NHS
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SCOTTISH EXECUTIVE

Health Department
Director of Service Policy and Planning

Dear Colleague

FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND: PERINATAL MENTAL ILLNESS/ POSTNATAL DEPRESSION HOSPITAL ADMISSION AND SUPPORT SERVICES

Summary

1. Attached to this letter is an expanded addition to the Service Profiles section of the Framework for Mental Health Services in Scotland. Its purpose is to assist commissioners, planners, service partners and staff to agree approaches for the organisation of accommodation, services and support to allow mothers suffering from a perinatal mental illness (including postnatal depression) to be admitted to hospital accompanied by their child.

Background

2. The Mental Health (Care and Treatment) (Scotland) Act 2003 includes provisions to allow mothers with postnatal depression to be admitted to hospital accompanied by their child. These provisions come into force on 1 April 2005. A Short Life Working Group was appointed in May 2003 to consider, prepare and publish appropriate guidance to inform the planning processes. Though the legislation uses the term *post-natal depression*, the Group adopted the more inclusive *perinatal mental illness* to better describe the desired wider scope of the new arrangements.

3. Given the April 2005 implementation date for these provisions, the attached guidance builds on the precedent by offering a template for the best organisation of joint admission services and lends itself equally for application as a planning or an audit tool. The document anticipates the forthcoming legislation and reflects current advice on the best organisation of services to allow mothers to be admitted to hospital, accompanied by their child.

4th March 2004

Addresses

For action
Chief Executives, NHS Boards
Chief Executives, NHS Trusts
Chief Executives, Local Authorities
Directors of Social Work/Chief Social Work Officers

For information
Chief Executive, COSLA
State Hospitals Board for Scotland
Chief Executive, Common Services Agency
Executive Director, NHS Education for Scotland
Chief Executive, NHS Health Scotland
Chief Executive, NHS Quality Improvement Scotland
Secretary, Mental Welfare Commission for Scotland
Scottish Partnership Forum
Appropriate voluntary/professional organisations

Enquiries to:

Mental Health Division

Phil Harley
Room 2N-08
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 3098
Fax: 0131-244 2970
E Mail:
Phil.Harley@scotland.gsi.gov.uk

4. Each NHS Board in consultation with their partners will decide how they wish to respond to the new statutory provisions. The attached template includes guidance (but does not impose a model) on regional approaches to cover what for some will be high cost but low volume care provision.

Action

5. Agencies are invited to incorporate proposals for local application and delivery of the service and support arrangements and approaches within their planning processes.

6. This HDL is also available at (www.show.scot.nhs.uk) and on the Mental Health and Well Being Support Group site (www.show.scot.nhs.uk/mhwbsg/).

Yours sincerely

IAN GORDON
Director of Service Policy & Planning

A FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND
SECTION 3: SERVICE PROFILES

PERINATAL MENTAL ILLNESS/POSTNATAL DEPRESSION HOSPITAL ADMISSION AND SUPPORT SERVICES

- *Framework for Mental Health Services in Scotland* provides the guiding principles for all approaches to perinatal mental illness/postnatal depression care.

- This document sets approaches for an admission template/specification for the organisation of services and supports to allow mothers suffering from a perinatal mental illness (including postnatal depression) to be admitted to hospital accompanied by their child, and adopts the model set out in the *Framework for Mental Health Services in Scotland - Section 3: Service Profiles.*

- The template/specification is consistent with the Mental Health (Care and Treatment) (Scotland) Act 2003 which includes provisions designed to improve the care and the care surroundings of mothers with perinatal mental illness, including postnatal depression, to allow mothers to be admitted to hospital and accompanied by their child. The guidance also recognises the need for access to developmental checks for the child and the required interventions (immunisations etc) to be undertaken while mother and child are in hospital and to ensure continuity of care on discharge.

