone/email)
- Weekly MDT invitations(telephone/email)
- Discharge (telephone/letter/email)

## **4.7 Multidisciplinary Team (MDT) Reviews**

Throughout the woman and her baby's stay in the MBU, there is a weekly multi-disciplinary meeting. Each woman is given a time slot which allows her partner or other family to attend along with other professionals involved in her care in the community. Since March 2020, the MDT has

been carried out via video conferencing software (Attend Anywhere/MS-Teams). All meetings will be chaired by a senior member of staff.

At the MDT review the inpatient team will:

- Review current care plan, including the pre-discharge plan
- Co-ordinate with the community team or mental health teams in other areas, maternity, health visiting, and, where appropriate, social services, to ensure effective discharge planning
- Maintain a record of the review in the case notes.

#### **4.8 Discharge Process**

Discharge planning commences from the date of admission to the MBU.

All patients discharged from hospital will have arrangements in place to be followed up within 3 days of discharge. NHS GGC patients will usually be seen by the CPMHT. Out with NHS GGC, follow-up by the local CPMHT (if available) or CMHT is co-ordinated.

A Discharge summary is sent to GP, HV and others involved in the woman and baby's care within 24 hours of discharge.

Patients and families have 24-hour access to telephone advice from the MBU for 4 weeks after discharge.

#### **4.9 MBU Staffing provision**

As the MBU is a national resource, one of only two MBUs in Scotland, the movement of inpatient staff to other wards should be a last resort and only after discussion with the Perinatal Senior Management Team.

## **5. Community Perinatal Mental Health Team (CPMHT)**

The community team is a specialist service providing assessment and treatment for women who have, or are at risk of having, significant mental disorder in pregnancy or the postnatal period. The service will also see women with pre-existing severe mental disorder for pre-pregnancy advice on risk and medication management.

PMHS specific roles in assessment, care and/or treatment include:

1. Women who have, or are at risk of having, significant mental illness newly arising or co-occurring in relation to pregnancy and the first postnatal year
2. Women who have pre-existing significant mental illness which places them at high risk of childbearing-related relapse and who require assessment and advice in advance of becoming pregnant
3. Developing, nurturing and maintaining the relationship between the woman and her infant and promoting optimal child development

The PMHS will work in partnership with partners and families, maternity services, primary care (including health visiting and Family Nurse Partnership), adult social services, children & families social services and other agencies, to design, implement and oversee comprehensive packages of health and social care to support people with complex mental health needs.

### **5.1 Community Function Includes:**

- Assessment and treatment of significant mental disorder co-occurring or newly arising in relation to childbearing
- Facilitation and enhancement of the developing mother-infant relationship to optimise infant development
- Assessment and facilitation of parenting skills in the context of acute maternal mental disorder.
- Therapies include a range of biological, psychological and psychosocial interventions including interventions to enhance the mother-infant relationship.

### **5.2 Maternity Liaison Service:**

The maternity liaison service is provided by members of the community perinatal mental health team. It is responsible for the assessment and treatment of women under the care of NHS GGC maternity inpatient hospitals (antenatal and postnatal wards) where they have, or are at risk of developing, significant mental disorder. The CPMHT will take into account the need to respond in a way that is appropriate to the particular needs presented in individual cases.

### **5.3 Role and Responsibilities of Team Members**

PMHS staff will act to:

- Reduce the stigma associated with mental health care
- Work in partnership with women, their partners and families
- Provide assessment, diagnosis and treatment working within relevant mental health legislative processes
- Focus upon improving the woman's mental and physical well-being
- Work, where appropriate, to facilitate and enhance the mother-infant relationship
- Always prioritise the safety and wellbeing of the infant and other dependent children
- Utilise the experience and knowledge of all team members to help facilitate a holistic approach to women, their partners and families
- Ensure care is delivered in the least restrictive and disruptive manner possible
- Stabilise social functioning and protect community tenure.
- Work in collaboration with partners in care.

### **5.4 Access and Referral System**

Women will be able to access services through referral from their maternity team, GP, health visitor, mental health team or other health and social care professionals. Referrals should be addressed to the PMHS and not individual disciplines. There is an online referral form.

