Delivering Effective Services Evaluation

April 2025

Contents

Executive Summary

Delivering Effective Services (DES) was published in 2019 to set out a series of recommendations to develop perinatal mental health services, across all tiers of service delivery to improve care for women, their infants and families who require support during pregnancy and/or the first year postnatally.

Perinatal Mental Health Network Scotland (PMHNS) carried out this evaluation in 2024/25 to review the progress made in developing specialist perinatal services, as well as identifying current clinical priorities.

Each DES recommendation was reviewed, and three questionnaires were developed for Community Perinatal Mental Health Teams (CPMHTs), Maternity and Neonatal Psychological Interventions (MNPI) services, and Mother and Baby Units (MBUs) to ask about the relevant recommendations. Additional data was gathered from other sources, included NHS Education for Scotland (NES) regarding workforce training.

Twelve boards returned questionnaires across 27 services. PMHNS would like to thank our clinical colleagues for their contribution to this evaluation as it would not have been possible without their input.

The 28 recommendations set out within DES reach across many areas of service development and delivery. It is evident there has been a huge expansion of service provision, availability of specialist services, implementation of new specialist roles, and workforce education in recent years. Many areas of good practice have been shared as part of this evaluation. Given the time since publication of DES in 2019, services have continued to evolve and there were emerging themes in this evaluation around workforce capacity challenges, funding limitations and the ability to meet the demands of the patient population. The report captures key considerations which are intended to help inform local, regional and national conversations about future priorities for further development and improvement.

Ownership Statement

This document has been prepared by NHS National Services Scotland (NSS) on behalf of Perinatal Mental Health Network Scotland (PMHNS). Accountable to Scottish Government, NSS works at the heart of the health service providing national strategic services to the rest of NHS Scotland and other public sector organisations to help them deliver their services more efficiently and effectively. PMHNS is a collaboration of stakeholders involved in care of perinatal and infant mental health, who are supported by an NSS Programme Team to drive improvement across the care pathway.

Accessibility

We are always working to improve the accessibility of our documents. If you require this document in an alternative format, please contact the Quality Team at **nss.npqualitydpt@nhs.scot**

Background

The Perinatal Mental Health Network's Delivering Effective Services (DES) Report was published in 2019. The report made recommendations for the development of perinatal mental health services 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 in the first year after birth, their infants, partners and families.

Given the significant advancement to service provision since the publication of DES, Perinatal Mental Health Network Scotland (PMHNS) have conducted an evaluation of its implementation. This aims to measure the progress made since publication and help identify future clinical priorities and potential areas for further improvement.

Public Health Scotland are also carrying out multiple **evaluations of the Perinatal and Infant Mental Health Programme Board**.

Methodology

Evaluation forms were developed for Community Perinatal Mental Health Teams (CPMHT), Maternity and Neonatal Psychological Interventions (MNPI) teams, and Mother and Baby Units (MBU) to ask these specialist services about the relevant recommendations from DES. For each recommendation, specialist services were asked what had gone well, what could have gone better, and to explain their rationale for any aspects where they deviated from the original DES recommendation. Information from specialist services was submitted to PMHNS between December 2024 and January 2025.

The PMHN programme team analysed the feedback received and summarised its key themes and insights in this report. It is important to note that this report provides a qualitative analysis of the key points and themes raised by services. The evaluation survey was not designed to provide quantitative data, and statistical analysis in this report is therefore limited. The learning points in this report reflect the specific circumstances of the services who provided that feedback. As a result, some points may not be equally applicable to all Health Boards across Scotland when considering service development and continuous improvement locally. However, where potentially unwarranted variation in practice has been suggested through the survey responses, this is picked up in the analysis.

Data Returned

Services were asked how familiar they are with the DES report. 19 said 'very familiar', 4 'somewhat familiar' and none answered, 'not familiar.'

Response rates were high, ranging from 86% to 100% of Health Boards. Responses were received from:

Mother and Baby Units	Community Perinatal Mental Health	Maternity and Neonatal Psychological Interventions
West of Scotland	NHS Ayrshire and Arran	NHS Ayrshire and Arran
Livingston	NHS Dumfries and Galloway	NHS Dumfries and Galloway
	NHS Fife	NHS Fife
	NHS Forth Valley	NHS Forth Valley
	NHS Greater Glasgow & Clyde	NHS Greater Glasgow & Clyde
	NHS Grampian	NHS Grampian
	NHS Highland (Argyll and Bute and North regions)	NHS Highland (Argyll and Bute region)
	NHS Lanarkshire	NHS Lanarkshire
	NHS Lothian	NHS Lothian
	NHS Orkney	NHS Orkney
	NHS Tayside	NHS Tayside
	NHS Western Isles	NHS Western Isles
100% of Boards	**86% of Boards**	**86% of Boards**

Information regarding the progress against recommendations relating to education and training has kindly been shared by NHS Education for Scotland.

Delivering Effective Services Recommendations

The following section summarises the feedback from specialist services, and/or other data sources, along with key considerations for the future development, under each of the 28 recommendations from Delivering Effective Services.

Recommendation 1: The Scottish Government and NHS Boards should ensure that Mother and Baby Units are staffed at the recommended level to provide a comprehensive clinical service.

Progress

There are two Mother and Baby Units (MBUs) in Scotland, one in St John's Hospital in Livingston and one in Leverndale Hospital in Glasgow (West of Scotland MBU).

Both MBUs noted their staffing level is reflective of the recommended levels set out in DES. However, when asked if the recommended level of staffing aligned with the needs of the team, one agreed and one disagreed.

What has worked well?

Safe staffing levels and skilled multi-disciplinary team (MDT)

- Having additional staff with expertise in different areas helps provide a holistic approach and deliver excellent care to patients due to safer staffing levels and opportunities for staff to engage in training and continued professional development (CPD).

What could be improved?

Protecting staff from being deployed to other wards

- Protecting MBU staff from being moved to support other wards if there are staff shortages across the hospital site.

Appropriate mix of MDT staff for patients

- Patients have voiced that, at times the number of therapists they see can feel overwhelming.
- Work is being done to explore therapists working outreach when patients are discharged.
- Appropriate representation and voice for staff at MDT.

Key Considerations

1. **Staffing Stability:** Implement clear policies to manage emergency deployment to other areas and advocate for sustainable workforce planning.

2. **MDT Balance:** Conduct regular skill mix reviews and coordinate MDT involvement to reduce duplication.

3. **Continuity of Care**: Strengthen partnerships with community teams and integrate outreach services post-discharge.

4. **Appropriate Representation**: Establish structured MDT meetings where all professions, including nurses, have appropriate representation and can provide input to the MDT discussion and decisions.

5. **Staff Development**: Embed protected time for Continued Professional Development (CPD) and promote joint training sessions across disciplines.

6. **Evidence-Based Planning**: Use workforce and patient feedback to inform service improvements and decision-making.

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

Progress

Ten out of eleven Community Perinatal Mental Health Teams (CPMHT) indicated they had no Peer Support Worker (PSW) provision. One CPMHT had 0.5 whole time equivalent (WTE). For MBUs, this was 0.5 WTE in one, and 0.93 WTE (split across two posts) in the second MBU.

What has worked well?

Peer Support & Lived Experience Integration

- Recognition of peer support in service planning.
- Access to third-sector services (Aberlour, HomeStart) for peer support.
- Employment of sessional staff with lived experience.
- Peer support involvement in service design.

Collaboration with the Third Sector

- Strong partnerships and joint working between health services and third-sector organisations.
- Support information sharing and recovery as women could be too unwell or did not want PSW involvement at that time.
- Funding received for peer projects (via the Mental Health Outcomes Framework).

Service User Feedback & Impact

- Positive impact of having individuals with lived experience in services.
- Service users value peer support but may have personal barriers to engagement.

What could be improved?

Challenges with Peer Support Workforce

- Staff turnover impacted continuity, with no ability to extend contracts due to non-recurring and limited funding.
- PSWs can experience distress reflecting on their own journeys as patients.
- Difficulties adjusting from being a patient to a staff role, which may affect relationships with colleagues.

Funding & Resource Limitations

- Variation in funding support for PSW roles: Some proposals for peer support funding were declined due to financial constraints but in other areas plans to recruit a PSW using additional Scottish Government funding were under discussion.

- Practical barriers, such as travel difficulties for mothers in rural areas, highlight the need for enhanced access.

Service Implementation & Workforce Pressures

- Peer support development had been delayed due to clinical pressures and inconsistent or unreliable staffing levels.
- Challenges with uptake of peer support due to service user preferences.
- Limited third-sector peer support for perinatal mental health is available in some areas.

Key Considerations

1. **Sustainable Peer Workforce**: Secure long-term funding, improve onboarding, including ongoing support and supervision, and offer flexible staffing to retain experienced peer workers.

2. **Funding & Resources**: Advocate for recurrent funding, demonstrate impact and address practical barriers like rural access.

3. **Service Integration**: Embed peer support within core services, strengthen third-sector collaboration and clarify MDT roles.

4. **Service User Engagement**: Co-produce improvements, address engagement barriers and expand outreach and digital access.

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

Progress

In 2023 Scottish Government commissioned NHS National Services Scotland National Planning to carry out an Options Appraisal with key stakeholders. At the time of writing, the completed Options Appraisal is with Scottish Government for consideration.

Key Considerations

Publication of the Mother and Baby Unit Options Appraisal to help inform next steps.

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

Progress

All CPMHTs (n=13) indicated they had sufficient access to a Mother and Baby Unit (MBU). The table below outlines the MBU admissions agreements in place for each Health Board. If the agreed MBU is full, the patient will be offered a bed in the other MBU, if available.

Table 1: MBU Service Level Agreements (SLA)

Health Board	SLA in place for MBU Admission
NHS Ayrshire and Arran	West of Scotland
NHS Dumfries and Galloway	West of Scotland
NHS Highland (Argyll and Bute)	West of Scotland
NHS Lanarkshire	West of Scotland
NHS Western Isles	West of Scotland
NHS Greater Glasgow and Clyde	West of Scotland
NHS Highland (North)	Livingston
NHS Fife	Livingston
NHS Lothian	Livingston
NHS Tayside	Livingston
NHS Borders	Livingston
NHS Forth Valley	None
NHS Grampian	None
NHS Orkney	None
NHS Shetland	None

For the Boards without an agreement in place, the following reasons were provided:

- **NHS Forth Valley** – Due to geographical location in NHS Forth Valley, a patient centred approach was taken to explore the option of admission to either MBU in Scotland.
- **NHS Grampian** – Work on an SLA with NHS Lothian is ongoing.
- **NHS Orkney** – Due to the small numbers, there had been no recent requirement for admission but there has been informal support from both MBUs. NHS Orkney has an SLA with NHS Grampian for general inpatient services, but no direct contract with an MBU.

What has worked well?

Effective Care & Coordination

- Strong working relationships, clear communication, and streamlined referral processes enable rapid access to care.

- Specialist perinatal teams have improved communication, referral and discharge processes.

Strategic Planning

- Use of **Scottish Perinatal Mental Health Care Pathways** and discharge planning meetings supports continuity of care.

Interagency Collaboration

- Good liaison between services enhances patient transitions and holistic care.

Consistency in Care

- Variability in age cut-offs for Child and Adolescent Mental Health Service (CAMHS) patients had been a barrier to MBU access but this has now been addressed.

What could be improved?

Capacity & Accessibility

- Limited bed availability and travel difficulties prevent some families from accessing specialist MBU care.

Timely Decision-Making

- Delays in referrals and transfers impact patient admission. Work has been done to streamline and standardise referral processes between both MBUs.

Integration with general Mental Health Services

- Stronger links are needed to assess each patient's full mental health needs effectively.

Discharge Communication

- Written handovers need improvement to ensure timely, clear information.

Key Considerations

1. **Expand MBU Capacity**: Address bed shortages and explore flexible solutions, such as additional units or community-based alternatives. (This will be addressed by the MBU options appraisal.)

2. **Improve Accessibility:** Further develop transport and accommodation support for families traveling long distances.

3. **Enhance Referral and Transfer Processes**: Standardise decision-making timelines to ensure appropriate and timely admissions.

4. **Strengthen Mental Health Integration**: Foster closer collaboration with adult mental health services to support women and their families holistically.

5. **Discharge Communication**: Ensure timely, comprehensive discharge letters to improve continuity of care after discharge from the MBU.

Recommendation 5: NHS Boards should ensure provision for accommodating partners or other family members near to each Mother and Baby Unit where they have to travel long distance.

Progress

One MBU stated they have provision for accommodating partners or family members near the MBU. The other MBU responded to note they did not have this provision.

What has worked well?

Both units said they have a Mother and Baby Family Fund (MBFF) in place, which worked well for families who can pay up front and claim their expenses back.

What could be improved?

Funding Limitations

- MBFF was exceeded in the last financial year, although all outstanding claims were met. The funding limit has now increased, but continued monitoring is needed to ensure it meets demand.

Lack of On-Site Accommodation

- One of the MBUs is not purpose-built and lacks attached accommodation. This constrains ease of access for families.