- The following publications and guidance will further inform the design and operation of Perinatal Mental Illness/Postnatal Depression Units and associated services:

  - United Nations Convention on the Rights of the Child (1989)
  - Criminal Procedure (Scotland) Act 1995 HMSO
  - the CRAG report *on Early intervention in Postnatal Depression, (1996);*
  - Services for Women with Postnatal Depression (18 March 1999), NHS MEL (1999)
  - the relevant sections of *Framework for Mental Health Services in Scotland, (Service Profile added, 1999);*
  - the Royal College of Psychiatrists' Council Report No 88 *Perinatal Mental Health Services* (2000);
  - the Mental Health Reference Group Report – Risk Management (Scottish Executive 2000)
  - Regulation of Investigatory Powers (Scotland) Act 2000, HMSO
  - *Protecting Children – A Shared Responsibility : Guidance on Inter-Agency Co-operation,* Scottish Executive (2000)
  - *Sure Start Guidance: Guidance on the Expansion of Support for Families with Very Young Children*, Scottish Executive (2000)
  - Reduce the Risk of Cot Death, Scottish Cot Death Trust/Scottish Executive guidance (Feb 2000), MEL 2000 (8)
  - the *Framework for Maternity Services in Scotland, (2001)*
  - *Why Mothers Die 1997 – 1999,* Confidential Enquiries into Maternal Deaths 2001
  - *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland* (Scottish Executive 2002)

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- the SIGN (60) guidance, *Management of Postnatal Depression and Puerperal Psychosis, (2002)*
- Engaging people: Observation of People with Acute Mental Health Problems (NHSScotland / CRAG 2002)
- Early Discharge Protocol for Patients in Secure Hospital Settings (NHS HDL (2002) 85
- Community Care and Health (Scotland) Act 2002
- the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) (NHS HDL(2003) 29, 49
- *Health for all Children Fourth Edition*, David M.B. Hall, and David Elliman, 2003
- *Managing Health at Work, Partnership Information Network Guideline*, Scottish Executive (2003)
- Protection of Children (Scotland) Act 2003
- *Implementing a Framework for Maternity Services in Scotland – Overview Report of the Expert Group on Acute Maternity Services, (EGAMS).* Scottish *Executive (2003*)
- Managing Health at Work, Partnership Information Network, Guideline. Scottish Executive (2003)
- National Programme for Improving Mental Health and Well-Being Action Plan 2003-06, Scottish Executive (2003)
- Agenda for Change, NHS HDL (2003) 36
- *Code of Practice for Registered Persons and Other Recipients of Disclosed Information, Disclosure Scotland* 2003
- and any other relevant published material.

- The National Audit of the Detection and Management of Postnatal Depression currently being conducted by NHS Quality Improvement Scotland and due to report in March 2005 will also inform best practice and standards for postnatal depression generally.

- The advice in this guidance complements but does not replace any existing relevant statutory provisions or related guidance.

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Principles

- The needs of the child and mother are paramount.

- This guidance and the approaches it promotes should be considered and advanced under the overarching principle that staff approaches and procedures be designed to enable and support, wherever possible, the mother as the principal carer for her child.

- Those protocols involving child protection and other security dimensions should be prepared in consultation with the local police and reflect legal advice.

- All Protocols referred to in this document should be prepared and agreed in consultation with all relevant parties and organisations and should be designed to ensure that all agencies and individual officers involved can deliver on the protocol conditions across geographic, statutory and other boundaries.

- All protocols and guidance arising from this document should be prepared in language and form that are accessible and, in terms of content, recognises the full range of ethnic and cultural differences.

- All protocols, procedures, training etc mentioned in this template should be kept under regular and on going review for continued relevance, and to ensure best practice, quality and individual rights are maintained. A written record of the reviews undertaken and follow up proposed and acted upon should be maintained and available for inspection.

- It is open to individual services to draw together a single practice protocol.