Referrers are encouraged to use the Advice Line if they have concerns and feel the woman may require sooner assessment.

The PMHS will prioritise access to women whose mental health and accompanying social care needs impacts most severely on their ability to function within the community and care for their infant, and to women who are at high risk of significant perinatal mental disorder.

The PMHS aims to be a 'one stop shop' for community/maternity liaison referrals, ensuring a single point of access for referrers, even where a woman is already known to other mental health services. The PMHS will act to triage referrals, ensuring they are passed on to a more appropriate service if appropriate, in a timely fashion, and the referrer and GP notified of this. This process is enhanced by the Advice Line operated by CPNs who will, if necessary, escalate referrals to urgent or same day response if required.

### **5.5 Eligibility**

Those eligible for a service from the PMHS are women who have, or are at risk of having, mental disorder in relation to pregnancy or the postnatal period, which significantly impairs functioning. This may include their ability to manage the developing relationship with their infant. Women referred will include those who are:

- Preconception and requiring advice on risk in relation to the interaction of significant mental disorder and pregnancy/childbearing.
- Pregnant and experiencing, or at high risk of experiencing, significant mental disorder, which requires specialist assessment, treatment and co-ordination of care.
- Within 24 weeks after delivery and experiencing, or at high risk of experiencing, significant mental disorder, which requires specialist assessment, treatment and co-ordination of care.
- Those between 24 and 52 weeks after delivery, who have previously been seen by the service in this index pregnancy/postnatal period, and who require re-referral.
- Women currently in the care of mental health services may be managed by PMHS or collaboratively with their usual mental health team, depending on clinical need and woman's wishes.

The service will prioritise:

- Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.
- Significant changes in mental state, particularly when occurring in late pregnancy and the early postnatal period.
- Complex disorders resulting in significant disturbance to the mother-infant relationship.
- Complex disorders where there are expressions, thoughts or acts of violent self-harm in relation to pregnancy or the postnatal period.
- Complex problems of management and engagement.
- Any mental disorder where there is a persistent risk of self-harm or harm to others where the level of support required exceeds that which a primary care mental health team (PCMHT) could offer.
- Urgent presentations arising between 28 weeks of pregnancy and 6 weeks postpartum.

## **5.6 Processing Referrals (Including Response Times)**

In order to process the referral, the team requires accurate clinical information. If this information is insufficient, the PMHS will gather further information in keeping with response times below prior to any assessment taking place. Health Professionals are encouraged to contact the PMHS Advice Line.

All referrals accepted for assessment by the PMHS will have a record created (or where a record already exists, continued). All members of the team are responsible for ensuring records are maintained according to professional and organisational standards.

The PMHS community team will aim to achieve positive engagement with people referred, prioritising the response depending on level of risk/need under three categories:

- Urgent
- Soon
- Routine

The PMHS will have local guidance/SOP specifying actions to be taken if a service user does not attend an appointment arranged within each of the categories (see below).

Category of referral	Response time by CPMHT after referral has been received	Referral method	Criteria
<b>Urgent</b>	<ul style="list-style-type: none"> <li>Telephone contact by clinician to patient on the same day to establish immediacy of response required.</li> <li>Full Initial Assessment within 48 hours</li> <li>In cases where an urgent same-day response (within 4 hours) is not possible, the team will liaise with appropriate mental health services, for example Crisis or IHTT.</li> </ul>	<ul style="list-style-type: none"> <li>Telephone call to Advice Line</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>Supporting written referral via PMHS Referral form or SCI gateway</li> </ul>	<p>Presentation with immediate risk of self-harm and/or active plans of suicide, significant risk to others, acute distress due to psychiatric illness or where someone with a mental health problem requires an immediate assessment.</p> <p>This may include the situation where a service user is acutely psychotic, has rapidly changing mental state or requires admission to hospital. (Refer to Psychiatric Emergency Plan)</p>
<b>Soon</b>	<ul style="list-style-type: none"> <li>Contact within 3 days.</li> <li>Assessment within 14 working days</li> </ul>	<ul style="list-style-type: none"> <li>PMHS Referral form</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>SCI gateway</li> </ul>	<p>As above, although immediacy is not present; referrer is satisfied patient and/or others is in no immediate danger but requires intervention within the next few days.</p> <p>Service users discharged from inpatient services to the community team will have contact within 3 days of discharge.</p>
<b>Routine</b>	<ul style="list-style-type: none"> <li>Assessment within 28 days</li> </ul>	<ul style="list-style-type: none"> <li>PMHS Referral form</li> <li>SCI gateway</li> </ul>	<p>Pre-conception assessment and advice.</p> <p>Moderate to severe mental illness.</p> <p><i>Medical outpatient and psychology appointments may necessitate a longer wait.</i></p>

