Agenda Item 13

NHS West Leicestershire Clinical Commissioning Group

NHS England

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11TH JUNE 2014

REPORT OF NHS ENGLAND AND WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

PROVISION OF PERINATAL INPATIENT MENTAL HEALTH SERVICES IN LEICESTERSHIRE

Introduction

1. The purpose of this report is to update Leicestershire Health Overview and Scrutiny Committee on the provision of inpatient perinatal mental health services on Leicestershire, including details of the stakeholder event and recent actions..

2. This document is a culmination of the report detailed above with the outcomes of the stakeholder event held in October 2013 by NHS England and West Leicestershire Clinical Commissioning Group (CCG) and the Perinatal Next Steps Meeting held in January 2014.

3. The provider Leicestershire Partnership Trust gave notice to NHS England that it could not comply with the service specification, necessary quality standards or invest the finances required to bring the current service up to standard.

.Current Provision

4. Contracted for 13/14 are 15 beds across the East Midlands with three providers delivering Inpatient Perinatal Services.
   Derby has a six bedded unit
   Leicester has three beds
   Nottingham has a six bedded unit

Background

5. The level of demand, numbers of beds and quality of Inpatient Perinatal Provision has been a discussion point for the last 5 years or so. In 2009 and 2010 as part of the Lord Darzi Next Stage Review and Towards Excellence Reviews, Perinatal Inpatient provision was considered across the three units within region by partners and stakeholders for the East Midlands Specialised Commissioning Group (EMSCG).

6. The work undertaken looked at capacity and demand as well as quality and cost. In 2010, a report to the EMSCG Board identified that National evidence indicates there are 2 to 4 admissions per 1000 live births. This would give the East Midlands a need for 9 to 18 beds and for planning purposes, the mean of 13 beds has always been used.

7. Nice guidance refers to a unit being typically between 6 and 12 beds and regional clinical opinion supported a minimum unit having 6 beds but a single unit of 13 beds for women plus 13 babies was not clinically supported. Therefore based on NICE guidance and clinical opinion a two 6 bed model was deemed appropriate.

8. In the report to the EMSCG Board in July 2010, the Board were asked to determine:
    - Whether the minimum size for an inpatient unit is 6 beds.
    - Whether to change the number of units commissioned.
    - Whether the number of units should be capped or allow market dynamics and quality standards to determine the future configuration of inpatient services. Consideration to be given to the White Paper and the need to engage the public in any decision to reduce the number of units.
    - Whether the other two mental health Trusts in the East Midlands who did not provide inpatient services could be included as potential providers.

9. The Board concluded that the SCG should seek to ensure; quality and value for money for the services and progress through the service specification designation route.

10. At the request of NHS Leicester City, NHS Leicestershire County and Rutland and Leicestershire Partnership Trust an independent review of the Leicestershire Inpatient Perinatal Mental Health Service was undertaken by Dr Roch Cantwell, Consultant Perinatal Psychiatrist and Elaine Clark, Nurse Consultant in Perinatal Mental Health from Glasgow Perinatal Mental Health Service. The subsequent report highlighted the strengths of the service that the staff were enthusiastic and dedicated, but highlighted that most of them did not work full-time within the service. All staff had a clear commitment to

the service and a desire to see further enhancements to the benefit of patients and their families. The reviewers met with one inpatient, who spoke warmly of the care received and the professionalism and caring attitude of nursing and medical staff. They also stated that plans were being explored for identifying staff to work exclusively within the service, and for changes to the layout of the mother and baby beds to ensure improved quality of access and physical integrity.

11. However, the report highlighted a number of changes that were required and one of the most significant issues related to the physical location of the 3 beds which are adjoining a general adult unit, with access to the mother & baby beds being through that unit. The report also highlighted that the toilet and kitchen facilities needed upgrading. There was no dedicated nursery, baby food preparation and storage area or play area. The general view was that the physical provision of the inpatient service was not at a standard that was suitable for a Perinatal Mother and Baby Unit and there were essential changes that needed to be made regarding the physical layout, staffing, training and supervision, baby care and safeguarding and commissioning environment. The report concluded with 20 essential recommendations which included becoming a member of the Royal College of Psychiatrists' Perinatal Quality Network.

