Mental Welfare Commission for Scotland

Report on unannounced visit to: St John's Hospital, Mother and Baby Unit, Howden West Road, Livingston, EH54 6PP

Date of visit: 25 February 2026

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 Mental Health Mother and Baby Unit (MBU) in Livingston is a regional inpatient service covering five NHS Health Board areas – Highland, Borders, Fife, Tayside, and Lothian. NHS Forth Valley and NHS Grampian have a 'buy in' agreement when required.

The MBU provides specialist care for mothers and their babies delivered by a full multidisciplinary team (MDT); most of the admissions are post-natal mothers with babies who are up to one year old. This means that women can receive appropriate care and treatment for their mental illness, while being able to maintain and develop their parenting role and relationship with their infant.

The unit can accommodate six mothers and their babies at any one time. On the day of the visit, the unit was providing post-natal care to six mothers and six babies.

We last visited this service in July 2024 and made no recommendations. On the day of this unannounced visit, we wanted to meet with individuals, carers and staff as well as look at the care and treatment being provided in the unit.

Who we met with

We met with three people and reviewed their care records. We also reviewed the care records of a further three people and met with one of relative.

We spoke with the clinical nurse manager (CNM), perinatal nurse consultant, charge nurse (CN), staff nurses and social worker.

Commission visitors

Kathleen Liddell, social work officer

Susan Hynes, nursing officer

What people told us and what we found

The individuals we spoke with on the day of the visit provided positive feedback about their care and treatment in the MBU. We heard that staff were “kind, caring and compassionate”. All individuals told us that they felt listened to and involved in discussions and decisions regarding their care and treatment. One individual told us that the care they were receiving was the “best care” they had ever experienced in a psychiatric ward.

We were encouraged to hear that mothers felt safe in the ward, had an awareness of their rights and did not feel restricted in the MBU setting. One individual told us that they “did not feel judged” for needing support with her baby and that the full MDT adopted a “collaborative approach”.

We heard that regular reviews were completed by the consultant psychiatrist and physical healthcare needs for mothers and their babies were regularly monitored and reviewed. We were told that psychological interventions had been particularly beneficial in supporting recovery.

All individuals had fully participated in both their own and their babies care plan. Where appropriate, individuals told us they were aware of discharge plans and that they and their family members had been fully involved in discharge planning.

We heard that families were made welcome in the ward and were actively encouraged to be involved in the care of the baby, which helped promote positive relationships between the babies, and their father and any siblings.

We heard from some individuals that not all planned activities took place. We raised this with the CN on the day of the visit who agreed that there were occasions when what had been planned did not take place however, this was not a regular occurrence. We were satisfied from our review of all individuals’ care records that regular activity was offered and frequently took place in the ward.

Comments from relatives

We met with one father who reported that he was “very happy” with the care and treatment his partner and their baby were receiving in the MBU. We heard that the father was involved in decision making, his views were regularly sought by the MDT, and that the level of communication was good.

We heard about the challenges associated with family members visiting the MBU due to its location and it’s remit as a national unit. We were pleased to hear about the benefits of the family fund in supporting regular visits and maintaining family involvement.

Comments from staff

We heard from the staff that we spoke with that there had been many changes in the MDT since the last Commission visit. We were told that the consultant psychiatrist and SCN, who had both been in post for many years, had left and that there had also been a high level of staff sickness during this period. We were encouraged to hear that, although this had been a challenging time for the MDT, the team had continued to work together to maintain specialist and high-quality care.

We were pleased to hear that a new SCN was now in post and that this appointment was viewed positively by the team. We were informed that the consultant psychiatrist post had not yet been recruited to on a permanent basis and that cover was currently being provided by the community perinatal service. We heard and observed that the current consultant psychiatrist arrangement involved a regular presence on the ward, similar to the previous arrangements. We were also pleased to be told that there was a full complement of nursing staff in post.