## **5.7 Patients in Crisis and/or presentation Out of Hours**

PMHS may be able to manage crisis assessment and support within working hours, however circumstances may arise where the intensity of support requires input of the local Crisis/IHTT team. Where it is necessary to involve the Crisis/IHTT team, and where possible, joint assessment would occur during working hours to ensure continuity of care, good communication and the provision/availability of specialist advice from the referring service.

If a first presentation is made via the crisis/unscheduled care service and appears appropriate for the PMHS, the perinatal service should be contacted on the same/next working day and arrangements made for a joint assessment with the PMHS within the next 2 working days.

PMHS will work jointly with local CRISIS, IHTT, Out of Hours and Unscheduled Care services to manage perinatal risk out with PMHS working times. PMHS should receive an update from other services the next working day.

## **5.8 Did Not Attends (DNAs) And Could Not Attends (CNAs)**

DNA/CNA protocol will follow NHSGGC policy

Patients who disengage from service – All health professionals and others who are involved with the woman will be informed and any risk to self or others including baby will be highlighted. NHS GGC policy will be followed.

## **5.9 Screening**

All referrals will be screened daily and urgent referrals will be dealt with on receipt. When it is clear from the information on the referral that an individual's needs would be more appropriately met by an alternative service/team, the referral will be passed by the PMHS to this service and this decision will be communicated to the referrer.

## **5.10 Before the Assessment**

Before assessment, PMHS staff will endeavour to ensure that the woman is informed of:

- the process of assessment and how long the appointment will last.
- if an interpreter is required
- the assessment will cover all aspects of their experiences and life.
- issues relating to confidentiality and data protection as this applies to them.
- the basic approach of shared decision-making.
- although they can be accompanied by a family member, carer or advocate for all or part of the assessment, it is preferable to see the person alone for some of the assessment.
- their right to refuse permission for any trainees or students to be present.
- choice of venue
- format of assessment may be telephone, face-to-face or video (eg Attend Anywhere) depending on clinical risk and need, in line with NHS GGC guidance.

- how to contact the team if they have any queries, for example changing appointment, difficulties getting to appointment etc.

## 5.11 Initial Assessment

All routine initial assessments will be undertaken within the time period mentioned above.

A Registered Practitioner will undertake an initial assessment of the individual's presenting mental health and social care needs. The initial information gathered from multiple sources includes:

- An exploration of the presenting problems
- The identification of clinical signs and symptoms, including ability to self-care
- The identification of immediate social stressors and social networks, including financial, housing, educational and vocational issues
- A risk assessment and management plan which is recorded in the service user's care plan
- Psychiatric history including past records, family history and medications
- Current pregnancy and obstetric history
- Mode of infant feeding
- An investigation of physical health problems:
  - Current physical health medication including side effects and compliance with medication regime including contraception
  - Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use
  - Consideration of risk of cardiovascular disease, metabolic disorders, and excessive weight gain
- An assessment of practical problems of daily living. This includes basic psychological and social needs, level of functioning and communication needs
- An assessment of the service user's needs strengths, skills and resources. This includes basic psychological and social needs, level of functioning and communication needs
- Identification of infant interaction/attachment
- Identification of risk to unborn baby or infant
- Identification and recording of the service user's primary carer, or lack thereof
- Identification of dependents including their wellbeing, needs, and any childcare issues. This includes the names and dates of birth of any young people.

On completion of the Initial Assessment a provisional diagnosis and holistic person-centred formulation including strengths, difficulties and personally defined goals is recorded in the service user's plan of care.

The outcome of the assessment is discussed and the plan of care will be agreed and shared with the service user and their carer (with consent) in a format that meets their needs. A copy of the assessment summary will be sent to the referrer, maternity, Health visitor and GP within 2 weeks following completion of the assessment.