PERINATAL MENTAL ILLNESS/POSTNATAL DEPRESSION HOSPITAL ADMISSION AND SUPPORT SERVICES

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A FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND
SECTION 3: SERVICE PROFILES

PERINATAL MENTAL ILLNESS/POSTNATAL DEPRESSION HOSPITAL ADMISSION AND SUPPORT SERVICES

Dimensions of Care	Description Of Need	Ways In Which Services May Respond
1. Planning Catchment area upper /lower limits Travelling distances/Transport Numbers likely to require admission Best management arrangements – lead NHS Board, consortia etc Local authorities are essential partners in all parts of service planning & operation Cost responsibilities	• Local/ regional area Unit, inter agency services and support to facilitate the admission of mother accompanied by her child • Assess local need or wider need if regional unit/response is proposed • Have regard to public involvement processes from the earliest stage.	• Plan for local or regional provision of inpatient unit and services (including addiction services) in conjunction with local social work authority (ies), and voluntary sector partners to ensure that local services are in place to facilitate and enable discharge and ongoing support of mother, baby and wider family. • Plan, in conjunction with Scottish Ambulance Service, organisation of transport to inpatient unit and other services. • Arrange provision of a specialist inpatient unit with ready access to both maternity, neonatal and paediatric care, ideally located close to general adult in-patient psychiatric services to ensure safe and effective care for both mother and baby. • Organise provision of a community based mental health service to support mothers at home in all but the most severe cases. Organise on basis of ongoing assessment of need and client feedback. • Identify a Psychiatric Consultant to include within his/her remit specific responsibility for the regional provision aspects of the mother and child facility and service. • Identify local Consultants to include within their remit specific clinical responsibility for the local link to the regional mother and child facility and service. Consider links to input by specialist obstetrics/midwife service for severe cases.

		• NHS Boards should consider combining Regional and local clinical leads and representatives from users and carers, voluntary sector and local authorities as part of a Managed Care Network. • Protocol will need to be agreed and signed off by all NHS Boards and other agencies joined in a partnership regional provision arrangement. Consideration is needed to arrive at a position which ensures financial sustainability of the unit and service through continuing contributions from partners. • Protocol will be required on share of costs for those referred to the services outwith their own area of residence, and generally on issues including transport costs for family visits, possible foster costs which may be incurred e.g. for single parent who may require other children to be cared for nearby. • Agree geographical area for sources of referral. • Establish links and protocols with all relevant maternity unit staff/ General Practitioners /Community Health Partnership Administrators/ Midwifes/ Social Workers /Health Visitors/ Housing Officers/links to Addiction Services/Asylum, Refugee support organisations/others. • A Partnership Agreement will be needed to agree any and all relevant performance and other audit of the unit and service delivery and quality of care. • Operating and supporting protocols on access and delivery of services for mother and baby must be agreed with all stakeholders including local authorities.

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2. Legal Issues: In planning a facility and service, regard should be taken of all related legislative positions, including among others, the following: ▪ United Nations Convention on the Rights of the Child (1989) ▪ Children (Scotland) Act 1995 ▪ Criminal Procedure (Scotland) Act 1995 ▪ Data Protection Act 1998 ▪ Human Rights Act 1998 ▪ Adults with Incapacity (Scotland) Act 2000 ▪ Regulation of Investigatory Powers (Scotland) Act 2000 ▪ Mental Health (Care and Treatment) (Scotland) Act 2003 ▪ Protection of Children (Scotland) Act 2003 ▪	▪ **The needs of the child or unborn child are paramount, and it must be clearly documented how and why a placement decision is made, and by whom.** ▪ Status of child in unit ▪ Duty of care to mother and child ▪ All procedures and guidance should be matched against appropriate legislation	▪ **Every admission must document:** *** the reasons for admission of mothers or mothers to be** *** who has made the decision;** *** identify key worker responsible for the care and safety of the child.** ▪ NHS Boards to decide on status of child while in the facility and ensure appropriate records are maintained covering the child's care while in the facility. All involved with primary and community care of the child to be informed of 'admission' and progress to discharge stage. ▪ Reflecting their existing responsibilities, NHS Boards will have a legal duty of care towards mothers, children and visitors to the facility. ▪ For example, if CCTV photographs, footage and images are considered for use for identity purposes, this procedure must be explained to the people involved in the process. Appropriate information, including signposts in and around the facility should be arranged and consent must be obtained where appropriate
Admission Criteria	▪ Criteria for admission must be clearly stated and available to all possible referrers	▪ Any age, ethnic, cultural or religious or other specific sensitivities/needs of the mother must be taken into consideration in the planning of care and in the responses to needs. ▪ To be admitted for care in the unit, the mother will be accompanied by their child. Mothers to be, with a perinatal mental illness may also be admitted not least to ensure continuity of care.