Staff told us that there had been a change in the "patient demographic", with an increase in levels of acuity of mental health symptoms, trauma-related presentations and diagnoses of personality disorder. Staff highlighted that in response to these changes, there had been an increased emphasis on psychological interventions, alongside adjustments to risk assessment processes and enhanced support from community services, to assist with ongoing care and discharge planning.

Care, treatment, support, and participation

We were told and saw that NHS Lothian had implemented a new person-centred care plan in April 2025. The new person-centred care plans we reviewed on TRAKCare, the electronic system used in NHS Lothian, had various headings, for example, mental health, stress and distress, meaningful activity, physical health, activities of daily living, discharge planning, and family/carer involvement.

The CN told us that the introduction of the new care plan system had been a significant transition for staff, as the team felt that the previous care plan template more effectively facilitated a multidisciplinary approach to care planning for mothers and their babies. Nevertheless, we heard that the team were committed to adapting to the new system and ensuring it continued to support effective, collaborative care planning for mothers and their babies.

We heard and saw that all individuals had a person-centred care plan in place. We saw the individuals only had some of the care plan headings completed and were unclear why additional care plans that appeared relevant to the individuals' assessed needs had not been completed. We were told by the CN that NHS Lothian expected four of the "core care plan" headings to be completed, as these were subject to audit through the MEG system; this information concerned us. We discussed our concerns with the senior management team, who acknowledged that care plans should be

informed by individuals' assessed care, treatment and support needs rather than being determined by service audit requirements. We were encouraged to hear that a review of the new care plan system was ongoing and that the service would consider the Commission's comments in the process.

We reviewed all care plans and found them to be of a high standard. We saw that some care plans had more comprehensive information completed than others, however the information that had been recorded consistently demonstrated a clear purpose of the admission and provided robust detail on the nursing interventions required to meet the identified care goals.

We saw examples of care plans that clearly documented the individuals' goals and specific aims, along with the interventions that were required to support the individuals to achieve these. All the care plans that we reviewed were individualised, goal-focused and person-centred, supported with the completion of the 'what matters to me' section.

Care plans addressed both maternal mental and physical health, as well as the baby's developmental and physical needs. Care planning included support for the mother-baby relationship, practical parenting skills, feeding, routines, and promoted safety and wellbeing for both mother and child; they also reflected future planning, links to community services, and ongoing monitoring of progress.

We saw that care plans were reviewed regularly and demonstrated progress towards recovery, with clear evidence of MDT involvement in supporting both mother and baby's ongoing care and treatment. We saw that comprehensive MDT assessments had been completed on admission, recording relevant historical, personal, and clinical information about both the mother and her baby

Family involvement was supported through the inclusion of partners or other relevant family members in care planning and discharge discussions where appropriate

We were pleased to find that discharge planning was discussed at MDT meetings from the time of admission. Although some discharge planning care plans had not been fully completed, regular discharge planning was evident in the care records. This information was comprehensive, person-centred and holistic, incorporating input from the individual, their family and relevant community services. We heard that this approach was highly supportive for both the individual and their family.

We reviewed the care plans of the five babies and found them to be individualised, focused on each baby's needs and clearly outlined the interventions required to meet those needs. The care plans reflected GIRFEC (Getting It Right for Every Child) principles and were informed by the SHANARRI wellbeing indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included). They also evidenced

the implementation of the United Nations Convention on the Rights of the Child (UNCRC), ensuring that the babies' rights and wellbeing were central to care planning.

Care plans were reviewed regularly and updated to respond to any new needs or changes in the baby's care, supporting a consistent, holistic, and rights-based approach.

We saw that physical health care needs were being addressed and followed up appropriately by either a midwife or duty doctor.

We reviewed risk assessments and found them found them to be a high standard. The risk assessments contained clear and concise information on past and current risk. They recorded protective factors, stressors and a risk management plan that detailed the interventions that were required to manage the risk. We saw regular reviews of the risk assessments and changes that were made to the management plan to reflect either new or reduced risks.