Challenges with the Family Fund

- The furthest health board within the MBU SLA is 300 miles away, requiring flights or a ferry and lengthy car or train journey. The £500 limit on the MBFF is insufficient to cover travel, accommodation and food costs for families traveling greater distances.

Mileage Reimbursement Levels

- Recent MBFF mileage funding cuts to 14p per mile further increase financial strain on families, potentially reducing accessibility and support during inpatient stays.

Key Considerations

1. **Review MBFF funding levels and criteria**: Providing wider and more equitable access to MBFF support.
2. **Explore improved accommodation options:** Consider provision of accommodation at or near both MBUs.

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

Progress

All Health Boards reported having a CPMHT. The table below show the service models used in each area who returned the questionnaire.

Table 2: CPMHT Service Models per Board and Birth Rate

NHS Board	Birth rate	Model of CPMHT
NHS Greater Glasgow & Clyde	More than 5,000/year	Stand-alone
NHS Grampian	More than 5,000/year	
NHS Lanarkshire	More than 5,000/year	
NHS Lothian	More than 5,000/year	
NHS Ayrshire and Arran	Less than 5,000/year	
NHS Highland (North)	Less than 5,000/year	
NHS Dumfries and Galloway	Less than 5,000/year	Dispersed
NHS Highland (North)	Less than 5,000/year	
NHS Fife	Less than 5,000/year	
NHS Forth Valley	Less than 5,000/year	
NHS Tayside	Less than 5,000/year	
NHS Borders	Less than 5,000/year	Regional
NHS Highland (Argyll and Bute)	Less than 5,000/year	
NHS Orkney	Less than 5,000/year	
NHS Western Isles	Less than 5,000/year	

NHS Highland (North) added that although currently considered a stand-alone model, they are intending to use some of the additional funding to ring-fence CPMH time in outlying Community Mental Health Teams (CMHTs) which is in aligned to a dispersed model.

What has worked well?

(a) Stand-alone models

Enhanced delivery of care and experience of patients

- All care providers who have concerns about a woman's perinatal mental health can now access specialist support, information and joint working to enhance their delivery of care. This includes daily referrals, advice line, urgent carousel, consultation slots and strong referral guidelines, pathways and protocols.

Enabled a full MDT approach

- Including psychiatry, psychology, parent-infant therapist, nursing, nursery nurses, occupational therapy, social work, administrative staff. However, staffing varies between Health Boards.
- Access to a team base and Continued Professional Development (CPD).

(b) Dispersed models

Clear structures and processes

- Enables making direct referrals, and clear referral processes are in place.

MDT approach and strong links with services

- Skill mix and a range of complementary roles within the team.
- As staff can work across different services, it enhances links and aids transitions of care to improve the patient journey.
- Integrated care pathway in place.

(c) Regional models

No data available.

What could be improved?

(a) Stand-alone models

Sub-optimal staffing levels and limited / non-recurring funding for clinical provision

- Challenges to meet patient needs and manage expectations from professionals with limited resources and staffing.
- Due to a lack of recurring funding, some CPMHT posts are fixed-term. This presents recruitment and retention challenges, which may put longer-term service delivery at risk.

Lack of funding for staff and service development

- Lack of funding for staff can restrict ability to attend national conferences, or national CPD events.
- Lack of funding to support progression to Perinatal Quality Network (PQN) accreditation.

(b) Dispersed models

Limited access for MDT model and requirement for joint working

- Delivering services in a rural and widespread region can exacerbate staffing and capacity challenges.
- Lack of access to regional sessional time.
- There is an ongoing requirement to work closely with Community Mental Health Teams (CMHTs) with complex cases as a small, specialised perinatal service cannot manage the needs and risks with high demand.

Limitations in referral processes and accommodation

- Due to limited hours allocated to some roles, referrals can only be submitted by some care professionals, creating bottlenecks in processing referrals.
- Unable to take direct referrals for nursing.
- Accessing dedicated space for bases has been challenging in some areas.

(c) Regional models

No data available.

Key Considerations

1. **Staff training** in the NES perinatal modules for the wider workforce, including Community Psychiatric Nurses (CPNs), to ensure the service is not person dependent.

2. **Baseline funding** would support longer term planning, service development and staff retention, as well as allocated permanent base accommodation for services.

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

The Delivering Effective Services report recommended the following staffing levels for NHS boards with birth numbers over 5,000/year. This is applicable to NHS Grampian, NHS Greater Glasgow & Clyde, NHS Lanarkshire and NHS Lothian. These health boards all have a stand-alone CPMHT service.

Table 3: CPMHT Staffing Recommendations

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

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

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

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

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

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

Progress

CPMHTs were asked if the recommended staffing levels reflected the actual need. Two of the four Boards with birth rates over 5,000 agreed, and two disagreed. Of all the CPMHTs who responded, five agreed the staffing levels reflected need, and seven disagreed.

What has worked well?

No data available.

What could be improved?

Lack of nursing provision and challenges with backfill

- There was no provision for additional Registered Nurses within the DES recommendations. This has resulted in significant capacity issues within the nursing cohort as there has been a demonstrable increase in demand and complexity. Greater nursing staff provision is required to take into consideration high demand, geographical spread, complex caseloads, and unscheduled care provision.
- Limited funding has resulted in challenges backfilling posts for maternity leave.

Limitations in regional provision

- Challenges in providing regional roles due to changes in funding.

Lack of psychological therapy provision

- Despite psychological therapies provision meeting DES recommendations and PQN standards, some CPMHTs have consistently been unable to meet the referral demand necessitating the introduction and management of a waiting list.
- Identified need for additional psychiatry and psychology provision – including junior grade staff/trainees to support delivery.

Local implementation of recommendations

- In some areas, local decisions resulted in not following the full staffing establishment recommended in DES. This has resulted in challenges and gaps in the parent-infant therapist, nursery nurse and mental health nursing staff roles.

Models of service provision and staffing resource

- The Royal College of Psychiatrists Perinatal Faculty has highlighted the need for sustainable consultant posts and the Royal College of Psychiatrists UK is updating the guidance regarding job planning.
- Identified need to review estimated sessions / resource required for Consultant Perinatal Psychiatrists and the nursing workforce, particularly in smaller health boards. This is likely to be reflected across multiple job roles.
- Recognition that models of service provision evolve. Given, the time since the publication of DES, there may be a need to review resourcing across roles in the future.

Key Considerations

1. **Consideration of the skill mix, disciplines and resource** within teams, particularly nursing, psychiatry, psychology, parent-infant therapist, and nursery nurse provision.

2. **Baseline funding** could provide additional support for backfilling posts during maternity leave.

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

The DES report recommended the following staffing levels for NHS boards with birth numbers under 5,000/year. This is applicable to NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Highland (North region and Argyll and Bute region), and NHS Tayside.

Chart 1: Dispersed CPMHT Model Description

Dispersed model of specialist community team provision

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

Progress

Most (71%) CPMHTs in Boards with less than 5,000 births per year indicated that the recommended staffing levels reflected the needs of their population while 29% disagreed.

What has worked well?

Multi-disciplinary team working

- The CPMHT MDT works well together to cover a large geographical area.
- Staffing need can be negotiated at implementation reviews.

- MDT working provided scope to explore measures to develop the CPMHT service to provide psychological therapy provision.

What could be improved?

Limited access to key roles

- Limited, and in some cases no access was noted for key CPMHT roles, such as consultant psychiatrists, mental health social support, peer support workers, medical and psychological input. There is also very limited access to regional provision across multiple professions. This was highlighted as a significant issue due to the complexity of referrals.
- No national psychology support since June 2024.

Referral process

- The limited size of the team is a barrier to changing referral criteria from severe illness only to moderate and severe.
- On occasion, patients must be referred to Community Mental Health Team for input if the specialist team does not have the necessary staffing capacity most suited to the needs of the patient.

Key Considerations

1. Ensure effective pathways and capacity across MDT roles to fully support complex referrals.

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

Progress

This recommendation applies to NHS Orkney, NHS Shetland and NHS Western Isles. CPMHTs were asked if the recommended staffing levels reflected the actual needs of the service. One board responded yes and the remaining boards gave no answer.

No further comments were provided on what had worked well or could be improved.

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

Progress

The chart and table below illustrate the provision and model of parent-infant mental health lead in CPMHTs and MBUs.

Chart 2: CPMHT with Parent-Infant Mental Health Lead

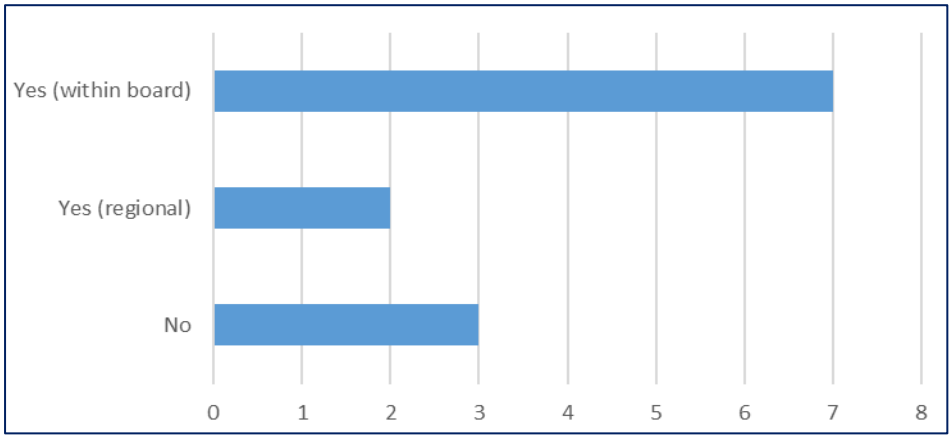


Table 4: Parent-infant Therapist WTE per Board

Health Board / Service	Parent-Infant Therapist WTE (where listed)
CPMHT: NHS Dumfries and Galloway	0.8 WTE
CPMHT: NHS Highland (North)	0.8 WTE
CPMHT: NHS Highland (Argyll and Bute)	1.0 WTE
CPMHT: NHS Greater Glasgow & Clyde	0.4 WTE (NHS GGC), 0.1 WTE (Regional)
MBU: West of Scotland	0.5 WTE
MBU: Livingston	0.64 WTE

What has worked well?

Parent-Infant Therapy Provision

- A range of Parent-Infant Therapy (PIT) interventions are available, supporting early relational health.
- Ongoing recruitment of sessional therapists to expand service capacity.

Strong Multi-Disciplinary Collaboration

- Good working relationships with infant mental health psychologists and occupational therapists, ensuring coordinated service development.
- Specialist Health Visitors play a key role in bridging perinatal and infant mental health services, although further collaboration could enhance impact.

- The CPMHT maintains strong links with the Infant Mental Health Team (IMHT) including:
- Weekly Perinatal and Infant Mental Health triage meetings.
- IMHT consultation prioritisation for infants requiring emotional well-being support due to parental mental illness.

Supervision and Workforce Development

- Regular 4-6 weekly clinical supervision for Parent-Infant Therapists, supporting professional practice.
- Transition from a Consultant Psychologist-led IMH model to a more structured approach with a dedicated IMHT and Team Leader.
- Local contacts identified to facilitate access to sessional services, strengthening service provision.

What could have been improved?

Workforce Capacity and Service Demand

- Limited staffing resources have resulted in a waiting list for some Infant Mental Health Teams, impacting timely access to care.
- Recruitment challenges persist due to financial constraints, limiting service expansion to respond to demand.

Clinical Space and Integration

- The CPMHT, MNPI, and IMHT operate in separate locations in some Boards, reducing opportunities for joint working and information sharing.
- Co-location of these services would enhance collaboration and service efficiency.

Alignment with Perinatal Quality Network Standards

- PQN standards recommend 1.0 WTE Parent-Infant Therapist (PIT) per 10,000+ births.
- Currently, some CPMHT operate well below this benchmark, highlighting the need for additional staffing.

Budget and Funding Delays

- Late confirmation of ongoing budget allocations at the local level has delayed the recruitment and progression of substantive staff hours/sessions.
- Addressing funding uncertainties would allow for more sustainable workforce planning and service stability.

Key considerations

1. **Short Term:** Address recruitment barriers and explore interim solutions. Where there is not a PIT in place, working closely with the Infant Mental Health Team.

2. **Medium Term**: Assess options for improved co-location and secure funding.

3. **Long Term:** Align workforce planning with PQN standards and national IMH strategies.

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

Progress

Of six Maternity and Neonatal Psychological Interventions (MNPI) services with a Specialist Perinatal Mental Health Midwife in the service, five services had a specific job description outlining the role, competencies and arrangements for clinical supervision from maternity and mental health. A further five boards reported they do not have a Specialist Perinatal Mental Health Midwife role.