12. The contract for the Perinatal Inpatient Service was held with the PCT until the beginning of 12/13 when the contracting responsibility for this service transferred to the Specialised Commissioning Group and the introduction of a regional service specification. The contract financial value transferred on the same basis as previous years as a block contract.

13. The activity during 12/13 was a total of 265 days. The beds were not used for two months of the year and four months saw activity ranging from 8 to 18 days. However, during this time patients from Leicestershire were sent to other units when they presented as emergencies as the unit was unable to staff the unit at short notice or when in use for male patients.

14. The service did not meet the standards of the regional service specification during 12/13 or the Royal College of Psychiatrists Quality Network for Perinatal Mental Health Services Standards for Mother and Baby Units.

15. During contract negotiations for 13/14 the incoming national service specification requirements for specialised services was raised as a potential further challenge for the service. The national service specifications for Specialised Services have been developed as a product by NHS England's Clinical Reference Groups, one of which is for perinatal inpatient services. The Clinical Reference Group (CRG) covers specialised perinatal mental health services. The scope of the CRG is to ensure that these services provide a safe and secure environment for the care of seriously mentally ill

women and their infants and meet NICE and Royal College Standards. The CRG therefore established a specification that reflected the need for the service to be separate from other acute mental health admission facilities. To provide care for women with serious mental illness including postpartum psychosis, schizophrenia, bipolar illness and other serious affective disorders, as well as those with complex needs. Provide expert psychiatric care for the mother whilst at the same time ensuring the care of the infant and avoiding unnecessary separation of mother and baby.

16. The CRG has a voluntary Chair who is appointed for a three-year term and clinical members are drawn from the 12 Senate areas in England and are voluntary appointments. There are up to four patient and carer members and up to four professional/training organisations that are eligible to join the CRG membership. An accountable commissioner holds the managerial accountability for the work of the CRG; collaborating commissioners also hold an interest in the work of the CRG.

17. NHS England requires that all providers must be compliant with the national service specifications by 1 April 2014 and a derogation process has been put into place from 1st October 2013 to allow providers who may need time to become compliant.

18. There had been several meetings between NHS England and the provider about the requirements of the current 12/13 specification which they were not compliant with and the forth coming 13/14 specification. The provider did look at what it could do to meet the Royal College and specification requirements and submitted a full business plan to their Board on 28 March 2013. However, NHS England received formal notice on 30 April 2013 that the provider was giving 12 months' notice on the Inpatient Perinatal Service.

19. The provider stated that it had been recognised for some time that current provision did not meet minimum standards as set by the Royal College of Psychiatrists nor does it comply with the regional service specification. In order to address these issues a significant investment would be required to relocate provision into a stand-alone unit and they had undertaken extensive work to look at the options to support this. The outcomes of this work had been shared with the Specialised Commissioning Group (now NHS England) through a series of meetings. A summary of the work undertaken by the provider and its outcomes is detailed below.

20. The first option considered was a significant investment in relocating and expanding the current 3 bedded unit to provide the 4-6 beds necessary to deliver a clinically safe and financially viable service. This would require capital investment in the region of £1m to bring an existing ward up to the required standard alongside the recruitment of a dedicated staff team to provide the service on an on-going basis. Together these will result in an

annual running cost of c£800k per annum which measures against a current income of £134,772.

21. The provider recognised that the current contract price was below the East Midlands and national average of c£700 per occupied bed day (OBD), however the beneficial impact of the application of a higher price was not sufficient to increase income to a viable level, raising it from c£135k to c£189k, leaving a gap of £611k to be bridged.