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	▪ Where a mother with parental rights expresses her wish to be admitted to unit accompanied by their child	▪ Mental Health Officer required where mother detained under legislation ▪ Check for completed Advance Directive (for those women deemed to be at risk of developing mental illness and who have been asked to sign a statement conveying their wishes in the eventuality of their becoming unable to express a choice).
Parental Rights and Responsibilities	▪ The parental rights of adults involved in each case must be established and recorded at the earliest point, with evidence sought and verified where necessary	▪ Admissions will of course be determined by the clinical team. ▪ In most cases a child may be accepted to the facility only if the <u>mother</u> expresses a wish to care for the child in hospital. ▪ A father with parental rights and responsibilities cannot require the child to be accepted but <u>may</u> be entitled to remove the child. ▪ A father has parental rights and responsibilities if he: ❖ is, or has been married to the child's mother, or ❖ has entered into an Agreement with the child's mother in terms of Section 4 of the Children (S) Act 1995, or ❖ has been awarded parental rights and responsibilities by a Court under section 11 of the Children (S) Act 1995. ▪ Other persons who are not parents but have an interest in or connection to the child (eg a grandparent) may acquire parental rights and responsibilities by making an application to court under section 11 of the 1995 Act.
	▪ Respecting the mother's wishes as to family involvement	• Consider with legal advice what can be enforced re respecting the mother's wishes as to the involvement or otherwise of the extended family.

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Staff	▪ Liability and Responsibility	▪ Vicarious liability (powers or authority delegated to staff) is in place for staff under duty of care etc. ▪ Protocols are required setting out in clear terms and for each discipline and grade what level of responsibility they have for the welfare of the child and mother. The protocols should cover procedures for assessing, detecting, reporting and managing risk.
Local Authorities	▪ Cross Council border placements ▪ Social work supervision ▪ Mental Health Officer duties ▪ Reciprocity	▪ Placements should follow ordinary residency for adults and children. ▪ Recommended that each child should have an allocated Children & Families social worker from the Local Authority where the child ordinarily resides ▪ Mental Health Officer duties and responsibilities should be clearly defined and understood by all ▪ Participating Local Authorities e.g. for each Region should agree joint protocols for access of services. This protocol should fit within a managed clinical/care network approach

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3. Unit Design **The following guidelines represent the minimum expectations for a recognisable mother and baby unit.**	• Size of unit • Single bedrooms • Single cot rooms • Security • sightlines • 'Pinpoint' or similar tagging system • locking • feed preparation • resuscitation equipment • family accommodation • Disability needs	• The 2002 SIGN guidance is clear. Annexes and side rooms are not appropriate for this purpose. This guidance supports that concept. • Size will be determined and informed by assessment of local needs and area(s) to be served (see "Planning" section). • Design must reflect and deliver staff and patient safety (care in safety), applying anti-ligature / good observation arrangements. • Consideration should accord as a minimum to that which applies to any adult acute admission ward. • Room specifications should include: ❖ Day/play area large enough to accommodate toys etc ❖ Side rooms to accommodate cot & changing facilities ❖ Visiting area conducive to older visiting children ❖ Separate kitchen for storage and preparation of feeds (see infection control) ❖ Nursery area where infants can be apart from mothers as required ❖ Consideration of physical needs of mothers and mothers to be. • Appropriate security systems, eg electronic baby tagging, CCTV, electronic door entry systems. • Safe environment for children including covers on sockets; corner protectors; safety gates; temperature control approx 18 ^{o}C. • Arrangements for partner accommodation in event of woman being admitted from outwith local area.