Chart 3: Specialist PMH Midwife Job Descriptions

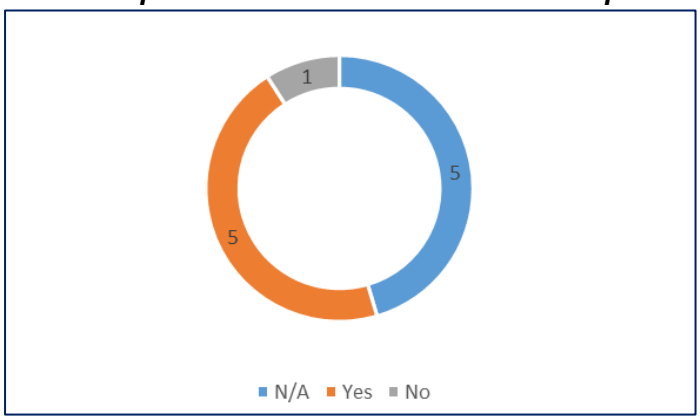
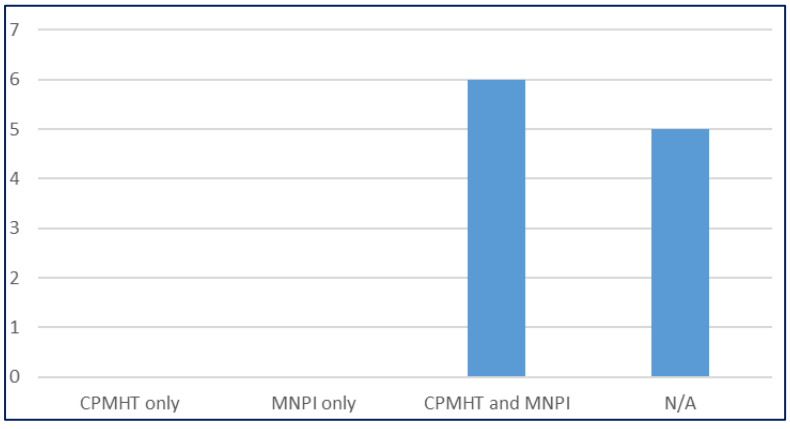


Chart 4: Specialist PMH Midwife Links



What has worked well?

Effective Midwifery & Mental Health Integration

- Specialist Midwife embedded within the MNPI team, receiving clinical supervision from a Consultant Clinical Psychologist.

- Active role in PMH and MNPI triage meetings and complex referral discussions to link back to referrers from maternity services and enhance communication to inform decision making.
- Strong collaboration between MNPI and CPMHT, ensuring effective links between maternity and perinatal mental health services.

Collaborative Working & Service Development

- Joint training sessions for maternity staff to enhance awareness of perinatal mental health and wellbeing.
- Established referral pathways between MNPI, PMHT, and maternity services.
- Birth Reflections service supports postnatal mental health needs.

Workforce & Role Clarity

- Additional Band 6 Midwife (0.2 WTE) supervised by the Specialist Midwife for MNPI.
- Ayrshire and Arran working closely with Birth Reflections Midwives, despite not having a Specialist PMH Midwife aligned to their team.

What could be improved?

Workforce & Role Clarity

- Specialist Midwife job description does not fully reflect current duties, prompting consultation for role alignment.
- Recruitment Gaps: Lack of maternity staff in certain localities to fill specialist midwifery roles.
- Specialist Role Challenges: Some areas have no dedicated perinatal mental health midwives, though some midwives have undertaken additional training.
- Job Title Confusion: "Perinatal Mental Health Midwife" creates uncertainty for referrers regarding team alignment.

Service Development & Capacity

- Limited Coverage: Limited specialist midwife time impacting service delivery.
- Supervision Structure: Clinical supervision is highlighted in job descriptions but lacks clarity on provision.
- Psychological Interventions: Specialist Midwives could benefit from additional training to deliver low-level psychological interventions and structured, evidence-informed support, while still retaining their midwifery specialism.

Key Considerations

1. **Sustainable Workforce Planning:** Address recruitment gaps by developing clear pathways for midwives to specialise in perinatal mental health.

2. **Role Clarity and Job Descriptions**: Standardise job titles and responsibilities to reduce confusion for referrers and ensure alignment nationally, including the resource requirements by birth rate

3. **Dedicated Specialist Midwives**: Secure long-term funding for specialist perinatal mental health midwife roles to enhance service continuity.

4. **Enhanced Training and Supervision:** Expand training for midwives to deliver low-level psychological interventions and clarify supervision structures.

5. **Stronger Multi-Agency Collaboration:** Strengthen links between MNPI, perinatal mental health teams and child protection services to ensure holistic care.

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

What has worked well?

Staff awareness sessions

- Increased understanding that MNPI is for more complex maternity and neonatal presentations. Combined with clear referral criteria and Standard Operating Procedures this has resulted in a reduction in inappropriate referrals.

Specialist PMH Midwives

- Specialist PMH Midwives attend weekly CPMHT referral and allocation meetings.
- Appropriate training for Specialist PMH Midwives, for example Enhanced Psychological Practice (EPP) training or NES 'Introduction to CBT for Anxiety' has allowed the Specialist Midwife to have a caseload of mild-moderate anxiety clients: *"The combination of midwifery experience alongside additional psychological training has been invaluable."*

Embedding clinical psychology input

- Input to, for example the Special Needs in Pregnancy Service – including reflective practice groups, CPD, development of birth trauma leaflets, development of EMDR as a therapeutic intervention, clinical psychology as part of multidisciplinary team input for women presenting with Placenta Accreta Spectrum (PAS).

Regional and national consultation

- This includes clinical supervision, PMHNS MNPI Forum, Scottish Perinatal Psychologist Interest Group (SPPIG) and BLISS, joint doctoral research projects with the University of Glasgow, and service websites.

Gather service user feedback

- Ensuring service development is informed by service user experiences. Mechanisms to gather feedback have included Care Opinion and local service questionnaires.

Close working with other services

- Partnership working with, for example third sector, core and community midwives, birth reflection and bereavement midwives, and neonatal services, has resulted in no waiting list in some areas and increased appropriate referrals.
- In some areas there is a weekly visit to the neonatal unit to meet with parents, provide emotional support, signpost to resources, screen for potential psychology input.
- Shared clinical psychology doctoral trainee placements across MNPI and Infant Mental Health.

- Joint working between MNPI and CB-UK, including joint information sessions across maternity & neonatal staff groups.

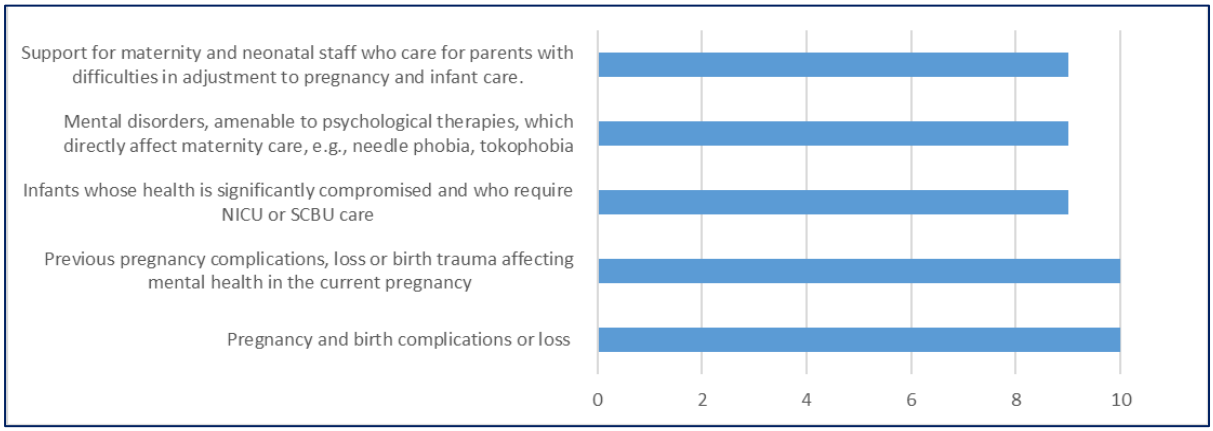
Good practice example – Working with the Third Sector

"We are currently running a pilot project, funding Held in Our Hearts to provide local bereavement counselling and 'Hospital to Home.' This project launched at the end of July 2024 and already has had a positive impact on MNPI waiting lists.

It offers better matched and timely care for those bereaved. We offer debriefs and up to three individual staff reflective sessions when required. This has had a good uptake and positive feedback.

We also have good links with the wider support services that we can signpost staff to."

Chart 5: Core Functions of MNPI



What could be improved?

Additional capacity and resource

- To meet increased demand, service capacity should be reviewed, in particular for psychology and dedicated specialist midwife roles.
- Capacity to backfill has been lacking in some areas, for example to cover maternity leave, which impacts on team capacity and waiting lists.
- Lack of access to additional training in psychological interventions for specialist midwives with backfill arrangements to attend. A hybrid version of NES training on responding to parental distress provided, along with Turas modules.

Secure funding to provide full service

- Challenges were identified in MNPI staffing levels due to lack of investment based on DES recommendations on maternity bookings and National Resource Allocation Calculations (NRAC). The current financial challenges have also resulted in posts not being replaced when staff leave and high levels of clinical demand continue.

Appropriate accommodation

- Some areas lack suitable accommodation to see patients within the maternity setting or to provide group interventions. Additionally, there is a lack of appropriate admin space and space for clinical leads to provide supervision and consultancy within the hospital.

Service Model

- Create space for teams to review service model as it cannot sustain current activity levels. This includes working closely with referrers to reduce inappropriate referrals.

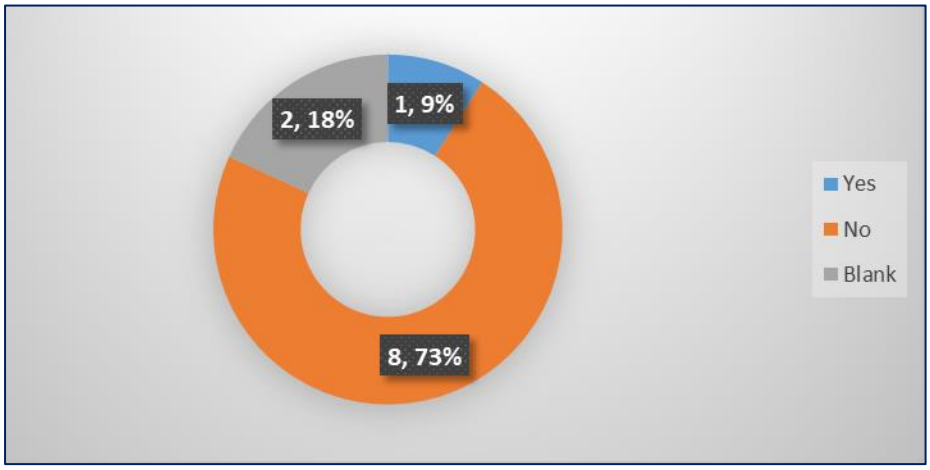
Deviations from recommendations

One service fed back that they do not currently offer a service to parents who have experienced pregnancy loss, unless the patient engages with maternity / perinatal services again and this previous loss is having an impact on their current maternity / perinatal experience. Instead, patients are directed to the third sector.

Staffing levels in MNPI

Most services (73%) did not consider current staffing levels to be adequate relative to patient needs and demand.

Chart 6: Staffing Levels meeting Actual Needs



What has worked well?

Referral pathways into and awareness of MNPI services

- One board reported the number of appropriate referrals has doubled since the MNPI team started.
- MNPI is a popular Doctorate in Clinical Psychology placement.

Staffing levels / skill mix

- Initially recommended staffing levels over-estimated the need for consultant psychologist time. This was later converted to other roles to provide a better skill mix in the team.

What could be improved?

Additional staffing

- Provide a role in bereavement work and run more reflective practice groups.

- Backfill for maternity leave positions would also be beneficial as gaps have led to waiting lists being created.

Review of service model

- Review roles and funding as services are currently vulnerable.

Improve waiting times

- Service demand means it is not always possible to see people within six weeks for therapy as recommended in DES.

Clearer national guidelines on how to manage cross-boundary referrals

- Current practice is inconsistent across Scotland. in how to manage referrals for patients who live in a different health board from where they gave birth.
- More guidance is needed on the specialist midwife whole time equivalent staffing required.

Deviations from recommendations

Service model

- MNPI is part of a combined CPMH/MNPI/IMH service in NHS Highland (North), an area with approximately 2000 births over multiple sites. Having an identifiable MNPI service in this area deviates from DES, which only recommends this for hospitals with birth rates >3000.

Staffing levels

- A further Clinical Psychologist post beyond DES recommended levels was funded locally to meet the demand for the service, and to enable MNPI to deliver input within the recommended timescales. The scope of the service has increased with time, with input into Trauma-Informed care training, bereavement care pathways and input for miscarriage. This has led to additional pressure on the service but has been felt to be relevant and essential work.

Key Considerations

1. **Review referral criteria and service capacity** to ensure services can meet increased demand and ensure patients receive therapy in a timely manner.