Everyone had a pass plan that detailed the agreed arrangements and interventions required to support passes. We heard and saw that the plans were reviewed regularly and adapted to reflect progress or any new risk. We saw that individuals who were admitted informally had consented to any restrictions in relation to pass planning, for example escorted pass, and that these restrictions were discussed regularly with them.

Care records

Information on individuals' care and treatment was held electronically on TRAKCare; we found this easy to navigate. The care records were recorded on a pre-populated template with headings aligned to the person-centred care plans**,** helping to ensure consistency and continuity in achieving care, treatment and support outcomes**.**

The care notes we reviewed were of excellent quality. The information recorded was person-centred, strengths-based, outcome and goal focussed and included forward planning. It was evident from reading the care records how the mothers' and their babies had spent their day, what interventions the members of the MDT had had with them and the outcome of the interventions.

We saw regular and detailed MDT observations relating to periods where there had been increased support needs, including clearly recorded interventions required to support individuals at these times. Regular one-to-one interventions were recorded, with detailed documentation of discussions relating to care planning, incorporating individuals' views; these demonstrated rights-based, collaborative care.

We saw that information recorded in the care records aligned with the treatment plans. We were pleased to see comprehensive recording from all members of the MDT.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. The MDT comprised of a consultant psychiatrist, trainee psychiatrist, nursing staff, nursery nurses, occupational therapist (OT), music therapist, art therapist, peer support worker, social worker, psychologists, pharmacist and health visitor. The parent infant therapist post was vacant, but we were encouraged to hear that this post was to be recruited to.

We saw psychological formulations for some of the mothers and their babies and found them to be of a high standard. These formulations were beneficial for both individuals and staff, providing a clear understanding of maternal mental health presentations, behaviours, and their impact on the mother-baby relationship. The formulations supported a holistic, family-centred approach, informing interventions that promoted maternal wellbeing, the baby's developmental and physical needs, and the mother-infant bond.

We were pleased to hear that psychology follow-up was being provided in the community for individuals from the Lothian area, ensuring continuity of care and ongoing recovery. While this was a positive development, access to community-based psychological support was not available for all individuals due to the regional nature of the unit. The Commission would suggest that all health boards consider strategies to provide equitable psychology follow-up for out-of-area individuals, which could further enhance continuity of care and support recovery for all mothers and babies.

The MDT met weekly in the unit, although Microsoft Teams was also used to host the MDT, which ensured greater participation and involvement from external agencies. The mothers and their families were invited to attend the weekly meeting if they wished. Individuals were supported to complete an 'MDT feedback form' prior to the meeting, outlining their views and any issues regarding their care and treatment that they wanted discussed at the meeting. The consultant psychiatrist met with the mothers after the MDT to discuss the outcome of the meeting and care planning for the week ahead.

We found comprehensive recording of MDT discussions, decisions, and personalised treatment plans for mothers and their babies. Family members were actively involved in MDT discussions and decision-making, supporting a collaborative and person-centred approach. There was clear evidence linking MDT discussions to care plan outcomes, with the documented progress towards achieving the aims and goals of the admission. The records demonstrated that all

members of the MDT were involved in care and committed to a holistic, mother-baby-focused approach.

When mothers and their babies were moving towards discharge, we found evidence of links made with community services and invitations for them to attend the MDT and discharge planning meetings.

Use of mental health and incapacity legislation

On the day of the visit, one individual was detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and subject to a community compulsory treatment order (CCTO). However, the individual had agreed to hospital admission on a voluntary basis. We were unable to find documentation relating to the Mental Health Act electronically stored on TRAKCare. We raised this with the CN who immediately contacted medical records to request this documentation was uploaded to the system.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. There was one consent to treatment certificate (T2) and one certificate authorising treatment (T3) in place under the Mental Health Act. Both were current and corresponded to the medication being prescribed.