In some cases following initial assessment, individuals referred to PMHS may be identified whose care and treatment is more appropriately managed by another service or team. In such instances it is the PMHS responsibility to avoid duplication in assessment and unnecessary delays for the

service users and therefore the PMHS will:

- Expedite the referral to the appropriate service
- Ensure the referral is considered/ discussed, and
- Ensure the individual is directed to the appropriate service taking account of clinical presentation / risk and urgency of response required

To support this, the initial assessment, risk assessment and all relevant documentation will be copied to the relevant service.

## **5.12 Involving Families and Carers**

Consistent with the principles of the Triangle of Care, PMHS staff will discuss with the person using mental health services if and how they want their partner or family to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances and should not happen only once. All decisions and discussions will be recorded in the plan of care.

If a woman wants her partner or family to be involved, PMHS staff will facilitate and discuss this involvement between the woman and her partner/family. This will include discussion of:

- Consent for partner/family involvement
- Confidentiality and sharing of information on an ongoing basis
- How partners and families can help support the service user and help with treatment plans
- Ensuring that no services are withdrawn because of the partner's or family's involvement in delivering aspects of care, unless this has been clearly agreed with the woman and her partner or family
- Verbal and written information about the mental health problem(s) experienced by the woman and the treatments indicated
- Their right to a formal carer's assessment and how to access this.

If the woman does not want her partner or family to be involved in her care, consistent with the Triangle of Care guidance, PMHS staff can:

- Give the partner/family verbal and written information on the mental health problem(s) experienced by the woman and the indicated treatments.
- Give the partner/family information about statutory and third sector/voluntary, local support groups and services specifically for families or carers, and how to access these.
- Tell the partner/family about their right to a formal carer's assessment and how to access this.

## **5.13 Assessment Feedback at MDT Meeting/Allocation**

There will be (as a minimum) a weekly Multidisciplinary Team Meeting held, supported and led by senior staff members including medical, nursing, psychology, occupational therapy and social work colleagues. At these meetings, formulations from initial assessments, team assessments and assessments requiring multidisciplinary input will be presented and discussed.

If the outcome of the initial assessment is acceptance into the CPMHT then a full assessment of the individual's health and social care needs will be undertaken to determine which intervention(s) is required to meet the assessed needs of the individual. A key worker/lead professional/named practitioner will be identified to coordinate completion of the assessment.

The assessment and a plan for the delivery of treatment interventions and expected outcomes should be completed within 6 weeks of the date of referral.

The outcome of the assessment is discussed and the plan of care will be agreed and shared with the woman. A copy of the assessment summary will be sent to the referrer within 2 weeks following completion of the assessment.

## **5.14 Interface with Specialist Mental Health & Social Services**

The inpatient and community services have established links with other specialist services and with the General Adult service. Protocols for interface/joint working are in place.

## **5.15 Interventions**

The PMHS operates as part of a whole-system of care. Where a person receives an intervention will be dependent on the level of severity, the skill mix available within the team and supervision arrangements.

Interventions delivered by the PMHS will be on a 'matched/stepped-care' basis, based on individualised assessment of need, and will be governed by the principle of the delivery of the *minimum effective level of intervention*. The PMHS, as a minimum, will provide:

- Full assessment of health and social care needs
- Evaluation of the effects of mental disorder on the developing mother-infant relationship and the mother's capacity to care for her infant
- Diagnosis including possible alternative explanations for an individual's difficulties.
- Formulation of a plan of care and interventions/treatments
- Risk assessment and formulation of a risk management plan
- Evidence based interventions aimed at promoting well-being, independent living, and recovery and relapse prevention
- Psychological therapies and interventions
- Interventions to facilitate and enhance the mother-infant relationship
- Medications management including physical health care where appropriate, as per NHSGGC policy
- Signposting and advice/guidance
- Support with activities of daily functioning
- Family and partner support
- Help in accessing local opportunities in work and education

The duration of treatment delivered will be in keeping with clinical guidelines and may be delivered in groups or on a 1:1 basis. Treatment delivery should be implemented flexibly in response to individual patient needs.