2. Review local service configuration to explore scope for **MNPI services being located within maternity/neonatal accommodation**

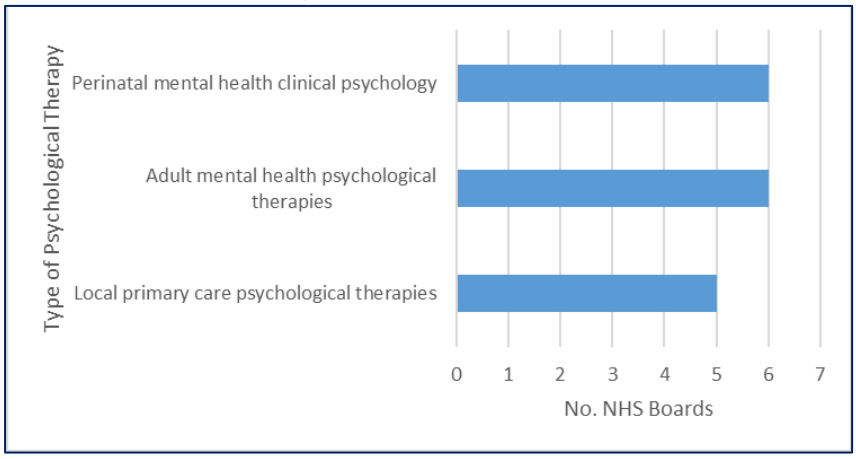
3. Develop a consistent approach to managing **cross-boundary patient flows**.

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

Progress

The graph below indicates how many boards have access to psychological therapies. Four responses noted N/A as they do have 3,000 deliveries or more per year.

Chart 7: Access to Psychological Therapies



When asked if there was sufficient access to psychological therapies, responses were mixed. Two services agreed, one disagreed, two answered “don’t know” and one service noted it depends as there are substantial waits for anyone directed to psychological therapy out with the combined CPMH/MNPI/IMH. Treatment is offered within the service where possible as there is no waiting list.

What worked well?

Case by case discussions with Adult Mental Health psychology lead

- Discussion of the suitability of MNPI requires a good understanding of maternity and neonatal services to consider systemic issues. Perinatal Psychologist supervision is offered but there is limited capacity and an emerging wait list.

Formalising referral pathways

Referral pathways between MNPI and both Adult and CAMHS services as waiting times are long for adult psychology therapies out with MNPI.

What could be improved?

Capacity and backfill

- Provision of backfill for appropriate staff to reduce waiting times and improve service provision.

Key Considerations

1. **Sufficient resources** to meet demand

2. **Consideration of prioritisation** for perinatal patients within local primary care psychological therapies services or adult mental health psychological services given the timeframes for maternity care and infant development.

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

Progress

Specialist teams provided a range of examples of self-help digital resources. SilverCloud was most frequently mentioned (n=20), followed by Solihull resources (n=5), and maternity and neonatal self-help national resources (n=3).

A range of other resources were also mentioned, as listed below:

Birth Trauma Association UK	Bliss pregnancy sickness support	Peer Support (Latnum)	Highland Mental Well-being
Dadpad	Neonatal Canopie App	Mind Matters App	Shout
Access Therapies Fife	PANDAS	Action on post-partum psychosis	Chris Williams 5 Areas Approach
Space for Perinatal	SIGN 169 App	Sleepio, Daylight	Beating the Blues

What has worked well?

Self-help and digital resources

- These resources are useful in offering a different format to meet the care needs of patients struggling with mental health during the perinatal period, including those who do not meet criteria for specialist services.
- The Maternity and Neonatal Self-help Resource was developed by NHS Fife through the MNPI forum and is available **here**.

Perinatal Silvercloud supporter role

- This has been transferred to Digital Therapies, which has increased capacity within the Perinatal Mental Health Service.

What could be improved?

Direct referrals to Silvercloud

- A direct referral option for community and hospital based maternity staff would streamline referral processes.

Wider awareness of self-help options

- Inappropriate referrals could be reduced through greater awareness of self-help resources by all agencies involved with birth parents in the perinatal period.

Key Considerations

1. Continue to share full range of self-help resources available.

2. Progress work to enable direct referrals to Silvercloud from maternity staff.

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

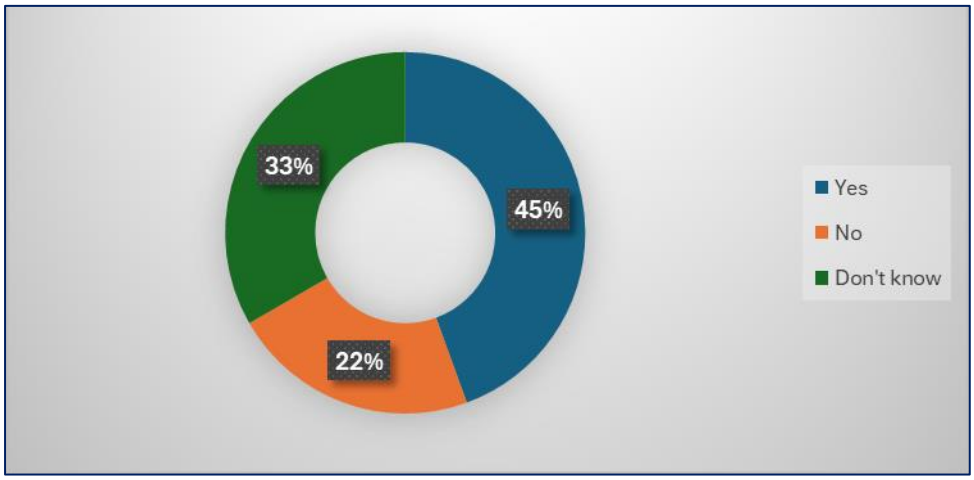
Progress

The implementation of the quality indicator outlined in this recommendation has not been fulfilled. There is a national quality indicator to commence psychological therapy within 18 weeks of referral. It is not clear how practical it would be to have an additional perinatal indicator.

In light of this not being fulfilled, stakeholders were asked whether non-specialist services were able to prioritise perinatal patients.

Just under half of services (45%) indicated that they felt non-specialist psychology services prioritise women in the perinatal period.

Chart 8: Non-specialist services prioritisation of women in the perinatal period



What has worked well?

Case-by-case prioritisation with Adult Mental Health psychology

- One board noted women within the first postnatal year should be given priority if there is potential negative impact on unborn / new baby and this is considered on a case-by-case basis.

What could be improved?

National Scottish Government guidance

- Scottish Government direction on the prioritisation of women in the perinatal period would help address current variation between Health Boards.

Key Considerations

1. Develop consistent policy and practice across Health Boards to prioritise access to general mental health services for women in the perinatal period.
2. Explore practicalities of having a perinatal quality indicator.

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

Progress

80% of MNPI teams stated that they did not think their Board has sufficient capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men. Only 20% of MNPI teams considered local Board capacity to be sufficient.

What has worked well?

Rapid access to low intensity input

- This includes websites and self-help guides as well as self-help workers in Adult Mental Health Psychology departments.

Close working with Neonatal Intensive Care Unit (NICU)

- This ensures all NICU referrals are seen within one week.

AMH Psychology waiting times are within the standard (not reported for all Boards)

- Signposting to other supports during any wait was also reported as beneficial.

What could be improved?

Reduce variation in training

- Primary care mental health nurses are based in GP practices but their psychological therapy training beyond mental health nursing is varied.

Increased resource

- Some boards who do not currently accept fathers as patients for direct intervention, and Boards with waiting lists would require, additional workforce capacity, which is restricted by current funding challenges.

Improved understanding of MNPI

- Greater awareness and understanding by all staff groups of the differences between MNPI and perinatal mental health services.

Improved referrer awareness and confidence

- Anyone in the perinatal period should be seen in specialist services, not in primary care. Referrers report not feeling confident in determining whether difficulties are mild to moderate or severe and complex.

Key Considerations

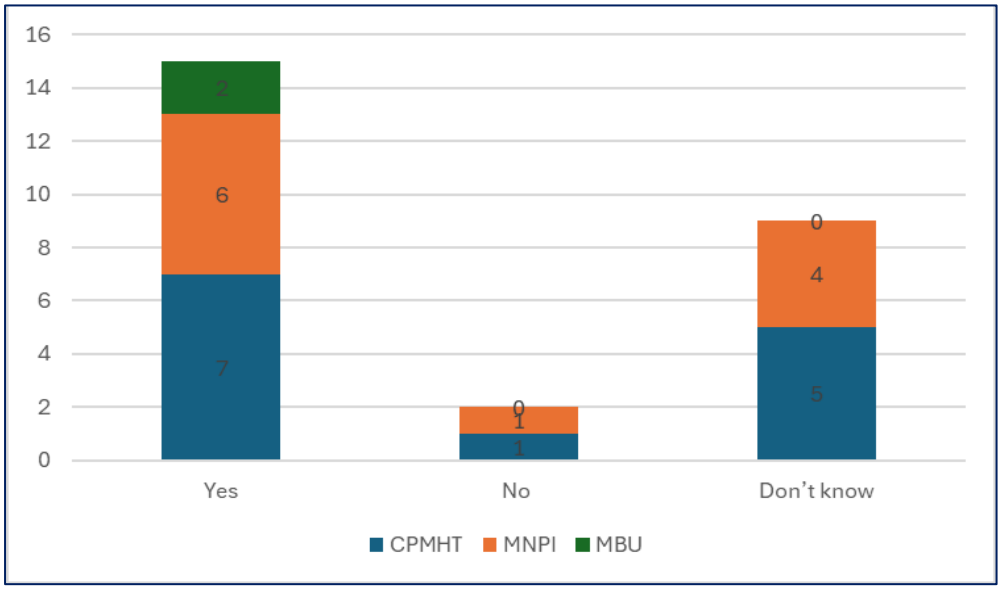
1. Improve **workforce capacity and training** across all tiers of service delivery.

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

Progress

CPMHT, MNPI and MBU services were asked if all parents and parents-to-be in their Health Board were made aware of third sector counselling and support services which exist in their area and how to access them? This included individual and couple counselling and support for the parent-infant relationship. Most services indicated that this was the case.

Chart 9: Parent Awareness of Third-sector Services



What has worked well?

Strong working relationships with third sector partners

- Regular meetings and champions keeping staff informed, networks and collaboratives.

Good awareness of services available

- Sharing information about third sector support on service websites, links on appointment letters, leaflets in waiting room, information via the Badger App, regular learning / CPD spotlight sessions so staff can signpost effectively.

What could be improved?

Secured funding for third sector provision

- Current funding arrangements for many third sector services are vulnerable.

Awareness that third sector service provision can differ across regions

- Improved staff awareness of regional variation in third sector supports.

Key Consideration

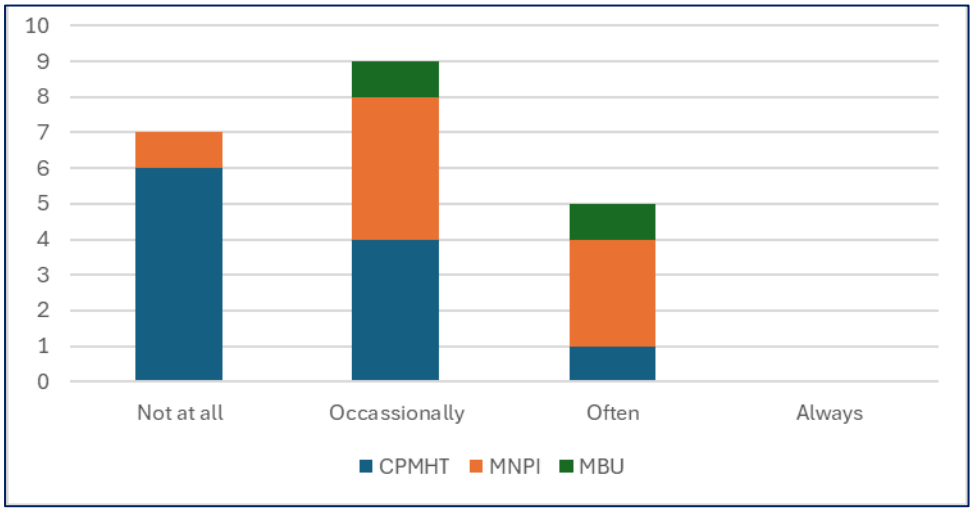
1. Ensure staff have awareness of third sector service provision across relevant areas.

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

Progress

CPMHT, MNPI and MBUs suggests that there is relatively little engagement with third sector partners in the development of services at local or regional level.

Chart 10: Third-sector Inclusion in Regional Networks



What has worked well?

Partnership working

- Some areas have bene successful in the formation of regional partnerships, networks and early years collaboratives with regular meetings to share developments.

What could be improved?

Greater regional co-ordination across third sector

- More co-ordination of third-sector provision could encourage equity of service provision across regions. There has been a lack of peer support worker development in this area.

Improve relationships at a regional level

- Build on the good work done in third sector collaborative projects. These are dependent on ongoing funding and limited to specific localities.

Increased support in engagement management

- Additional, permanent roles would support the ongoing management of engagement with third sector partners.

Increased staffing capacity within the CPMHT

- Increased CPMHT capacity would support more collaboration with third sector groups in the community which have a focus on adult and infant mental health.