Rights and restrictions

The MBU continued to operate a locked door on entry. The entry/exit was facilitated via a buzzer system and a door closing mechanism. At the entrance of the ward, there was a security system to monitor visitors, which was commensurate with the level of risk identified for mothers and their babies.

The individuals we met with during our visit had a good understanding of their rights, whether detained under the Mental Health Act or admitted informally. We were pleased to note from care records that discussions about rights and individuals' views regularly took place with various members of the MDT.

We noted that some information on rights was available in the ward, although we were of the view that this could be improved to ensure that mothers had multiple opportunities to be made aware of their rights throughout their admission.

We saw from our review of the care records that many of the individuals who were in the ward were there on a voluntary basis, although had restrictions placed on elements of their care, for example, pass planning. All of the individuals that we spoke with were aware of the restrictions, had consented to them and found them supportive. On reviewing the care records for these individuals, we saw that the restrictions were regularly reviewed and discussed with them. We were pleased to see that progress in reducing restrictions had been made for many of the individuals.

We were pleased to see that the MDT actively promoted the rights of babies in the MBU. The use of the GIRFEC framework ensured a strengths and rights-based approach to care and treatment. Implementation of the UNCRC was evident in care records, demonstrating that the babies' health, development, safety, and wellbeing were central to care planning and interventions. This rights-based practice was particularly evident during 'baby reflections', which incorporated mentalisation of the babies' views and consistently kept both baby and mother at the forefront of the MDT's considerations and decision-making.

We saw that for some babies, the Children (Scotland) Act 1995 provided the legislative framework for Scotland's child protection system. Where potential harm was identified, the MDT, particularly the social worker, was actively involved in liaising with children and families' social work teams to support and promote the baby's safety and wellbeing. Child protection considerations were clearly integrated into the baby's care plan. We saw evidence of families being involved in discussions where appropriate and all actions and decisions were clearly documented, demonstrating a holistic, rights-based approach to safeguarding.

When reviewing peoples' files, we look for copies of advance statements, which are written under sections 275 and 276 of the Mental Health Act and allow a person with capacity to document the treatments they would or would not want. Health boards have a responsibility to promote advance statements. While we did not find copies in the files reviewed, we were pleased to hear from our discussions with some mothers that they were aware of advance statements and were interested in completing one.

Information on advance statements was available on the ward, however the Commission would suggest that more proactive work is undertaken to support mothers in creating advance statements to ensure their treatment preferences are clearly recorded and respected. We spoke with the senior management team, who agreed to review how the service promotes advance statements and to take steps to implement improvements in this area.

Advocacy was available and provided by the local mental health advocacy service. We were told that advocacy attended the ward on request and provided a good service to mothers who wished to engage with this service.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

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

Activity and occupation

We heard and found evidence of a broad range of activities that were available to mothers and the babies in, and at times, out with the ward. The activities available included baby massage, sensory groups, messy play, music and art therapy, mindfulness, yoga, crafting, local walks to cafes and shops, baking, and a breakfast club.

Activities were provided by various members of the MDT, however the OT and music therapist were particularly involved in arranging both group and individualised activity that provided psychologically informed interventions alongside therapeutic and skills-based activities to support recovery and wellbeing.

In addition to the psychologically informed interventions, we saw that valuable practical support was provided by nursery nurses to mothers and their babies. We heard and observed that nursery nurse interventions promoted mothers' skills, knowledge, and confidence in providing safe care for their baby, while also supporting the development of attachment and bonding.

The mothers we spoke with on the day of the visit were generally positive about the activities offered. We heard that preferred activities for the week ahead were discussed at the weekly community meeting, supporting involvement and choice in the activity programme.

