Mental Welfare Commission for Scotland

Report on announced visit to:
West of Scotland Mother and Baby Unit, Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Date of visit: 19 March 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The West of Scotland Mother and Baby Unit (MBU) is a six-bedded regional unit for the West of Scotland, which is located in Leverndale Hospital, Glasgow.

The MBU receives admissions from Dumfries and Galloway, Ayrshire and Arran, Greater Glasgow and Clyde, Highland (Argyll region), Lanarkshire and Western Island health boards; it can also receive admissions from Forth Valley and Grampian health boards who can spot purchase beds when necessary. The unit may also receive boarding patients when Scotland's other MBU, located in St John's Hospital, Livingston is full.

The ward is co-located with the local community perinatal team which is based on the first floor of the same building and this team offers outpatient clinics and outreach support for women living in the Greater Glasgow and Clyde area.

The MBU accepts referrals from women at a late stage of their pregnancy and during their first postpartum year. The key purpose of any admission is to assess and treat the mental health needs of a mother while supporting the bond or attachment developing between the mother and child. After a child's birth, the MBU admits only those mothers whose baby can also be admitted.

If a mother requires hospital admission but their baby cannot be admitted for whatever reason, the mother is admitted to a hospital ward elsewhere. On occasion, the mental health needs of the mother may mean that she requires more intensive inpatient care than the MBU can provide. On these occasions, the mother can be transferred from the MBU and the baby cared for separately, until such a time when both can once again return to the MBU for further care if appropriate.

The MBU was accredited last year as part of the Perinatal Quality Network (PQN) which is a peer led network established by the Royal College of Psychiatrists that sets standards for care in inpatient perinatal services across the UK. The PQN visits wards every three years and produces a report. The MBU is next due to be visited by the PQN team in 2027.

On the day of our visit there was one vacant bed and one individual was on pass.

We last visited this service on an announced basis in May 2024 and made a recommendation about care planning and the need to ensure that care plans are consistently integrated with the decisions made in multidisciplinary team meetings.

We were told that an exercise reviewing the care plans across Leverndale Hospital has since taken place and a system of Patient Centred Care Plans (PCCP) has been introduced. These are recorded on EMIS (the electronic note system in use) and are structured to easily link with the outcomes of the weekly multidisciplinary team (MDT) meetings.

On the day of this visit, we wanted to look at the unit's clinical documentation and hear about how the service is developing its practise following the introduction of the UNCRC (Scotland) Act 2024.

Who we met with

We met with, and reviewed the care of four people, three of whom we met with in person and also reviewed the care notes of two babies. We were able to speak with one relative.

We spoke with the senior charge nurse (SCN), one of the charge nurse, a number of the ward nurses and the unit's consultant clinical psychologist. We also met briefly with the service manager.

Commission visitors

Dr Helen Dawson, medical officer

Kathleen Liddell, social work officer

What people told us and what we found

Everyone we spoke to was very positive about the care they received in the unit. We were told that staff were very supportive and thoughtful, and people found the unit to be a welcoming place where they felt genuinely valued. One family member told us that they were very pleased by the care and support they themselves received and spoke of how important it was to feel confident about the care provided to their partner and child.

Importantly, people told us that they found their involvement in their treatment was meaningful and that they found communication to be good so that, even though there were a range of clinical staff involved in their care, they found that they did not have to keep repeating themselves to different people. People specifically mentioned how helpful it was to have the weekly care planner that timetabled each person's activities each week including recreational activities, time off the ward and meetings with professionals.

Care, treatment, support, and participation

Care records

The MBU uses EMIS that contains the clinical information gathered as part of an individual's admission.

For any admission, the mother is regarded as the identified patient, however clinical personnel are also dedicated to the care of the baby in the clinical team e.g. nursery nurses, health visitors. As a consequence of this pairing, the MBU has specific needs in relation to clinical record keeping, with the need to document information relating to the care and treatment of both the mother and the baby during their stay on the ward. There is also the need to ensure that documentation relating to the mother and her baby is well integrated and that systems are in place to ensure co-ordination and synchronisation of the two sets of case notes.

Each mother had a file on EMIS that contained information relating to her care and treatment and each baby has a separate file "child EMIS" that detailed their care needs during their and their mother's inpatient stay.