Key Considerations

1. Maintain focus on strong relationships with third sector organisations to ensure awareness of local services on a regional basis.

2. Explore opportunities for more long-term funding support for third sector services, including opportunities to address variation in provision across Scotland.

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

Progress

The Peer Support Evaluation Toolkit For Perinatal and Infant Mental Health Services was created in partnership with Inspiring Scotland, Evaluation Support Scotland and Scottish Government. In addition, peer support is recognised in the Perinatal Mental Health - Action Plan - 2020-2023.

The Peer Support Worker role definition was published in 2021, which summarises the knowledge and skills required to fulfil the requirements of these posts. Perinatal Mental Health Network Scotland carried out an evaluation of the Peer Support Worker role in Mother and Baby Units in 2023. This involved collating feedback from Peer Support Workers, staff and patients within the MBU setting.

Further work took place in early 2025 to develop a lessons learned report to summarise what has gone well, and what could have been better, in the development of the PSW role. This included experiences across the MBUs, CPMHT and the third sector including recruitment, training and induction, roles and responsibilities, patient experience and funding. The report is available on the **PMHNS website**.

Across specialist perinatal mental health services and the third sector, the peer support worker role was found to be valuable and continues to develop over time.

Key considerations

1. **Continue to share best practice** and challenges across statutory and third sector services as the PSW role continues to develop.
2. **Continued support and supervision** for PSW from the outset. The recent lessons learned report highlighted the importance of clarity of the role, ability to respond to patient feedback / needs, appropriate and ongoing training, and to establish peer to peer support within the service where possible.

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

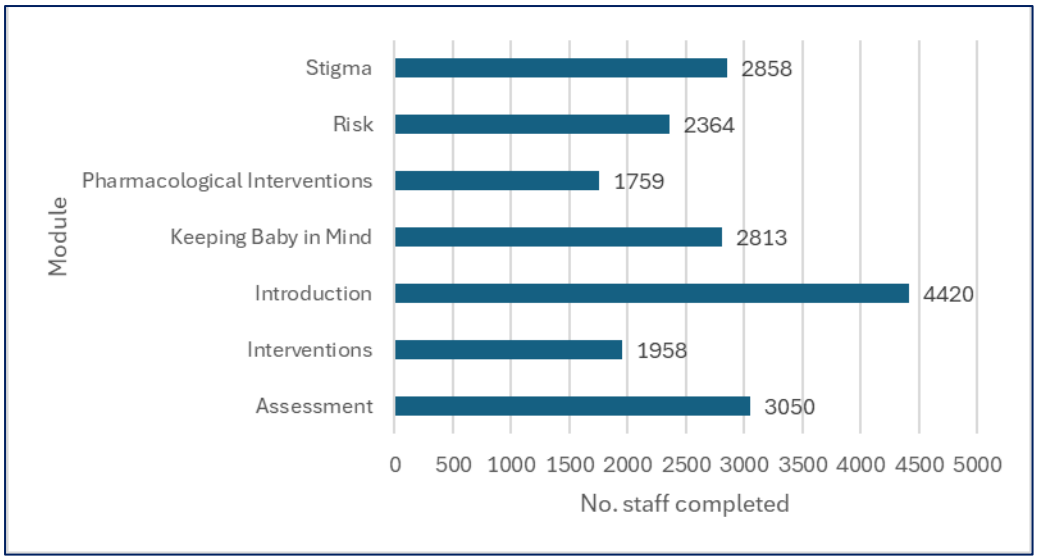
Progress

Learning Modules from NHS Education for Scotland

NHS Education for Scotland (NES) had a critical role in supporting this recommendation through the development of evidence-based learning modules and targeted educational initiatives. NES designed these to align with the Curricular Framework for Perinatal Mental Health, ensuring that staff across Scotland received standardised training that meets national requirements.

Available via TURAS, the Essential Perinatal Mental Health modules aim to cover key aspects of perinatal mental health, addressing gaps in knowledge, improving clinical practice, and enhance multi-agency and multi-disciplinary working.
Figures based on data from December 2024 from NES.

Chart 11: Essential Perinatal Mental Health Modules: Number of modules completed

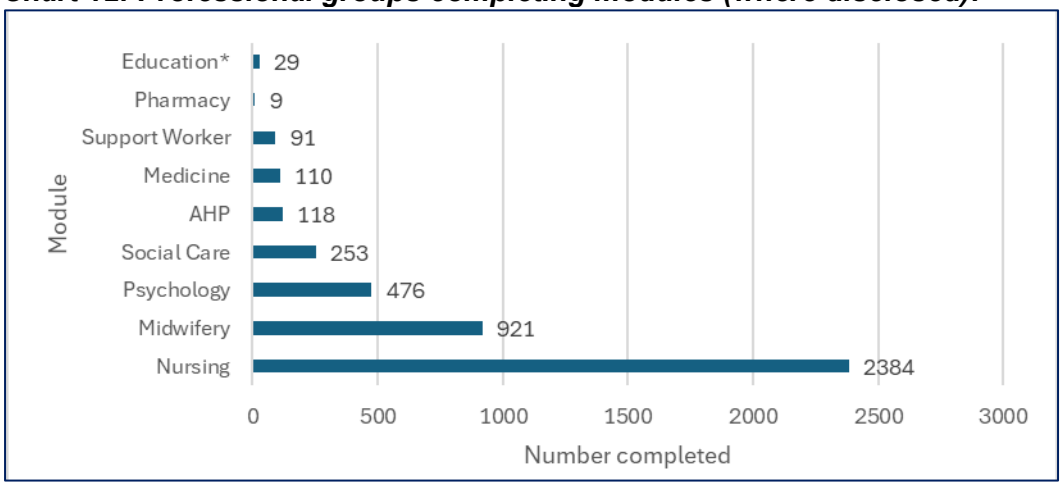


Source: NES December 2024

When the Essential Perinatal Mental Health modules were first released, they were promoted via the PMHNS and on social media, which resulted in a large uptake. This has continued periodically since then to capture new staff and raise awareness with the wider workforce. The modules have been updated regularly to ensure they align with contemporary evidence and respond to user feedback.

Overall, the distribution of the module completions appears to reflect the expected workforce composition in the wider perinatal mental health system, with the highest engagement from nursing and midwifery professionals.

Chart 12: Professional groups completing modules (where disclosed):



Source: NES December 2024

* *Includes staff from University West Scotland, Robert Gordon University, Glasgow Caledonian University, Edinburgh Napier University, University of Dundee, University of Stirling, University of Edinburgh, Queen Margaret University, University of Glasgow*

Follow-on Training

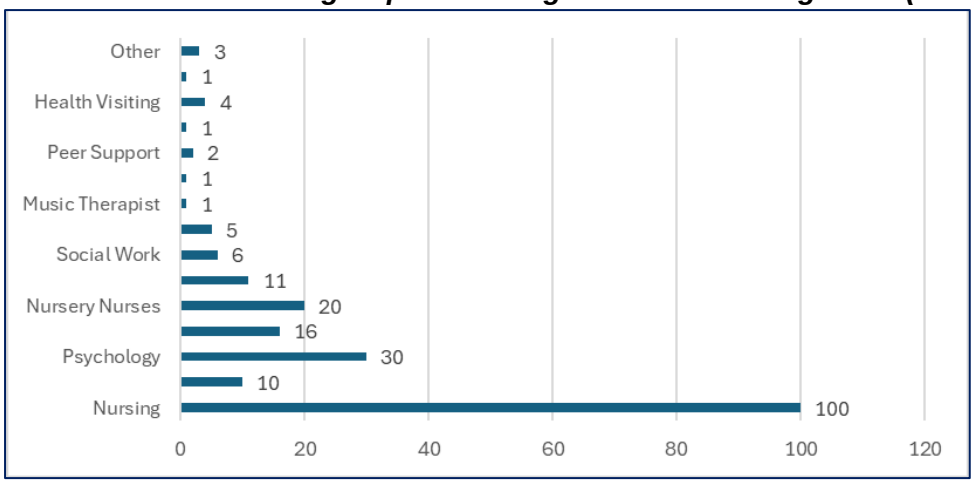
The follow-on training is offered as an induction programme for professionals working within specialist CPMHT and MNPI teams. The content is more advanced and therefore all participants are expected to have completed the Essential PMH modules prior to attendance.

Table 5: Number of staff attending following-on training:

Module	Number completed
Perinatal and Infant Mental Health	212
Maternity and Neonatal Psychological Interventions	67
Total	**279**

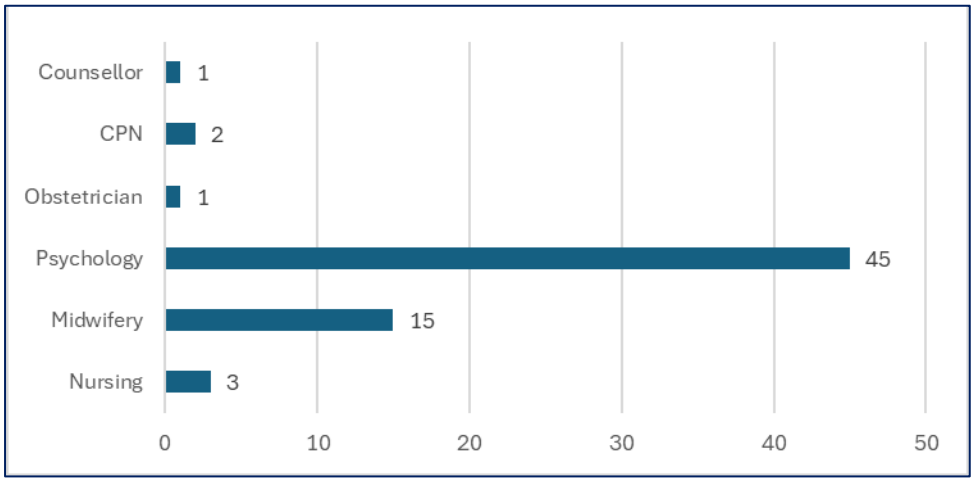
Source: NES December 2024

Chart 13: Professional groups attending follow-on training PIMH (where disclosed):



Source: NES December 2024

Chart 14: Professional groups attending follow-on training MNPI:



Source: NES December 2024

Dimension 3 of the Curricular Framework for Perinatal Mental Health is regarding Parent – Infant relationships. Therefore, a training plan was developed to upskill professionals across competency levels.

Table 6: Infant Mental Health (IMH) training:

Education and Training Offer	Level of Practice	Reach
Solihull Approach Foundation Level Training	Skilled	3,362
Solihull Approach Train the Trainer	Skilled	298
Solihull Approach Online	Informed	22,029
Solihull Parenting Groups	Skilled	8
Warwick Infant Mental Health Online (IMHOL)	Enhanced	432
Video Interaction Guidance (VIG)	Enhanced/ Specialist	102
Mellow Parenting	Enhanced/ specialist	3
MSc in Psychoanalytic Observation and Reflective Practice	Specialist	10

		(+ 5 currently in training)
Circle of Security Parenting (COSP)	Enhanced	47
Newborn Behavioural Observation (NBO)	Enhanced/ Specialist	15
Child-Parent Psychotherapy	Specialist	5 currently in training
Parent Infant Interaction Observation Scale (PIIOS)	Enhanced/ specialist	3

Source: NES December 2024

PIMH Champions training

The Perinatal and Infant Mental Health (PIMH) Champions Programme is designed to build the non-specialist workforce capacity. PIMH Champions are professionals from universal services who undergo specialised training to enhance their knowledge, enabling them to cascade awareness level training to colleagues across community services. This approach aims to strengthen multi-agency collaboration and ensures a wider reach of knowledge. The table below provides an overview of the number of Champions trained and the subsequent reach of their training delivery.

Table 7: PIMH Champions Training:

	Number completed
PIMH Champions completed training	232
Number of participants attended PIMH Awareness Training Cascade *(delivered by PIMH Champions)*	662
Total	**894**

Source: NES December 2024

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

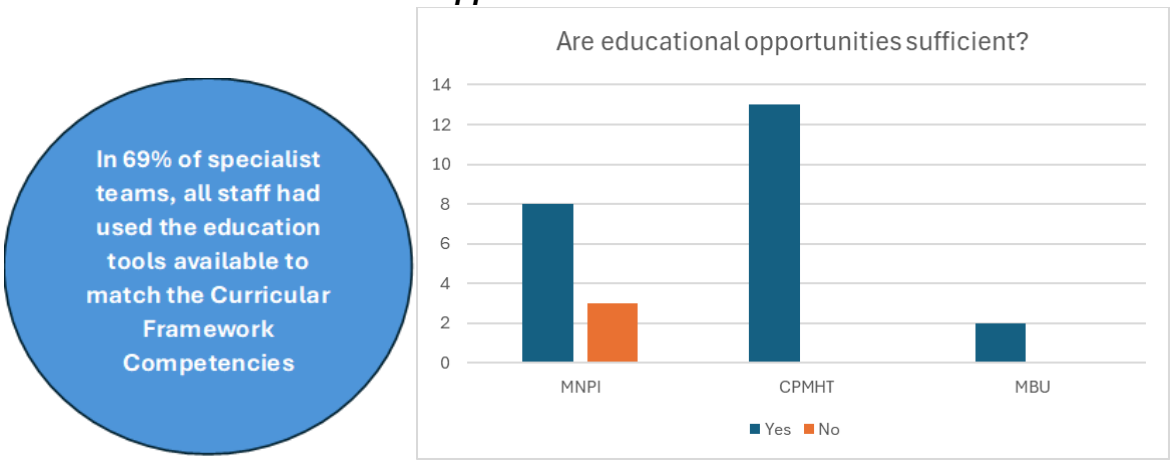
Progress

Staff across CPMHT, MNPI and MBUs were asked if the educational opportunities are sufficient for all new staff. The chart below shows the majority (88%, 23 out of 26 responses) said yes.