## **5.16 Management of Perinatal Risk**

The assessment and management of perinatal risk is an integral part of the screening and assessment processes and is an ongoing process with constant consideration to Adult Support and Protection and Child Protection. All women will have a current completed perinatal risk assessment and associated perinatal risk management plan.

Perinatal Risk assessments and management plans will be regularly reviewed at MDT Reviews (the frequency of MDT reviews will be outlined in the plan and will occur as a minimum 3-monthly, and at least once in the antenatal and postnatal period). Out with these times, risk assessments will be updated at points of transition and if there is an alteration or change to the woman's presentation or their management/treatment plan.

All information relating to risk assessment and risk management plans will be recorded in the woman's health records and on the electronic patient records system.

In line with NHSGGC policies, information relating to the woman's risk assessment and management plan will be communicated in a timely, concise and effective manner to all those concerned in providing care, including external agencies.

Given the core importance of child protection to the work of the PMHS, staff will prioritise attendance at Social Work child protection meetings where possible or provide information via the NHSGGC Adult Mental Health Child Protection reporting template

## **5.17 Care Planning**

All women and, where appropriate, their partners and families, will be involved in the formulation of their plan of care. Care plans will be formulated and agreed utilising a strength-based and recovery-focused approach to care delivery which optimises the woman's ability to self-manage. Women will be asked to consent to and agree their care plan and this will be recorded in the care plan. Where the woman disagrees/lacks capacity/does not wish to proceed with the care plan, this will be recorded within the care plan.

The PMHS will keep GPs, maternity services, health visitors and other members of the multi-disciplinary/multi-agency team(s) informed of any changes to an individual's care plan including medication changes. This will occur as an update on progress or following a 3-monthly review if there are no changes to the plan.

All women will have a Pregnancy & Early Postnatal care Plan (PEPP) completed by 32 weeks which is agreed with the woman and shared with maternity, GP, health visitor and other relevant professionals or organisations

## **5.18 Record Keeping**

All patients should be registered on EMIS Web. The PMHS must comply with EMIS Web and other systems data recording standards.

All written and electronic records must adhere to the Health/Local Authority recording policies and in accordance with professional standards to provide an objective overview of all contacts and actions relating to the individual woman.

All records, paper or electronic, are treated as confidential documents. Information is only shared on a 'need to know' basis with the woman's permission and under the scrutiny of the Caldicott principles and in accordance with NHS/GGC Information Sharing policy, unless the situation meets necessary risk requirements which would require those rights to be breached.

An entry will be made in the clinical record for each clinical contact. This record will include details on the intervention delivered, be signed, dated and include details of the practitioner's job title and team (or similar equivalent when using electronic patient records). The entry will also include details of the next planned session, where this is applicable.

Formal communication with GPs/referrers/Health Visitors/Maternity and any others will be at the point of

- assessment (including DNA)
- medical outpatient clinic review
- update by CPN every 3 months or if significant change to presentation or treatment
- disengagement from PMHS
- discharge.

An entry will be made in the clinical record for each clinical contact. This record will include details on the intervention delivered, be signed, dated and include details of the practitioner's job title and team (or similar equivalent when using electronic patient records). The entry will include details of the next planned session, where this is applicable

## **5.19 Multidisciplinary Team (MDT) Reviews**

There will be regular community MDT review meetings (at least weekly), at which all new assessments will be scheduled for review and complex cases and untoward events discussed.

All service users will be formally reviewed within 3 months of allocation to the PMHS.

If continued input is required from mental health services after the infant is 12 months old, discussions will take place with the woman's local CMHT, or appropriate service, to transfer the case.

The named practitioner (coordinator of care) / key worker will complete MDT documentation prior to the meeting, for example using SBAR.

All meetings will be chaired by a senior member of clinical staff.

The named practitioner/ key worker will attend and contribute to the MDT review by updating the team on all aspects of care and progress recorded in:

- Record of care
- Risk assessments and plans.
- Staying Well Plan – as appropriate.
- Crisis management plans – as appropriate.