Admission documentation

When we reviewed individuals' files, we found good evidence of record keeping in relation to admission documentation. An admissions proforma for each person was used to support information gathered and recorded and this included a physical health assessment that has been developed and adapted to include elements relevant to pregnant women or women who have recently given birth.

We found the information relating to the admission was clearly laid out and easy to navigate.

Care records
We found the care records to be accessible and easy to navigate. We found the PCCPs to be well laid out and detailed, with clear outcomes that were recovery focussed and reflected the person's individualised circumstances. We noted that the language used in the care plans avoided specific clinical terminology which facilitated their use in being shared with the mother.

PCCPs had specific themes relating to physical health, mental and psychological health, social circumstances, legal aspects of their care and spiritual health which included a range of specific goals and treatment focus. We found the progression of the care plans easy to track and could identify when they were reviewed, amended or discarded altogether. Overall, we found the MDT notes to be comprehensive and clear and helpful in providing a summary of the progress of treatment over the course of an inpatient stay.

The MDT was structured so that there was a professionals-only meeting one morning of the week and then a smaller meeting later that afternoon between the mother and core members of the clinical, where outcomes from the earlier meeting were discussed.

We found there to be good correlation between the PCCP and the MDT notes in the cases we reviewed.

Medication
The MBU uses HePMA an electronic medication recording system. It was good to note that HepMA had alerts for when mothers are breastfeeding or on high dose medication which automatically alerted practitioners who were using the record to consider the risk of medication in relation to the baby, or in relation to the mothers additional need for physical health monitoring for example.

Risk assessment
Individuals had clear and comprehensive risk assessments (CRAFT) in place and we saw evidence that these had been updated and informed the relevant care plans, where appropriate. We were told that the CRAFT risk assessment was completed and reviewed at the first MDT meeting and then only changed if the clinical situation changed. We have been told that risk assessments form part of the MBU's ongoing monthly audit processes for individual records, to support the high standard in record keeping and care.

Multidisciplinary team (MDT)
The MDT in the unit is large and reflects the complex needs of the mothers and babies and the nature of the mother-child bond. In addition to the psychiatry and nursing staff, the unit has its own social worker, clinical psychologist, pharmacist, occupational therapist, health visitor, nursery nurses, nurse therapist and a parent-

infant therapist. A local GP surgery supports care for the babies and in recent years, peer and hospital support workers have joined the clinical team. The unit has access to the hospital physiotherapist. We were told that the nurse therapist is currently on sabbatical and so the SCN has taken over some of their work in supporting partners of the mothers admitted to the unit.

On admission, every woman is provided with a named nurse and associate nurse. A key challenge in a clinical team, with such a diverse range of staff supporting either mother or baby individually or jointly, is the need for role clarity and good communication. As the clinical team has expanded, we were told that this has developed incrementally and remains an ongoing process. The regular MDT meetings are key to support integration of activity in the unit and also with community services. Each week every person is invited to the ward round and asked who else they would like to attend (either in person or via teams).

We were told that the use of Microsoft Teams to host the MDT meetings continues to be beneficial to the service, as this supports greater participation and involvement by external agencies in an individual's care.

Use of mental health and incapacity legislation

On the day of the visit there was no one detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act, including certificates were easily accessible and organised on EMIS.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We were told that it is rarely the case that a patient on the ward requires to have a certificate certifying authority for treatment.

We were told that urgent mental health officer (MHO) cover for the ward continues to be provided by Glasgow Health and Social Care Partnership (HSCP). This is an important resource given the regional nature of the unit, with many people coming from areas far from Glasgow, and access to an MHO from the individual's home area could be very difficult on an emergency basis.

Rights and restrictions

Exit from the ward is facilitated via a buzzer system and a door closing mechanism but it is not locked from the inside. Access onto the ward is more controlled and all access is gained via the unit's reception area and switch card system.

Individuals are provided with written information about the unit as part of a patient information pack which is currently being updated. The unit has produced an online virtual tour that is available on NHS Greater Glasgow and Clyde's (NHS GGC)

website. This helpfully introduces the unit and gives mothers an opportunity to find out about it prior to admission.