For the teams answering no, it was noted that additional training in line with the NES curricular framework was completed by all MNPI clinicians. However, clinical demands on the MNPI team limited their capacity to deliver training to upskill wider staff groups.

Specialist services were asked what percentage of staff in the specialist service have used the education tools available to match to the Curricular Framework Competencies. 69% of responses noted 100% of staff had used the tools available. 15% were unsure or did not have the data available. 8% (2 responses) answered not applicable due to their not being a specialist service. 4% (1 response) noted a training date had been booked for a staff member and the remaining response noted 60% of staff had used educational tools available.

Chart 15: Level of Educational Opportunities



What has worked well?

Training and Education Initiatives

- Staff are encouraged to complete Essential Modules related to perinatal mental health.
- NES has delivered training on parental distress, birth trauma, and mental health to neonatal nurses and midwives.

- Various additional CPD opportunities are available, including:
  - NBO (Newborn Behavioural Observations)
  - EMDR training (Eye Movement Desensitization and Reprocessing)
  - Sensory Beginnings training
  - ACT (Acceptance and Commitment Therapy)
  - Schema Therapy and Trauma-Informed Care
- Specialist healthcare professionals, including mental health nurses, health visitors, psychiatrists, and junior doctors, receive structured training.

Workforce Development and Specialist Roles

- Senior nurses play a key role in ensuring the completion of training across their region.
- One area has a senior nurse provide perinatal mental health training to students.
- Specialist perinatal CPNs (Community Psychiatric Nurses) receive targeted training aligned with national standards.
- Knowledge required of non-specialist staff is acknowledged and training provided.
- Newly qualified nurses receive induction training in perinatal mental health to allow them to integrate more quickly into their role.

Service Integration and Multi-Disciplinary Collaboration

- Training sessions are regularly scheduled to ensure compliance with national guidelines.
- A weekly triage meeting within the Perinatal Mental Health (PMH) service facilitates rich discussions and reflection on perinatal mental health cases and outcomes for infants. This helps us identify training gaps.
- Multi-agency collaborations include third-sector organisations and universities. Recognising the wide systems involved in holistic PMH care.

Quality Assurance and Continuous Learning

- The Perinatal Faculty and Quality Network Conferences provide opportunities for staff development and service improvement in addition to the NES offers.
- Some areas have internal teaching programs to cover a variety of relevant topics. These involve training on infant feeding, autism, and trauma-informed care. Which are all relevant to the perinatal patient population, but not solely mental health professionals.
- Learning opportunities are provided through peer supervision, case discussions and 1:1 clinical supervision.

What could be improved?

Accessibility and Delivery of training

- Some training is difficult to access in person, with heavy reliance on online learning. Different learning styles mean that in-person training would be more suitable for some.
- Face to face sessions can strengthen networking and professional relationships, which is rarely available due to heavy workloads and cost pressures on staff travel.
- Feedback suggests that all local training should be face to face rather than primarily online.

Confidence and Skill Development

- Not all professionals feel confident working with perinatal mental health.
- Ongoing support and development are needed to build confidence in applying any theoretical learning.

Workforce Competency and CPD

- Although CPD opportunities exists in most areas, these need to be further enhanced.
- There is a need for both updates and more advanced training for specialists in PMH.

Key Considerations

1. **Maximise Training Accessibility Without Extra Burden**
   - Embed learning into existing meetings to reduce additional workload.
   - Consider, short, bite-sized learning and targeted in-person options.

2. **Support Confidence & Skills Development Efficiently**
   - Use structured peer mentoring and reflective practice to increase confidence in the workforce.
   - Encourage cross team knowledge sharing locally and nationally to spread expertise.

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

Progress

NES developed learning pages to hosting information relating to the Perinatal Mental Health Curricular Framework. The framework sets out the different levels of knowledge and skills required by members of the Scottish workforce to promote positive well-being and good mental health in mothers, babies and their families during the perinatal period.

The Perinatal Mental Health Curricular Framework can be accessed here: **Perinatal and Infant Mental Health | Turas**.

Further resources have been developed, including the SIGN 169 patient-facing toolkit. The toolkit can be access here: **Advice for women, birthing parents and their partners | Right Decisions**.

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

Progress

All teams were asked if a multi-professional group was set up and still active in their Board to co-ordinate and lead perinatal mental health service development and evaluation. 15 said this was the case and 10 said no.

Chart 16: Local multi-professional coordination and leadership

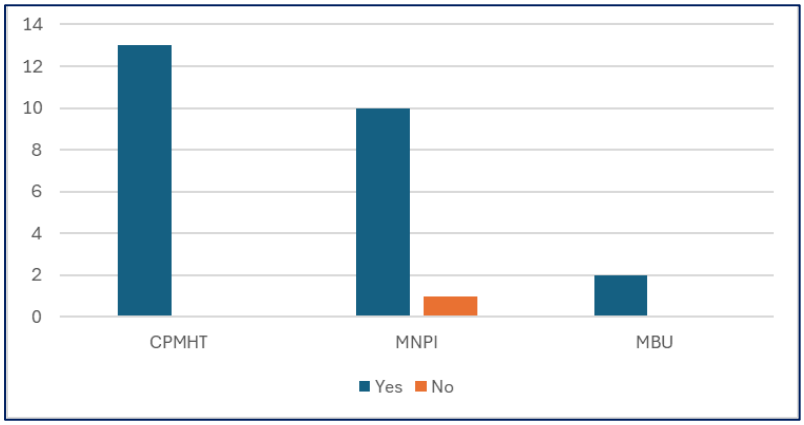
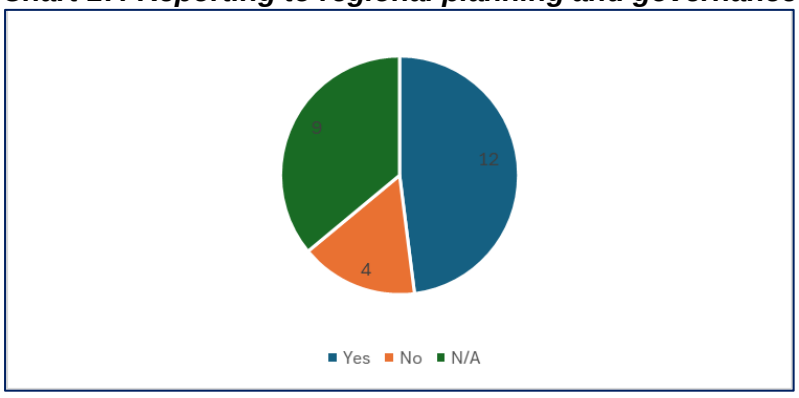


Chart 17: Reporting to regional planning and governance



What has worked well?

- Strong leadership, buy-in and governance structures that are continually evolving with the service.

What could be improved?

- Capacity challenges in supporting and leading on co-ordination of the group to ensure momentum continues.

Key Considerations

1. Consider further development of local and national structures to provide a consistent infrastructure to lead and support the development of perinatal and infant mental health services.

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

Progress

The Scottish Government published **the Mental Health and Well-being Workforce Action Plan 2023-2025**.

A short-life working group was set up by Scottish Government to develop a Perinatal Mental Health Service Specification. This document will be ratified by the Joint Strategic Board Child and Family Mental Health before being published.

Key Considerations

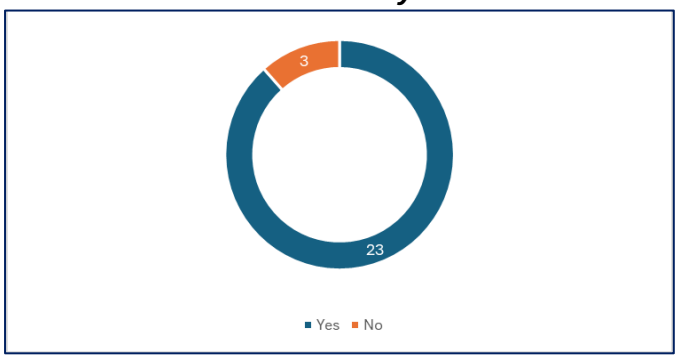
1. Implement the action plan across Scotland and continue to work with Scottish Government on perinatal and infant mental health service.

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

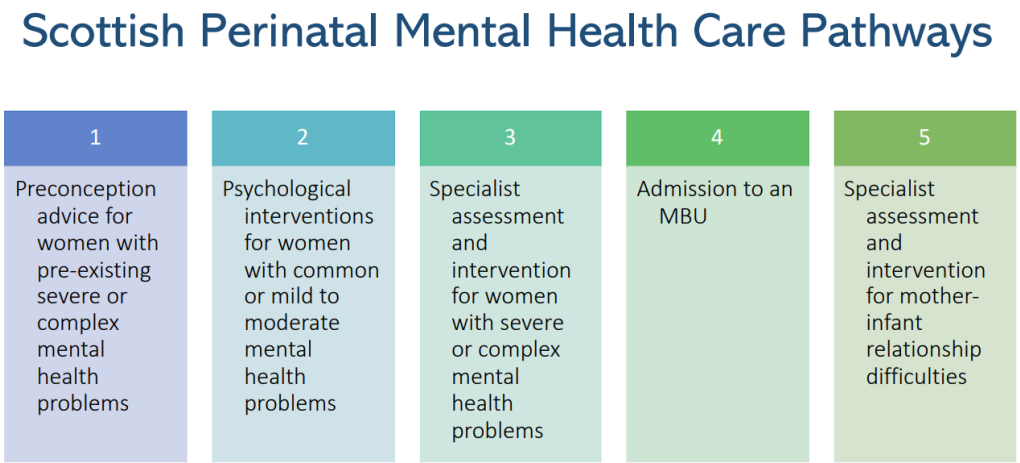
Progress

The vast majority (23 of 26 or 88%) of specialist services reported to have a local care pathway in place.

Chart 18: Local Care Pathways



In addition to local care pathways, **the Scottish Perinatal Mental Health Care Pathways** were developed through PMHNS to help women, their infants and families, access the most appropriate specialist perinatal and infant mental health care, should they require it. For referrers and service providers, they should help guide the development of pathways which are responsive to the needs of their local population and organisation.



Five short videos were published by PMHNS to accompany each of the specialist perinatal mental health care pathways. They were designed to help women, their infants and families, know what specialist perinatal and infant mental health care is available in Scotland.

- **Pathway 1: What's pre-conception advice? How can it help me if I'm planning a pregnancy?**

- **Pathway 2: What are Maternity and Neonatal Psychological Interventions Teams? How can they help me and my family?**
- **Pathway 3: What are Community Perinatal Mental Health Teams? How can they help me and my baby?**
- **Pathway 4: What's a Mother and Baby Unit? How can it help me and my baby?**
- **Pathway 5: What is parent-infant therapy? How can it help me and my baby?**

What has worked well?

Clear pathways and good interfaces

- Effective interface between CPMHT, MNPI and IMH services, as well as with maternity and health visiting services.

Joint working and pathways of care

- Working closely with other services and carrying out joint assessments if required.

Ease of access

- Specialist services providing easily accessible guidance and advice to referrers.

What could be improved?

Reducing gaps and improving seamless provision between services

- Learning review being conducted to ensure continual improvement.

Inappropriate referrals

- Poor understanding of referral criteria.

Maintenance of Pathways

- Some local pathways are outdated and/or not reflective of current service provision.

Key Considerations

1. Continue to develop local and national care pathways to be reflective of the current service and ensure they are accessible, with guidance, to improve appropriate referrals rates.

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

Progress

Mother and Baby Units

- The West of Scotland MBU is currently accredited by the Perinatal Quality Network (PQN) until 2027.
- The MBU in Livingston has been accredited for many years but lost the accreditation in 2024-25 due to not being able to regulate the temperatures in the rooms on the ward. The Livingston MBU is not a purpose-built unit and the MBU has no independent heating controls from other parts of the hospital. Despite meeting with the estates department, the Royal College confirmed there was no scope for an exception on this point. The Livingston MBU received no other recommendations and had a positive report on all other aspects of the accreditation.

Community Perinatal Mental Health Teams

- Of the four Boards with birth rates greater than 5,000 per year, two Boards are members of the Royal College of Psychiatrists' Perinatal Quality Accreditation Network, and the remaining two are not, although they aimed to become a member.
- One smaller Board noted they aspire to become a member.

What has worked well?