4. Integrated Care Pathway		• Have regard to NHS MEL (1999) 27 on Services for Women with Postnatal Depression (18 March 1999). • Identify a member of staff with knowledge of the clinical area to co-ordinate or lead to advance NHS Board ICP policy for the perinatal mental health interest. • A senior local clinician and lead commissioner should be identified as product champions. • Integrated Care Pathways as recommended by SIGN (60) should be developed to reflect local needs and conditions. ICP should identify who and what is available in each area to ensure all accounted for in terms of training and information. • The ICP should be kept under ongoing review, evaluation and adjusted where/when required.
5. Assessment a) Identifying and building a relationship with those thought to be at risk	• Early identification of risk. • Antenatal assessment arrangements (Midwife /Health Visitor)	• Arrange antenatal screening sufficiently sensitive to assess risk of illness development in consideration of previous case history. • Any agreed protocol for risk and other assessment will be aided and informed where the arrangements include a key member of the Midwifery team with increased knowledge of mental health/social issues to act as co-ordinator during pregnancy. • Consider the role for general mental health services or for local hospital and other services working together to provide a whole package of care.

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		• Ensure all staff (ie GP, social worker, midwife, health visitor, family planning, mental health and psychology staff and all other relevant staff) are trained or have access to training on identifying risk and resilience factors linked to perinatal mental illness including postnatal depression. All midwives will need to be able to observe for identifiable mental illness.
b) Pre-admission	• Pre-admission protocol	• Agree pre-admission protocol scoped to include early/urgent response times and exploration of how, where and by whom pre-admission assessments could be carried out. • Consider what staff/mix should conduct the assessment (eg medical/ nursing) and what input from others involved currently and previously with the patient. . • Risk assessment must be carried out prior to mother's admission to determine if it is safe and in the best interests of the child to accompany the mother to a psychiatric mother and baby unit. • For those women who are deemed at risk of developing mental illness, clinicians should consider obtaining an advance directive of mothers' wishes for admission. • Consideration to include postnatal medical and paediatric needs and speed of response.

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c) Admission	• Single point of referral for **all** multi-professional, multi-agency contacts including tertiary referrals.	• Publicise single point of clinician referral contact arrangements. • Agree local core baseline criteria for referrals to and from the Unit which should be to a senior member of staff, eg Consultant/ Supervisor/Manager/Inspector or equivalent level in every case. Incorporate procedures to ensure consideration and application of "informed choice" by patient within the criteria. • Agree local baseline admission criteria for mothers (accompanied by their child), incorporating "informed choice" and personal capacity issues. (This calls for good links, agreed protocols and clear lines of communication with referring service(s)).
	• Mother and baby have separate needs assessment	• Protocols should detail which local authority or NHS Board has lead responsibility for professional child protection/ MHO input during inpatient stay. The protocol should identify and allocate responsibilities for statutory duties under Child Protection/Mental Health legislation. • Carer should be offered an assessment and should be undertaken where necessary.
	• Allocated key worker required for mother and separately for baby • Identify needs of child	• Protocols required on separate assessments of need for mothers and babies, detailing the who, what and when of the process. • Day to day management and care should be designed around a culture that highlights and ensures the needs of the child be considered when assessing the day to day care management of the mother.