At the MDT review the community team will:

- Review current care plan and consider discharge/transfer or requirement for stepped up/down care.
- The named practitioner/key worker will record on the MDT SBAR: actions agreed in relation to the service user's care; those persons responsible for completion of the actions; date by which actions are to be completed; how and when actions to be reported back to MDT.
- Maintain a record of the review in the case notes.
- Review Pregnancy & Early Postnatal Plan (PEPP)
- Updates from the MBU

## **5.20 Discharge/ Transfers**

Consideration and planning for discharge is an integral part of ongoing care planning. Discharge from the PMHS will be arranged following the implementation of a care plan and following discussion with the woman, and where appropriate partner/family/other professionals/agencies involved in their care. All patients will have advance notice of intention to discharge/transfer and be provided with clear information in relation to any future access to services. Joint visit with local CMHT or other service that the woman is being transferred to will be facilitated by PMHS where possible.

Prior to discharge it is essential that risk assessments are updated in relation to both the Mental Health (Care and Treatment) (Scotland) Act 2003,2015; Adult Support and Protection Act; and Child Protection issues. The outcome of these assessments must be recorded within the integrated health record and shared as appropriate with agencies involved in the woman and baby's care.

A written discharge summary will be provided to both the patient and their GP within 10 working days of discharge.

The summary will include;

- A summary of interventions provided
- The effectiveness of those interventions
- Recommendations for ongoing future treatment (including medication).
- Identified triggers and/or an indication of the early warning signs of future deterioration of the individual's mental health

- Any ongoing or potential risk factors
- Mother-infant relationship using GIRFEC principles
- Advice on future pregnancies including pre-conceptual counselling
- Arrangements for referral back to the PMHS if required

The discharge summary will be filed in the woman's health record (and any other relevant IT systems).

### **5.21 Transfer- CPMHT to Inpatient Care and Vice Versa**

When a woman is admitted for inpatient care, the CPMHT will continue to have active involvement and will contribute to plans for discharge.

All women known to the community team who are discharged from inpatient care will have arrangements in place to be followed up within 3 days of discharge.

### **5.22 Service Interfaces/Transitions**

When a woman is moving from one distinct part of the service to another, PMHS will maintain active involvement with the service user until transition is complete.

Agreed protocols and guidance will be developed with other mental health services where care is shared or there is significant involvement in a patient's care pathway.

## **Following Sections Apply To Both MBU & Community Perinatal Mental Health Team**

### **6. Co-Ordination of Care**

#### **6.1 Co-Ordination of Care**

Co-ordination of care is key to delivering better outcomes for patients through better integrated mental health services. It should:

- Empower people who use services by giving them greater choice in how their support and care are tailored to meet their needs.
- Ensure greater continuity and speedier delivery of care.
- Ensure services reach key decisions and determine service outcomes quickly and effectively.
- Shape the development of more integrated and more responsive services, with better results for people who use them.
- Support service users in the application of self-directed support.
- Use of Care Programme Approach if clinical presentation requires.

#### **6.2 The scope of co-ordination of care within the PMHS**

Co-ordination of care is relevant only for those individuals with complex, rapidly changing or unstable needs who may require a range of coordinated services and is available for as long as necessary to support people who are the most vulnerable or dependent in terms of their mental health and community care needs.

The key function of co-ordination of care within the PMHS is to have a “named practitioner” tailor services to meet individual needs; and to co-ordinate the range of services and interventions required to support the individual and their carer within the community.

In doing so, the PMHS aims to:

- Target co-ordination of care for those with complex unstable needs.
- Prevent duplication, omission and confusion for the service user, their family / carers and referrers.
- Provide individualised and carefully coordinated plans of care
- Support service users (where applicable) to apply for and make use of “Self-Directed Support” (SDS). Self-directed Support allows people, their carers and their families to make informed choices on what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes
- Ensure timely and seamless step-up or step-down care within the team and within integrated mental health service.
- Liaise with Named Person (Health Visitor)

### **6.3 Named Practitioners: Role and Responsibilities**

Co-ordination of care will be characterised as intensive condition management and will be undertaken by a range of professionally qualified staff in health and social work. The designated coordinator of care (named practitioner) combines planning and co-ordination of care with a therapeutic, clinical and supportive role for service users who have complex and frequently changing needs.

During periods of leave which may cause disruption to service delivery when the coordinator of care /named practitioner is not available, the Nurse Team leader will ensure allocation of caseload to other professionals. This will be communicated to the service-user and where appropriate, the carer.