22. The provider also said that alongside this and more critically, there is the issue of the apparent lack of demand locally for this service which is significantly below that expected in light of available epidemiological and demographic data. The current volume of referrals, including a minimal number from outside of Leicester, Leicestershire and Rutland (LLR), has equated to around 275 OBD for each of the last three years – an occupancy of around 30% of current capacity. They recognised that a small number of referrals will have been referred to other services in the East Midlands due to their on-going capacity issues; however, the volume of this is in single figures and is not sufficient to bridge the gap.

23. In light of this they had worked in partnership with the Specialised Commissioning Group (SCG) to look across the full Midlands and East region to assess any unmet need / inappropriate referrals that an expanded unit would be able to provide for, taking account of not only LLR but looking also at Northampton, Milton Keynes, east of England and adjacent CCGs in Coventry and Warwick. Despite this extensive catchment potential, and recognising sporadic referrals from each of the areas listed, they were unable to identify sufficient current demand to sustain a viable unit.

24. The provider said that it recognised that there may be the potential for the SCG and LPT to work together to stimulate the market in the south of the region. This would need a sustained programme of work over an extended period and, in absence of obvious unmet need, has no guarantee of success. The approach would need to increase demand to a level some 8 times the current volume and generate total income of circa £800k - around £611k more than contracted activity level at the expected tariff price. It seemed an unlikely outcome based on information available at present and is a risk that sits wholly with LPT, a position which will be exacerbated by the move to cost per case contracts due to take place from April 2013.

25. In view of the above, and following a discussion at the Trust Board, LPT found itself in a position where it felt the only option was to give notice on the future provision of this service, recognising that this gives an adequate period for the consultation and due process necessary for any service closure / relocation; a process that would need to include the wider health and social care community with full consultation and engagement of

colleagues in local authorities, University Hospitals of Leicester, CCGs and other LPT services.

Way forward

26. Since receiving written notice, NHS England has been liaising with LPT and the CCGs regarding the way forward and the need to ensure that the pathway to Inpatient Perinatal beds is clear and widely known by all stakeholders to ensure that women receiving effective treatment and admission when identified as appropriate by the Community Perinatal Service.

27. At the end of October, an Engagement Event was held and key stakeholders were invited to attend to look at the care pathway, to hear from a patient with experience of services and the other two regional units.

What does good look like?

28. The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, bringing together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities has written The Guidance for Commissioners of perinatal mental health services.

29. The guide highlights a number of areas including why Perinatal Mental Health Services are important to commissioners and provides guidance and key principles to “What does good look like?”

30. These key principles state that services:

- A good service requires a perinatal mental health strategy which includes a commissioning framework and service design for populations large enough to provide a critical mass for all the services required across a clinical pathway. This will require collaboration with providers and other commissioners.

- Services should be provided on the basis of the known epidemiology of perinatal conditions taking into account any special geographical or socio-economic features of the area to be covered.

- The delivered population should be the denominator for service planning and provision.

- Good perinatal mental health services will use an integrated care pathway drawn up and agreed by all stakeholders to ensure the timely access of women to the most appropriate treatment and service for their condition.

- All women should have equal access to the best treatment for the condition irrespective or where they live, their socioeconomic status, their ethnicity.

- Good perinatal mental health services should promote prevention, early detection and diagnosis and effective treatment.

- The right treatment should be evidence based, effective, personalised and compassionate. It should meet the needs of both mother and infant, respect the wishes of the mother wherever possible and compatible with the safety of the infant and promote optimal care and outcome for the infant.

- A good service should accommodate the cultural and religious practices for a newly delivered woman compatible with the health and safety of mother and infant.

- Good perinatal mental health services promote seamless, integrated, comprehensive care across the whole clinical pathway and across organisational and professional boundaries. This requires close working relationships and collaborative commissioning between mental health services and maternity services, children's services and social care, primary care and voluntary organisations.

- Good perinatal mental health services will ensure that no woman is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant if she is mentally unwell. If she requires admission to a psychiatric unit, she must be admitted to a specialised mother and baby unit unless there are compelling reasons not to do so.