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	▪ Advocacy • Information to be disseminated including written and verbal	• Mother has a right to independent advocacy • Best interests of the child will normally be promoted by the Social Work Department. • Protocols should be prepared on supporting visits and reflecting the agreements reached on how specialist advocacy services, particularly for baby, are to be delivered. ▪ Disseminate information to the mother on the way in which the service will provide support during and after the in patient stay and include a process for responding to stated preferences. Consider written material.
d) Discharge Planning	• Transition to local Services	• Discharge planning should start on mother's admission. • Perinatal Service team member should be identified to lead on planned transition/cohesion arrangements between service and community based care. • Establish a clear protocol for multi-agency pre-discharge planning involving appropriate members of the Community Mental Health Teams in the "receiving area". • Discharge planning and written plan should include case discussion with all disciplines involved in both the patient's and child's continuing care. All avenues of communication should be utilised (eg teleconferencing etc).

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	• Care Programme Approach (CPA)	• Identified team member should be responsible also for ensuring clarity about the who, what ,when and where, responsibilities and any funding issues, including consideration of appropriateness or otherwise of formal Care Programme Approach (see below). • Community and out patient follow-up should be provided by staff with specialist knowledge in perinatal mental illness. • Key psychiatrist in local area should be involved from earliest point and clear lines of communication established with local Community Mental Health team including Social Work and Housing Officers. • Explore potential link for Surestart initiatives. • CPA should be followed for those mothers detained in terms of the Act. • The joint care principles of CPA should apply in all other cases. The available Community Mental Health Team or equivalent should be involved in the discharge planning and post discharge care. • Have regard to Early Discharge Protocol for Patients in Secure Hospital Settings, HDL (2002) 85.

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6. Clinical Practice a) Care Plan: Care planning in the Multi-disciplinary Team Who consents to what on behalf of whom Availability of child care skills – maintenance of skills, supervision Prescribing for the child Where to access advice/assistance in an emergency	• Multi-disciplinary Team Care • Care Planning	• Separate care plans for mother and child should be agreed by multi-disciplinary team with particular emphasis on: ❖ effects of mental illness on childcare and parenting abilities ❖ effects of parenting responsibilities/child developmental needs on mother's mental state • Plans for continuing care post discharge • Staff should have skills and knowledge relevant to specialist nature of perinatal psychiatry including- mother-infant relationship/interaction/ attachment/child development/use of medication during pregnancy and lactation • Consider information and guidance (counselling) for the mother in terms of helping her avoid unwanted pregnancy. Consider also any change needed to method of contraceptive as a result of treatment plan. • Recognise, wherever possible, that the mother is the lead carer.

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7. Risk Management *a) Ongoing review* Making continuing assessment of risk an essential part of day-to-day management Risk from others	• Potential risk of harm to (patient's) self, baby or by others due to potential risks associated with individuals suffering from mental illness	**A risk assessment protocol should be developed and agreed to ensure/include considerations of:** • risk in context of mother /child/environment. • suitability for mother's admission to the facility • Inpatient observation levels in accordance with Scottish Executive guidance *"Engaging People: Observation of People with Acute Mental Health Problems. A Global Practice Statement* (NHS Scotland/CRAG, June 2002). • Raising the awareness of and application of mother and child observation arrangements will be an integral part of the overall care management within the mother and baby service. • Recommendations from Confidential Inquiry into Suicides and Homicides. • regular review at minimum intervals and outcomes recorded in the care plan with adjustments made accordingly.
	• Managing the risk of injury to children from other patients	• detailed procedures required. • Information leaflets required to inform mothers of possible risks, with signed consent. • The issue of any hospital liability must be addressed.

b) Infection Control	• Infection free environment	• A local protocol should be drawn up with the infection control team on steps to minimise the risk of infection, including within its terms the management and control of childhood illness. • A separate kitchen will be required for the preparation and storage of infant formula/breast milk. Appropriate sterilisation equipment will be needed. • The principles and practice set out in the Scottish Infection Manual should be applied in all respects including the creation of a monitoring system for on-going review of infection control.
c) Child Protection	• Potential risk of harm to children - child's welfare and safety needs must be given primary consideration	**To minimise risks to children**: • All staff working with patients (including agency or reserve list of staff) must receive prior clearance through enhanced *Disclosure Scotland* checks regarding their suitability to work with children. • All staff working with patients who are parents should receive regular awareness training in child protection and related issues and have access to appropriate clinical supervision. • NHS Boards and partners should have a child protection guidance/protocol in place (incorporating multi-agency policy on Child Protection issues) and available to all staff which should be adjusted accordingly to meet the local needs of the service. • Consider the Child Protection dimensions of unplanned subsequent pregnancy.