The guidance was used to inform the development of the service.

Key Considerations

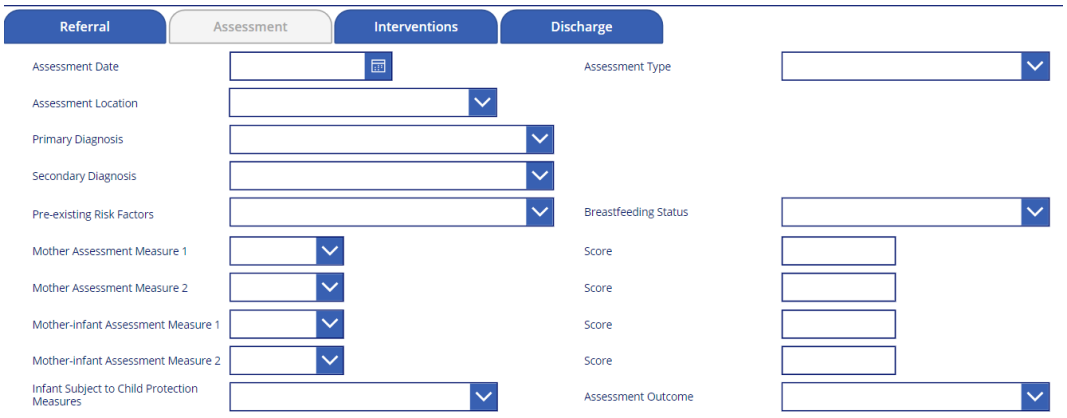
1. Continue to work towards accreditation where possible. This is a significant piece of work and required financial agreement to allow the service to do this.

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

Progress

The Perinatal Mental Health data set has been developed through the National Managed Clinical Network Clinical Audit System (CAS) using the PowerApp as a data collection front end. The data set was co-designed with clinical colleagues in specialist services. The PowerApp was initially used in the Mother and Baby Units before rolling out to CPMHTs and MNPI services. All NHS Boards were offered the option of using the PowerApp to enter data about their service from a point that was most appropriate to them. The Mother and Baby Units, NHS Greater Glasgow and Clyde MNPI, and NHS Grampian CPMHT and MNPI went live in 2022-23, with other services across Scotland joining in 2023-24 and 2024-25.

The data set captures referral, assessment, intervention and discharge information across MBU, MNPI and CPMHT. The data set is an audit tool with the aim of supporting service development. It does not replace clinical notes. An example of the assessment page for the CPMHT data set is shown below.



Quarterly dashboards have been created on PowerBI with Board level data. The dashboards have been continually improved since they were first issued in August 2023. The first national dashboards for CPMHT and MNPI were published in summer 2024. Data is the national dashboard is anonymised but aims to give a national overview, as well as the opportunity for boards to benchmark against similar sized boards.

At the time of publishing this report, the following services are using the PowerApp:

Board	Team	Status	Comments
NHS Ayrshire and Arran	CPMHT and MNPI	Active	Live from 21 August 2023
NHS Borders	CPMHT	Active	Live from 1 April 2025
NHS Dumfries and Galloway	CPMHT/MNPI	Active	Live from 1 Feb 2025
NHS Fife	CPMHT and MNPI	Active	Live from 1 May 2024

NHS Forth Valley	CPMHT and MNPI	Active	Live from 1 December 2023
NHS Grampian	CPMHT and MNPI	Active	Live from 9 January 2023
NHS Greater Glasgow and Clyde	West of Scotland MBU	Active	Live from 1 September 2022
	MNPI	Active	Live from 9 December 2022
	CPMHT	Active	Live from 1 April 2024
NHS Highland	North CPMHT and MNPI	Active	Live from 1 September 2023
	Argyll and Bute CPMHT / MNPI	Active	Live from 1 November 2024
NHS Lanarkshire	CPMHT and MNPI	Planning	Awaiting sign-off for Data Protection Impact Assessment from local information governance.
NHS Lothian	CPMHT, MNPI and MBU	On hold	Lothian are adapting local Trak Care system to add perinatal mental health data. Exploring options for use of PowerApp locally.
NHS Orkney		Not started	No response
NHS Shetland		Not started	No response
NHS Tayside	CPMHT and MNPI	Paused	Live from 1 November 2023. Paused in Sept 2024 due to local capacity challenges / vacancies.
NHS Western Isles		Not started	No response

What has worked well?

Development of dashboards

- The quarterly dashboards have developed over time as more data and functionality within PowerBI became available.
- Dashboards have been developed for local level data, and national datasets displaying data across all services. Small numbers are removed from the national dataset to ensure anonymity.

National data

- As outlined in the DES recommendations, the PowerApp has been used to develop a national dashboard which allows teams to benchmark against similar sized boards.
- National data for specialist perinatal mental health services in Scotland was not available before.
- National dashboards are updated quarterly for MNPI and CPMHT.

What could be improved?

System functionality

- The functionality available through the CAS and PowerApp is limited and update requests are made centrally which therefore makes it apply to all Boards, even when local requirements may vary.
- There can also be significant delays implementing change requests.

- Access to data at a local level has evolved since the start of the PowerApp roll-out and some Boards are able to access more detailed reports locally. However local data access still varies considerably.

Capacity and data entry

- The system is for audit purposes and does not replace clinical notes. This does mean some information is entered into multiple systems and can result in capacity issues within services for that duplicate data entry.
- National capacity can also be a challenge when producing national reports, meaning there is a lag in when the information is received after the end of the reporting quarter.

Availability of national data

- As not all Health Boards are currently able to enter data into the PowerApp the national data set is not yet able to fully reflect a national picture.

Key Considerations

1. Ensure the data collected is at a level that is beneficial to Health Boards, without negatively **impacting on capacity** for already stretched clinical services.

2. **Review effectiveness of the data collected** to inform service development, and/or identify issues to resolve.

3. Explore approaches to national data collection that reflects progress made locally in data collection to **reduce duplication** and ensure data collection and analysis processes are efficient.

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

Progress

The Scottish Government committed to improving perinatal mental health through its Perinatal and Infant Mental Health Programme Board. While the Programme Board has now concluded, it played a key role in funding and shaping specialist services, including a focus on vulnerable populations such as women experiencing problematic substance use. Complimentary work includes the National Trauma Training Programme, led by NHS Education for Scotland. This initiative aims to embed trauma informed practice across all sectors and is particularly relevant given the high prevalence of trauma among women who use substances.

In 2021, the Scottish Government launched a national mission to reduce drug deaths and improve the lives of people who use substances. This included investment for whole family approaches to services that respond to the needs of pregnant and postnatal women.

In April 2021, recognising the complexity of need in this population, the Scottish Government, in conjunction with the Perinatal Mental Health Network Scotland and Inspiring Scotland, hosted an online stakeholder event to bring together professionals and people with lived experience to identify service gaps and inform future planning. At this event, the **Supporting Women, Reducing Harm report**, published by PMHNS, was launched, setting out the case for integrated, trauma-informed and gender and child-sensitive services, with clear pathways of care across maternity, mental health, and substance use services. The Scottish Government also announced the formation of a Short Life Working Group (SLWG), intended to use the feedback from the event to shape future direction of services.

The SLWG was established in 2024, and aims were agreed:

- Produce a good practice guide for all agencies supporting women who use substances, and their infants and families, during pregnancy and the first postnatal year; this should be aligned to related national policies to improve outcomes for women and infants.
- Develop a plan for the dissemination of the good practice guide within members' networks and sectors, outlining what further steps should be taken to deliver positive change for women and their infants and families.
- Support the implementation of clear referral pathways and improved joint working to meet the needs of women who use substance and their infants and families, spanning universal and specialist services.

This group are progressing with the work plan and aim to complete their work in 2025.

Key Considerations:

1. **Lived experience insights** have been influential in shaping national priorities and should continue to inform service improvement.

2. **Trauma and stigma** continue to impact women's engagement with substance use services, requiring sensitive, relationship-based approaches.

3. There is growing recognition of **whole family working**, but models of care and workforce confidence in delivering these are still developing.

Conclusion

It is evident from the data presented in this report that there has been a significant expansion in specialist perinatal mental health service provision since the publication of *Delivering Effective Services*. As well as new services, there have also been new roles created to further enhance care for women and families. This evaluation, alongside related, more detailed reviews of specific roles (for example, Peer Support Workers), highlights the value of these roles and their contribution to working within a multi-disciplinary team environment.

Engagement in workforce development through the training opportunities available across all tiers of service delivery has also been strong. Specialist teams have worked closely with other services to raise awareness of perinatal mental health services and improve the rate of appropriate referrals. While this is a welcome, positive development, it coincides with an increase in overall demand on these services and many specialist teams reported that staffing levels were not able to meet the demand, with some services having to start waiting lists.

By having specialist teams in place and staff appropriately trained, communications around referral and discharge processes have improved. However, the feedback demonstrates a clear need for investment in staff and resources.

It is important to acknowledge the financial pressures facing NHS Scotland at the time of this evaluation report. This has impacted on staff recruitment, and therefore workforce capacity, through funding challenges to fill vacancies, backfill maternity leave and secondments and to secure permanent funding for posts.

This evaluation aimed to provide an overview of the progress made since the publication of DES, celebrating the huge successes that have been achieved over that period of time. The report also highlights a range of challenges and points to areas for wider consideration in order to continue and build on the improvements that have been made to date. These key considerations are not recommendations for specific actions but they are intended to help inform local, regional and national conversations about future priorities for development and improvement.

Appendix

Appendix 1: CPMHT Survey questions

No.	DES recommendation	Question	Answer	What has worked well?	What could have been better?	If you deviated from the recommendation, please explain why and if this was intentional
1	Specialist perinatal mental health services (MBUs and community teams) should include peer support workers as part of their provision. The Scottish Government should work with NHS boards and third sector funders to review models of peer support to specialist services and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.	**A) In whole time equivalent (WTE), how much peer support provision do you have?**	A) WTE:			
		B) How are these posts funded?	B) ☐NHS Board ☐ Scottish Government ☐Third Sector ☐Other			
2	All NHS boards should have equity of access to a regional MBU for those women who require inpatient care. The Scottish Government should ensure that MBU beds are provided as a national resource and decisions on admission made exclusively on clinical need.	**A) Do you have sufficient access to a regional MBU for women who require inpatient care?** **B) Do you have an agreement in place for admission to a MBU, if so, which one?**	A) ☐Yes ☐No Comment: B) ☐Yes ☐No ☐West of Scotland ☐Livingston			
3	All NHS boards should have community specialist perinatal mental health provision. The specific model will be dependent on birth numbers, socio-demographic	**Do service users in your NHS board area have access to a specialist CPMHT? If so, which, model.**	☐Stand- alone ☐Dispersed ☐Regional ☐None			

	and geographical needs and, for smaller boards, may be provided in part by boards collaborating together through regional structures. Sessional time for some highly specialised staff may also be provided through regional collaboration. The Scottish Government should ensure that implementation of this work and longer-term roll-out is included in a national delivery plan as soon as practicable.					
4	Recommended staffing levels by service model (**page 21-23**)	**Did the recommended staffing levels align with the actual needs of the team?**	☐Yes ☐No			
5	NHS boards should ensure that perinatal mental health services identify a parent-infant mental health lead who will co-ordinate evidence-based interventions and provide clinical expertise to the specialist team. This resource may be provided on a regional basis.	**Do you have a parent-infant mental health lead to co-ordinate evidence-based interventions and provide clinical expertise to the specialist team? This resource may be provided on a regional basis.** **If yes, what is their WTE?**	☐Yes (within board) ☐Yes (regional) ☐No WTE:			
6	The Scottish Government should ensure that self-help and digital resources are adapted to meet the distinctive needs of pregnant and postnatal women, and their families.	**Which self-help resources do you direct service users to?**				
7	NHS boards should ensure that all parents, and parents to be, are made aware of third sector counselling and	**Are all parents and parents-to-be in your health board made aware of third sector**	☐Yes ☐No ☐Don't know Comment:			

	support services which exist in their area and how to access them, including individual and couple counselling and support for the parent-infant relationship.	**counselling and support services which exist in their area and how to access them?**				
8	The third sector should be included in regional networks, with a specific remit to advise on the provision of counselling services and peer support worker development.	**To what extent have third sector partners been included in regional networks to advise on the provision of counselling services and peer support worker development?**	☐Not at all ☐Occasionally ☐Often ☐Always			
9	NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.	**Are educational opportunities sufficient to ensure staff have the knowledge, skills and attitudes to deliver appropriate care?**	☐Yes ☐No Comment:			
10	The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services.	**What percentage of staff in your specialist service have used the education tools available to match to the Curricular Framework Competencies ? This includes the induction / follow-on training for specialist staff.**				