### **6.4 Working in Partnership and Interface with Specialist Mental Health & Social Services**

Partnership working is actively promoted within the PMHS as a mechanism for improving health and social care outcomes for service users. The service uses a number of digital platforms.

Protocols for interface/joint working are in place and included in the Perinatal SOP guidance document maintained by the service.

Partners (local and regional) include:

- Service users, families and carers
- Mental Health services including CMHTs and Specialist services
- Primary care workers – GPs, Health Visiting staff
- Child & Family Social Work
- Maternity services
- CRISIS, Out of Hours and Unscheduled care services
- Eating Disorders
- CAMHS
- Other local authority staff
- Police and probation services
- Voluntary and third sector organisations and community groups
- Housing associations
- Liaison teams

The PMHS will maintain close working relationships, particularly in relation to joint working and interface, with:

- Maternity services
- Health visiting
- Children and families social work services
- Community Mental Health Teams and other Specialist services

- CRISIS, Out of Hours, Mental Health Assessment Centres and Unscheduled care services
- ESTEEM First-episode psychosis service
- Substance misuse services
- Eating disorders services
- CAMHS
- Learning disability psychiatry

When women are assessed as having a dual diagnosis (predominantly mental illness combined with a learning disability, eating disorders, physical disability or misuse of substances) the PMHS will work in partnership with colleagues in other specialist teams.

PMHS will work in conjunction with other professionals and agencies to provide education and guidance about perinatal mental health issues.

As a key member of National Managed Clinical network for Perinatal & Infant Mental Health MBU and CPMHT forum, this allows engagement with regional and national partners including digital platforms.

In addition to the above,

#### **MBU**

- The MBU has established links with other specialist services and with the General Adult service.
- As a regional inpatient service, the PMHS will maintain close relationships with mental health, health visiting and social work services in other NHS boards admitting to the West of Scotland MBU. This will include yearly feedback (from and to referrers and managers) about patterns of service use and any issues arising.

#### **Community**

- The PMHS offers advice and support to colleagues, including the provision of medical advice and information (particularly concerning medication issues in pregnancy and breastfeeding), to GPs, health visiting, maternity and other mental health staff. This is delivered through educational sessions and the PMHS Advice Line.

### **6.5 Equality, Recovery and Social Inclusion**

The PMHS will adhere to local and national guidance on equality, recovery and social inclusion.

## **7. Quality Improvement, Key Performance Indicators (KPI) and Outcomes**

Both the MBU and CPMHT are members of the Royal College of Psychiatrists Perinatal Mental Health Quality Network and endeavour to maintain National accreditation standards.

The National Managed Clinical Network for Perinatal and Infant Mental Health are collecting data from MBU and CPMHT which are aligned to the Care Pathways for Perinatal and Infant Mental Health.

Relevant information mentioned below is included in the annual clinical governance report.

### **7.1 Quality Improvement**

Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. The PMHS will endeavour to utilise Quality Improvement methods to:

- Understand emerging problems, with a particular emphasis on what the data illustrates
- Understand the processes and systems within the organisation - particularly the patient pathway – and whether these can be simplified
- Analyse the demand, capacity and flow of the service
- Choose the tools to bring about change, including leadership and clinical engagement, skills development, and staff and patient participation
- Evaluate and measure the impact of a change

Audit, Critical Incidents and Service User and Carer feedback are some of the rich sources of learning and data available from within the Board and should be used to help inform quality improvement work within the PMHS.

The indicators chosen represent high level 'core' aspects of each of the 6 quality dimensions and align with Governmental targets / local delivery plan standards and the following quality statements:

1. People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.
2. People using mental health services are actively involved in shared decision-making and supported in self-management.
3. People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
4. People can access mental health services when they need them.
5. People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
6. People using mental health services jointly develop a care plan with mental health and social care professionals, and where possible are given a copy with an agreed date to review it.
7. People using mental health services who may be at risk of crisis are offered a crisis plan.