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d) Physical Health of Child	• Continuity of child health care	• Identify appropriate qualified medical lead responsible for the child (eg GP Practice/Paediatrician/Community Paediatrician). • Health visitor service should be provided within unit and links should be made with child's allocated Health Visitor to ensure continuity of child developmental assessments and immunisations and that records are kept to this effect. (If child is not from local area, arrangements must be made with "home" area to ensure continuity). • All staff and associated protocols should adhere to the guidance within Scottish Cot Death Trust/Scottish Executive guidance (Feb 2000) *"Reduce the risk of cot death"* or any subsequent guidance.
	• Alcohol and Substance misuse and Smoking policies	• Substitute prescribing should be continued for those already receiving treatment and considered for those who are not yet on a formal alcohol or substance misuse programme. • The mother and baby in-patient unit should adopt strict Smoking/ Alcohol and Substance Misuse policies within the unit and enforced. • Policies should be prepared and applied which reinforce the message of the damage to health by a smoke environment, particularly the risks associated with respiratory difficulties and Sudden Infant Death Syndrome.

e) Critical incident Who does what with mother/child if a critical incident occurs	• Guidance on priorities for action to deal with critical incidents • Critical incident review, feeding into clinical and organisational governance : (CNORIS)	• Staff may benefit from "mock" incident training. • There may be benefit in specific "mock" training around a scenario involving a calm and, separately, an irate individual with parental rights seeking to remove the baby from the unit. • Agreed protocol should be established on the who does what and when aspects of critical incident response. Protocol should cover initial response, emergency action, follow up, reporting and recording. The protocol should encompass health and safety requirements. The protocol should include training, review and audit. • Agreed protocol should be consistent with the terms and procedures set out in the area Critical Incident Protocol.
f) Training		• The development of training policies and programmes should be designed around the combined interests of NHS specialist, secondary, primary, joint community and local authority staff/professional needs.
g) Security		• The design and supervision of entry and exit controls (eg CCTV, card swipe access, electronic baby tagging etc) should be given careful consideration. The aim should be for a secure but child friendly environment. Legal and local police advice should be sought. Good practice guidelines need developed to ensure appropriate care and attention is applied to this important aspect of care in safety.

		• Care in safety principles can be extended through a tagging procedure and sensitive application and extension of the policy for children in the care of perinatal mental health services.

8. Human Resources	▪ Workforce Planning	• Develop with partners the Generic, Professional and Managerial/Leadership skills and competencies required.
		
		• Determine staffing levels (WTE) and skill mix of staff (ie. Nursing, Allied Health Professionals, Medical, Psychology, Social Work, Ancillary, Administration) for each area (In-patient, Community Services, Outreach Services) and agree a budget.
		
		• Develop a Recruitment Plan, incorporating:
		
		  • Job Descriptions and Person Specifications
		  • recruitment and management of staff
		  • Regular review of staff State Registration and qualifications for their posts

	• Organisational Development	• Develop and promote perinatal service objectives setting out for all the key care and outcome objectives.
		