A number of the individuals we spoke to had been treated on a compulsory basis earlier on in admission and told us that they thought their rights at this time had been well explained to them. The Commission has developed *Rights in Mind.*[1] which is a pathway document designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

We noticed copies of the Commissions' Rights In Mind guidance on the ward however noted that the Rights in Mind booklet did not form a standard part of the patient's information pack. Given that the patient information pack is currently being updated, we made a suggestion that the service strongly consider the inclusion of Rights in Mind as part of the information pack in the future.

We were told that mothers are referred to advocacy on an individual basis and information is given about advocacy and their rights to this.

Scottish Government funding remains a useful resource to help support the travelling expenses, the meal and accommodation costs of close family or carers who visit the unit. We heard that there continues to be good uptake of this.

We enquired about the ways in which MBU practise and policy is developing as a consequence of the UNCRC (Scotland) Act 2024. This legislation incorporated the United Nations Convention on the Rights of the Child (UNCRC) into Scottish law and provides children and their parents with rights in law.

During our visit we saw no specific reference to the UNCRC in the files that we reviewed or in the information provided to patients either in the ward noticeboards or in the patient information pack. When we asked about UNCRC we were told that the MBU standard operating procedure is currently being reviewed and updated.

Last year we discussed section 278 of the Mental Health Act that requires hospital services to mitigate the impact of any detention in hospital on the relationship between parents and their children. The s278 requirement arises directly out of UNCRC rights relating to parents and their children. Last year, we asked the ward to look into our previous themed visit report on this area of practise and consider how they might implement any of its findings in relation to care provided including formally considering the use of specific care plans to support parents in their parenting roles. When we asked about this area this year we were told that a decision had not been made to make specific goals in PCCPs relating to s278.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We were told, and we noticed on several occasions, the involvement and inclusion of support for partners; some individuals told us about how their contact with older children had been helpfully supported during their hospital stay. Article 12 of the UNCRC describes the rights of the child to express their views on matters relating to them.

We were told, and observed how the baby's needs and perspective was integral to the care and treatment provided in the unit, and how the perspectives of the nursery nurses and parent infant therapist were core elements involved the clinical discussion taking place in every MDT. As the implications of the UNCRC Act become clearer it might be helpful for the ward to be able to identify and frame some of their current activities and practice in an UNCRC framework and so be able to evidence their compliance with the law and demonstrate their recognition of its requirements.

Activity and occupation

The ward provides a comprehensive range of activities, delivered by various professionals throughout the day and evening. We were told that where staff have particular areas of interest, this is encouraged, developed and promoted in the unit to enrich the activities and resources available to mothers and their babies on the ward.

In addition to more formal events, we were told that there was plenty of opportunity for socialising more informally throughout the unit. Activities are discussed on a daily basis in meetings with nursing staff, and participation in activities is recorded.

The ward had a number of attractively designed noticeboards, with organised activities displayed and information about various aspects of health, across different locations that facilitated ease of access and promoted information sharing whenever possible.

Each individual is provided with a weekly planner and this is prepared each week and describes what activities are planned, any passes that are planned off the ward and details of meetings with clinical staff or the MDT.

The physical environment

The MBU is located in a purpose built two-storey building in Leverndale Hospital. It is a light and spacious ward and located on the ground floor. The ward overlooks a secure, private garden which is south facing with areas to sit outside in a range of weathers. We were told that plans are being made to develop the garden further to support its appearance throughout the year.

The ward appeared clean, welcoming and well decorated with a number of recreational areas where mothers and babies can relax and spend time together or with others. We were told that there were no issues reported with respect to noise

levels or light levels in the unit, and the heating and ventilation appeared appropriate for an environment that catered for the needs of babies.

Every bedroom has private en-suite facilities and is provided with a cot. One bedroom has facilities for disabled access which also can be used when twins are admitted to the unit. A nursery is situated at the centre of the unit and there is a separate baby-feeding kitchen, baby bathroom and laundry facilities.

The unit's layout enables staff to observe mothers and their babies unobtrusively. The open plan lounge appears large and bright with a dining area that looks out over the garden. A family room and separate playroom provides space for individual and group activities.

Summary of recommendations

The Commission made no recommendations therefore no response is required.

Service response to recommendations

While there were no recommendations made, the Commission would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This can be added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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