11	Each NHS board should establish a multi-professional group to co-ordinate and lead service development and ongoing monitoring and evaluation. Perinatal mental health regional networks should be established in the north, east and west of Scotland, under existing regional planning structures and governance. The Scottish Government and NHS boards should ensure that perinatal mental health service development is included in regional delivery plans.	**A) Was a multi-professional group set up in your board to co-ordinate and lead service development and evaluation?**	A) ☐Yes ☐No ☐N/A			
		B) Is the group still active?	B) ☐Yes ☐No ☐N/A			
		C) Is this group accountable to the regional planning structures and governance bodies?	C) ☐Yes ☐No ☐N/A			
12	NHS boards should ensure that there are clear care pathways for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services. Information should be easily accessible to women and their families.	**Do you have a local care pathway for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services?**	☐Yes ☐No ☐N/A			
13	NHS boards should ensure that MBUs, and community specialist perinatal mental health teams providing care for delivered populations greater than 5,000 births/year, are members of the Royal College of Psychiatrists' Perinatal Quality Accreditation Network.	**Are you a member of the Royal College of Psychiatrists Perinatal Quality Accreditation Network?**	☐Yes ☐No ☐N/A			
14	Further Comments:					

Appendix 2: Mother and Baby Unit Survey Questions

No.	DES recommendation	Question	Answer	What has worked well?	What could have been better?	If you deviated from the recommendation, please explain why and if this was intentional
1	The Scottish Government and NHS boards should ensure that MBUs are staffed at the recommended level to provide a comprehensive clinical service. **DES set out recommended staffing levels for MBUs (**DES page 16)	**A) Does this reflect your staffing level? If no, please provide your staffing profile and highlight any vacancies.**	☐Yes ☐No Comment:			
		B) Did the recommended staffing levels align with the actual needs of the team?	☐Yes ☐No Comment:			
2	Specialist perinatal mental health services (MBUs and community teams) should include peer support workers as part of their provision. The Scottish Government should work with NHS boards and third sector funders to review models of peer support to specialist services and develop an evidence and evaluation base. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable.	**A) In whole time equivalent (WTE), how much peer support provision do you have?**	A) WTE:			
		B) How are these posts funded?	B) ☐NHS Board ☐ Scottish Government ☐Third Sector ☐Other			

3	NHS boards should ensure provision for accommodating partners or other family members near to each MBU where they have to travel long distances.	**A) Do you have provision for accommodating partners or family members near the MBU?**	A) ☐Yes ☐No			
		B) Is yes, how would you rate the adequacy of this provision?	B) ☐Very adequate ☐Somewhat adequate ☐Not adequate			
4	NHS boards should ensure that perinatal mental health services identify a parent-infant mental health lead who will co-ordinate evidence-based interventions and provide clinical expertise to the specialist team. This resource may be provided on a regional basis.	**Do you have a parent-infant mental health lead to co-ordinate evidence-based interventions and provide clinical expertise to the specialist team? This resource may be provided on a regional basis.** **If yes, what is their WTE?**	☐Yes (within MBU) ☐Yes (regional) ☐No WTE:			
5	NHS boards should ensure that all parents, and parents to be, are made aware of third sector counselling and support services which exist in their area and how to access them, including individual and couple counselling and support for the parent-infant relationship.	**Are all parents in the MBU made aware of third sector counselling and support services which exist in their area and how to access them after discharge?**	☐Yes ☐No ☐N/A Comment:			
6	The third sector should be included in regional networks, with a specific remit	**To what extent have third sector partners been included**	☐Not at all ☐Occasionally ☐Often			

	to advise on the provision of counselling services and peer support worker development.	**in regional networks to advise on the provision of counselling services and peer support worker development?**	☐Always			
7	NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.	**Are educational opportunities sufficient to ensure staff have the knowledge, skills and attitudes to deliver appropriate care?**	☐Yes ☐No Comment:			
8	The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services.	**What percentage of staff in your specialist service have used the education tools available to match to the Curricular Framework Competencies? This includes the induction / follow-on training for specialist staff.**				
9	Each NHS board should establish a multi-professional group to co-ordinate and lead service development and ongoing monitoring and evaluation. Perinatal mental health regional networks should be established in the north, east and west	**A) Was a multi-professional group set up in your board to co-ordinate and lead service development and evaluation?**	A) ☐Yes ☐No ☐N/A			
		B) Is the group still active?	B) ☐Yes			

	of Scotland, under existing regional planning structures and governance. The Scottish Government and NHS boards should ensure that perinatal mental health service development is included in regional delivery plans.		☐No ☐N/A			
		C) Is this group accountable to the regional planning structures and governance bodies?	C) ☐Yes ☐No ☐N/A			
10	NHS boards should ensure that there are clear care pathways for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services. Information should be easily accessible to women and their families.	**Do you have a care pathway for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services?**	☐Yes ☐No Comment:			
11	NHS boards should ensure that MBUs, and community specialist perinatal mental health teams providing care for delivered populations greater than 5,000 births/year, are members of the Royal College of Psychiatrists' Perinatal Quality Accreditation Network.	**Are you a member of the Royal College of Psychiatrists Perinatal Quality Accreditation Network?**	☐Yes ☐No Comment:			
12	Further Comments:					

Appendix 3: MNPI Survey Questions

No.	DES recommendation	Question	Answer	What has worked well?	What could have been better?	If you deviated from the recommendation, please explain why and if this was intentional
1	NHS boards should ensure that, where they are provided, specialist perinatal mental health midwives have a clear job description outlining their roles, competencies and arrangements for clinical supervision from maternity and mental health and should have explicit links with the specialist perinatal mental health team and with maternity and neonatal psychological interventions services.	**A) If there is a Specialist PMH Midwife in your board, is there a specific job description outlining the role, competencies and arrangements for clinical supervision from maternity and mental health?**	A) ☐Yes ☐No ☐N/A			
		B) Does the Specialist PMH Midwife link with:	☐MNPI only ☐CPMHT only ☐MNPI & CPMHT ☐N/A			
2	The Scottish Government should work with NHS boards to review models for multidisciplinary psychological interventions provision to maternity and neonatal services, beginning in larger maternity units. These should be led by clinical psychology, with additional staffing from psychological therapists or midwives with additional psychological training. Implementation of this work and longer-term roll-out should be included in a national delivery plan as soon as practicable	**Please tick which of the Core Functions of a MNPI Service listed in DES are provided by MNPI in your board.**	☐ Pregnancy and birth complications or loss ☐ Previous pregnancy complications, loss or birth trauma affecting mental health in the current pregnancy ☐ Infants whose health is significantly compromised and who require NICU or SCBU care ☐ Mental disorders, amenable to psychological therapies, which directly affect maternity care, e.g., needle			

			phobia, tokophobia ☐Support for maternity and neonatal staff who care for parents with difficulties in adjustment to pregnancy and infant care.			
3	Recommended staffing levels (DES Page 26)	**Did the recommended staffing levels align with the actual needs of the team?**	☐Yes ☐No			
4	NHS boards should ensure that maternity hospitals with fewer than 3,000 deliveries per year have access to psychological therapies in local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology. Services should have sufficient psychological therapist provision to meet this need.	**A) Do you have access to psychological therapies in the following.**	☐Local primary care psychological therapies ☐Adult mental health psychological therapies ☐Perinatal mental health clinical psychology ☐N/A			
		B) Is there sufficient access to psychological therapist provision to meet the need?	☐Yes ☐No ☐Don't know Comment:			
5	The Scottish Government should ensure that self-help and digital resources are adapted to meet the distinctive needs of pregnant and postnatal women, and their families.	**Which self-help resources do you direct service users to?**				
6	At the next revision of Mental Health Quality Indicators, the Scottish Government should introduce a Quality Indicator to measure how many women are seen for	**Do non-specialist psychology services prioritise women in the perinatal period?**	☐Yes ☐No ☐Don't know Comment:			

	primary care psychological interventions in pregnancy, and the first postnatal year, within 6 weeks of referral. Systems should be put in place to record this at national level and the data used to drive service improvements. This should be included in a national improvement and delivery plan as soon as practicable.					
7	The Scottish Government and NHS boards should develop additional workforce capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men. This should be developed incrementally, with evaluation of local need conducted in parallel.	**Does your board have sufficient capacity to deliver timely psychological interventions for mild to moderate perinatal mental health disorders in women and men?**	☐Yes ☐No Comment:			
8	NHS boards should ensure that all parents, and parents to be, are made aware of third sector counselling and support services which exist in their area and how to access them, including individual and couple counselling and support for the parent-infant relationship.	**Are all parents and parents-to-be in your health board made aware of third sector counselling and support services which exist in their area and how to access them?**	☐Yes ☐No ☐Don't know Comment:			
9	The third sector should be included in regional networks, with a specific remit to advise on the provision of counselling services and peer	**To what extent have third sector partners been included in regional networks to advise on the provision of counselling services and**	☐Not at all ☐Occasionally ☐Often ☐Always			

	support worker development.	**peer support worker development?**				
10	NHS Boards, Integrated Joint Boards, Local Authorities and other relevant organisations should ensure that all staff working with women during pregnancy and the postnatal period have the knowledge, skills and attitudes to ensure they deliver appropriate care. Staff should meet the requirements of the Curricular Framework for Perinatal Mental Health and undergo induction and regular updated training where appropriate.	**Are educational opportunities sufficient to ensure staff have the knowledge, skills and attitudes to deliver appropriate care?**	☐Yes ☐No Comment:			
11	The Scottish Government should work with NHS Education for Scotland and the Perinatal Mental Health Network to develop a suite of educational tools matched to the Curricular Framework competencies, and an induction programme for all staff new to specialist services.	**What percentage of staff in your specialist service have used the education tools available to match to the Curricular Framework Competencies? This includes the induction / follow-on training for specialist staff.**				
12	Each NHS board should establish a multi-professional group to co-ordinate and lead service development and ongoing monitoring and evaluation. Perinatal mental health regional networks should be established in the north, east and west of Scotland, under existing regional planning structures and	**A) Was a multi-professional group set up in your board to co-ordinate and lead service development and evaluation?**	A) ☐Yes ☐No ☐N/A			
		B) Is the group still active?	B) ☐Yes ☐No ☐N/A			
		C) Is this group accountable to the regional planning	C) ☐Yes ☐No			

	governance. The Scottish Government and NHS boards should ensure that perinatal mental health service development is included in regional delivery plans.	structures and governance bodies?	☐N/A			
13	NHS boards should ensure that there are clear care pathways for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services. Information should be easily accessible to women and their families.	**Do you have a local care pathway for pregnant and postnatal women with mental distress or disorder to ensure ease of access to care and seamless provision between services?**	☐Yes ☐No ☐N/A			
14	Further Comments:					

Further Publications and Resources

Perinatal and Infant Mental Health Programme Board: The Programme Board was set up to oversee the investment fund and was chaired by Hugh Master. The Programme Board concluded in March 2023 and the interim Perinatal and Infant Mental Health Advisory Group was put in place as an interim governance structure to support the Perinatal and Early Years Mental Health Policy Team to sustain the programme of work. A Joint Strategic Board for Child and Family Mental Health has since been put in place.

Perinatal Mental Health Network Scotland, Managed Clinical Network: This website hosts resources supporting the recommendations in DES, including role definitions, service development guides and care pathways.

NES Perinatal Mental Health Curricular Framework: This framework sets out the different levels of knowledge and skills required by members of the Scottish workforce who have contact with mothers and their babies, to enable them to support mothers, babies and their families to have positive well-being and good mental health during the perinatal period.

Perinatal and Infant Mental Health Fund Update Report: Inspiring Scotland is the fund manager for the Third sector Funding investment.

Supporting Women, Reducing Harm Report – Review of services for women with problematic substance use, and their infants, in pregnancy and the postnatal period. It reports on work done by PMHNS in 2020 to identify current services and make recommendations for future provision.

Evaluation of the Perinatal and Infant Mental Health Programme – The evaluation is being led by Public Health Scotland.

Wellbeing for Wee Ones: This focused on the provision of mental health and support services in Scotland for children under 5, specifically for babies and those aged under 3 years. It maps services provided by local authorities and third-sector organisations.

Programme Team

Perinatal Mental Health Network Scotland's Programme Team is part of NHS National Services Scotland. At the time of producing this report, the programme team is formed of the following team members:

Dr Gavin Philipson, Perinatal Clinical Lead
Marie Balment, Infant Mental Health Clinical Lead
Carsten Mandt, Senior Programme Manager
Sarah Gargan, Programme Manager
Anna Johnson-Kio Paul, Programme Support Officer
Chris Spratt, Data Analyst

Acronyms

AMH – Adult Mental Health
CAMHS – Child and Adolescent Mental Health Service
CMHT – Community Mental Health Team
CPMHT – Community Perinatal Mental Health Team
CPD – Continued Professional Development
DES – Delivering Effective Services
IMH - Infant Mental Health
MDT – multi-disciplinary team
MNPI – Maternity and Neonatal Psychological Interventions
MBU – Mother and Baby Unit
MBFF – Mother and Baby Family Fund
NES – NHS Education for Scotland
NRAC – National Resource Allocation Calculation
PIT – Parent-Infant Therapist
PMHNS – Perinatal Mental Health Network Scotland
PMH – Perinatal Mental Health
PQN – Perinatal Quality Network
NHS NSS NSD – National Health Service, National Services Scotland, National Services Directorate
WTE – Whole time equivalent