		• Roles, responsibility and accountability of staff on legal, clinical and professional levels to be set out in clear terms
		
		  • Line management responsibility
		  • Professional Responsibility
		  • Clinical Responsibility

		• Training Plan to include:
		  • Regular review
		  • Training in generic skills for perinatal mental health services
		  • Training in Professional/Clinical skills
		  • Training and development of Management/Leadership skills
		• The multi-disciplinary team to:
		  • Be aware of the service objectives and overall philosophy
		  • Ensure effective communication within/outwith team (see under communication)
		  • To develop an appraisal system and personal development plans for all staff

	• Professional Accountabilities	• Staff trained in adult and paediatric CPR and appropriate resuscitation equipment available dependent upon local arrangements for emergency response. • Arrange appropriate training of community staff, with on going update and refresher component. • Organise and keep under review, training programmes on Child Protection guidelines for all staff. • Consider all methods for increasing awareness of perinatal mental

		illness and postnatal depression in all relevant settings. • Before appointment, all Registered Mental Nurses who are likely to have a role in the delivery of child care should receive training in basic child care and have been assessed as competent to practice. • The role played by Disclosure Scotland and their processes should be explained to all concerned in the context of ensuring a care in a safety environment. • Staff directly responsible for provision of child care should have appropriate skills/training/clinical supervision, eg National Nursery Education Board or SVQ or equivalent qualification.
	• Communication	• Establish a communication plan to ensure effective communication with all agencies and interests. • Introduce and maintain an induction programme at organisational and unit level for all staff • Ensure regular fora to address professional issues for staff groups not in perinatal care team and ensure ongoing support and professional development
	• Partnership Working	• Promote partnership involvement of all interests, including staff side representatives, in the development, review and operation of services and protocols including policy consideration. • Establish service links into existing partnership and industrial relations fora.

	• Terms & Conditions	• Implementation of relevant terms and conditions of service or agreed local terms & conditions for all staff, eg Whitley Council. • Implementation of Agenda for Change and equivalents is applicable.
	• Development of policies and protocols	• Ensure compliance with existing local and national policies • Ensure policies and protocols developed comply with current legislation. • Ensure that all policies and protocols are reviewed and updated where required on a regular basis. • Determine protocols for supervision and access for non core team staff.
9. Awareness, Information, Networking and Research	• Accessible information for mothers and others on perinatal mental illness and on the unit and its services.	• Information to be made available to all patients, relatives, carers and staff. • To make available information leaflets about the inpatient unit, its role and care and domestic and other arrangements. • Consider merits of 1 page summary of condition/services and support for mothers.

	• Information and Networking	• Comply with any agreed dataset requirements for recording information on children in the care of admitted mothers • On going collection of data in collaboration with ISD – admission, re-admission length of stay, etc. • Consideration should be given to a local/national research agenda including support needs of women admitted, recovery and later impact on child and family. • Audit of service provision locally and nationally. Consider local fit with national programmes, campaigns and initiatives, (eg NHS Health Scotland, NHS Education Scotland).

Scottish Executive Health Department
December 2003

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Service Standards

- Services should adopt a system of quality assurance for their Perinatal Mental Illness service which *promotes public confidence that the services provided are safe; are kept under regular review; deliver the highest possible standards of care.*

- In a health context, each NHS body has a duty to monitor and improve the quality of healthcare which it provides to individuals as part of the clinical governance process. Thus **quality assurance** is *improving performance and preventing problems through planned and systematic activities including documentation, training and review*. **Accreditation** is a process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.

- A system of quality assurance and accreditation for the Perinatal Mental Illness service provided would comprise:

  - Setting standards – in an open collaborative way between the service providers, partner agencies, the users of the services, those who care for them and a public view;
  - Self-assessment of performance locally in relation to the standards derived;
  - Undertaking external peer review of performance against those standards;
  - Reporting findings, regularly, publicly and transparently; and
  - A developed database for breastfeeding and prescribing in pregnancy.

- Standards should:

  - Focus on those care issues which impact on the quality of care;
  - Be written in simple language;
  - Be based on valid evidence as far as it exists;
  - Otherwise be based on what is generally accepted as good practice;
  - Take account of other relevant and recognised standards and clinical guidelines;
  - Be clear and measurable;
  - Focus on improving the outcomes of care;
  - Be published and widely available;
  - Be regularly evaluated and revised to make sure they remain relevant and up to date; and
  - Take cognizance of the findings from the Clinical Effectiveness Programme Subgroup audit when they are available.