The care records that we reviewed evidenced regular and person-centred activity, however there was an absence of a structured activity care plan and without this, it was not clearly demonstrated how individuals' activity goals and assessed outcomes were being planned, implemented, monitored, and reviewed. We raised the importance of having a clear and meaningful activity care plan with the service. The team acknowledged this and advised that a review of the current care planning documentation would be undertaken imminently to strengthen this area of practice.

We were told that the unit offered groups and support for fathers and siblings. Family therapy sessions were offered, which could involve siblings.

The physical environment

The MBU was located on the first floor of St John's Hospital. The unit was well maintained, brightly lit with some homely furnishings which created a comfortable environment for the mothers and babies. The walls had some artwork that gave a sense of a warm and welcoming environment.

The day area was used by mothers and babies as the main communal space and also functioned as a dining area, with a small kitchen and a TV lounge. The room was bright and included sensory areas for mothers and their babies. We were pleased to see that the MBU had created an environment that balanced the

requirements of a clinical space for delivering care and treatment with a therapeutic space that supported recovery for both mothers and babies.

Five of the six bedrooms had en-suite facilities, and there was a bathroom immediately next door to the bedroom where there was no en-suite. The bedrooms were spacious and had room for a cot. New cots had been purchased since the previous visit. There was a nursery with a cot and baby changing facilities. We were told that mothers were encouraged to have their babies sleep in their rooms with them, although nursery nurse staff were available to offer support throughout the night if required. We heard from mothers that the option to have support from nursery nurse staff at night was “extremely supportive” to promote rest and enable their recovery.

The nursing station is at the centre of the ward and immediately visible on entry. There were two bedrooms behind the nursing station for mothers who required increased level of support and supervision. On the day of the visit, there was good visibility of staff in all areas of the ward and at the nursing station.

During the visit, we observed some ligature risks in the ward. We discussed these with the senior management team, who acknowledged the presence of these risks and confirmed they were recorded on the risk register. However, it was a concern that no timescale had been set for completing the required work. We enquired what the service was doing to mitigate the risks and were told that environmental risk assessments were completed on admission and reviewed regularly throughout the admission. Staff also conducted 30-minute floor and window checks.

We were told that if an individual was assessed as a ligature risk, continuous observation (CI) may be implemented. While we acknowledge that CI can support risk management, we were concerned that the need for such restrictive practices was influenced by environmental risks, rather than solely by individual clinical needs.

We previously made a recommendation regarding high temperatures in the ward. During the visit, we were concerned to hear that high temperatures remained an issue and could potentially affect safe sleep and the wellbeing of babies. We were disappointed to learn that the service recently lost its accreditation with the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI) due to this issue. The senior management team told us that they are actively seeking quotes for air conditioning to reduce the temperature, support safe sleep practices, and help the service regain accreditation.

The MBU had access to a garden area located on the ground floor. We did not view the garden on the day of the visit as a section that contained decking was not in use and required replacement. We were pleased to hear that plans were in place to replace the decking to allow safe use of the garden. The garden was used regularly

by mothers, particularly in warmer weather, as part of their care and treatment plans, including supporting contact with children and siblings.

Recommendation 1:
Managers should review and address environmental factors in the MBU, including ligature risks and high temperatures, to ensure a safe, therapeutic, and recovery-focused environment that supports both mothers and babies.

Any other comments

The feedback from all individuals and relatives regarding their experience of care and treatment in the MBU was very positive. We observed high standards of care that reflected this feedback. Despite significant changes in the MDT since the previous visit, the quality of care provided to mothers and their babies remained consistently high, with staff demonstrating ongoing commitment to specialist, compassionate and holistic care.

It is unfortunate that environmental factors have impacted the service's accreditation with the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI). Nevertheless, this does not detract from the ongoing high standards of MDT care that we observed.

Summary of recommendations

Recommendation 1:
Managers should review and address environmental factors in the MBU, including ligature risks and high temperatures, to ensure a safe, therapeutic, and recovery-focused environment that supports both mothers and babies.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also 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 has been 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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