## **7.2 Key Performance Indicators**

Key Performance Indicators (KPIs) support the monitoring of the performance of the PMHS across a range of areas. PMHS will make use of KPIs to ensure that they:

- Provide evidence of quality and positive Service User experience
- Provide measurement of change
- Provide measurement of variance
- Provide efficient and effective services
- Undertake benchmarking against other services

Local services will regularly review their KPI performance via the Mental Health Dashboard.

The KPIs will be reported regularly through sector and HSCP governance structures, and form part of the monitoring of the performance of the PMHS through the appropriate local performance review process.

## **7.3 Outcome Measures**

The PMHS will utilise an array of outcome measures to demonstrate, measure and evaluate interventions and treatments offered by the service.

## **8. Management Arrangements**

### **8.1 Clinical and Operational Leadership**

The PMHS will have an identified clinical lead and managerial lead. This role may be delivered by one post holder, or may be two separate roles, depending upon local agreement. However this is organised, it is imperative that these roles are clarified in the SOP.

PMHS Senior Management Team meet monthly to review governance issues, critical incidents, finance, staffing, service development and interface with others.

The PMHS Senior Management Team consists of:

- Clinical Lead
- Managerial Lead
- Consultant Psychiatrists
- Nurse Consultant
- MBU Senior Charge Nurse
- Community Nurse Team Leader
- Consultant Clinical Psychologist

### **8.2 Clinical and Line Management Supervision**

The PMHS Management Team in collaboration with the clinical and professional leads is responsible for ensuring all staff working within the PMHS will have access to, and participate in, Clinical and Caseload / Line Management supervision commensurate with the clinical interventions that are being delivered and adhere to Professional, Organisational and Governance policies.

### **8.3 Health and Safety**

It is the responsibility of the PMHS Manager to ensure that all staff attend relevant Health and Safety training identified by local risk assessment and statutory requirements.

All PMHS staff must ensure that they are familiar with and conform to the local HSCP Health and Safety policy and procedures including lone working, fire safety, child protection, incident reporting, recording and reviewing policies.

## **9. Workforce**

### **9.1 Staffing and Resources**

Clinical services provided by the PMHS will comprise of staff qualified in Nursing, Nursery Nursing, Psychology, Medicine, Occupational Therapy, Health Visitor and Social Work.

A competency-based approach will be taken by all teams to ensure that the clinical interventions set out in this operational policy can be delivered appropriately and in a manner which is:

- Caring.
- Psychologically minded.
- Responsive to the individual woman's needs and those of her infant, partner and family.
- Characterised by enthusiasm, commitment and skill achieved by investing in the supervision of clinical practice, training, maintaining time for reflective practice and avoiding burn-out.

Linking competency to the workforce and workforce development, the core training plan for the PMHS will aim to ensure all staff, as a minimum, are trained in and have competence in,

- Person Centred Care
- Recovery based approaches to care
- Effective communication skills
- Suicide prevention/first aid
- Risk assessment and risk management
- Assessment skills
- Working with families and carers
- Equality and Diversity
- Infant mental health, attachment and development
- GIRFEC
- Prescribing and administration of medicine in pregnancy and breastfeeding
- Complications late stages of pregnancy and early postpartum
- Psychological interventions at a variety of levels
- Specific perinatal mental health training requirements as per the perinatal training matrix
- NES Perinatal and Infant Mental Health modules linked to the Curricular Framework for Perinatal and Infant Mental Health at Specialist level 4

### **9.2 Workload Management**

Clinical activity (direct and indirect) should make up no less than 70% of each practitioner's time and this requires continuous monitoring through caseload management and job planning arrangements.

The PMHS Management Team, in collaboration with the clinical and professional leads, is responsible for monitoring the team's workload, ensuring that systems are in place for setting

priorities for allocation and discharge and making certain that there is an equitable distribution of cases across team members.

In fulfilling this function, the following factors will be taken into consideration:

- The service demand and capacity
- Prioritisation of those in greatest need
- Team members individual caseloads and functions that they serve (complex acute/stable)
- Demand/impact on administration staff

## **10. Further Information on Perinatal Mental Health Service**

The PMHS has an expanded web presence with detailed information for referrers, 'top tips' and virtual tour for prospective inpatients

[www.nhsqgc.org.uk/perinatalmentalhealthservice](http://www.nhsqgc.org.uk/perinatalmentalhealthservice)