- Good perinatal mental health services should include an education and training programme which should be provided for non-specialists involved in the care of pregnant and postpartum women including general psychiatric teams, GPs, midwives, Health Visitors and IAPT workers to ensure the early identification of those at high risk:
    - early diagnosis
    - an understanding of the maternity context
    - the additional clinical features
    - and risk factors associated with perinatal disorders
    - the developmental needs of infants.

- Good perinatal services should be part of a clinical network. With so many different agencies and services, providers and differing commissioning arrangements in the pathway of care from early pregnancy through to the postpartum period, it is essential that systems are in place to maintain the integration and collaboration of these agencies. Part of the perinatal mental health strategy should include a managed (strategic) network made up of all stakeholders, including patients' representatives, to ensure the functioning of the whole service pathway and to allow for development and innovation as new evidence arises. A clinical network also has the important function of advising both commissioners and providers.

- Good perinatal mental health services will include a range of services including:
  - specialised inpatient mother and baby units
  - specialised community perinatal mental health teams
  - parenting and infant mental health services
  - clinical psychology services linked to maternity hospitals
  - specialist skills and capacity within:
    - maternity services
    - general adult services
    - IAPT
    - general practice and the extended primary care team
    - health visiting.

31. The guide says that a good specialised perinatal service should be organised on a hub-and-spoke basis so that inpatient mother and baby units to serve the needs of large populations are closely integrated with specialised community perinatal mental health teams provided by Mental Health Trusts in each locality.

Mother and baby units

32. A good mother and baby unit should be accredited by the Royal College of Psychiatrists' quality network and meet their standards. It should:
    - provide care for seriously mentally ill women or those with complex needs who cannot be managed in the community in late pregnancy and in the postpartum months
    - provide expert psychiatric care for seriously ill women whilst at the same time admitting their infants, avoiding unnecessary separation of mother and infant
    - offer advice, support and assistance in the care of the infant whilst the mother is ill, meeting the emotional and developmental needs of the infant

- provide a safe and secure environment for both mother and infant
- offer timely and equitable access such that mothers are not admitted to general adult wards without their baby prior to admission
- be closely integrated with specialised community teams to promote early discharge and seamless continuity of care.

Specialised community perinatal mental health team

33. A good specialised community perinatal mental health team will be a member of the Royal College of Psychiatrists' quality network. It will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately managed by primary care services. It should:
    - respond in a timely manner and have the capacity to deal with crises and emergencies and assess the patients in a variety of settings including their homes, maternity hospitals and outpatient clinics
    - have close working links with a designated mother and baby unit
    - manage women discharged from inpatient mother and baby units
    - work collaboratively with colleagues in maternity services (including providing a maternity liaison service) and in adult mental health services with women with prior or longstanding mental health problems.

34. A good community perinatal mental health service will offer pre-conception counselling to women with pre-existing mental health problems and those who are well but at high risk of a postpartum condition.

35. Since NHS England has developed a national service specification to ensure that all Perinatal Inpatient Units across the country are of the same standard and deliver the same quality and standard of care, the East Midlands CCG's and Perinatal Quality Network are working together to write a regional service specification for Community Perinatal Services. This will also ensure that all areas of the East Midlands are working towards a Gold Standard service for pregnant women and mothers with mental health problems. And no matter where a woman may become ill the quality and standard of support she receives will not depend upon the area, county or postcode where she resides or receives her treatment.

Perinatal Mental Health Event

36. On 31st October 2013 key stakeholders were invited to a half day event with Dr Margaret Oates CRG Clinical Lead and Karen Lockett Programme of Care Lead NHS England welcoming everyone in attendance. Mel Thwaites from West Leicestershire CCG and Ruth Sargent from NHS England set out the current position regarding the position regarding the Leicester Perinatal Services and pathway issues.

37. During the morning stakeholders heard first-hand about Jo's Story, a patient experience and journey whilst experiencing perinatal mental illness. Jo gave a frank and heart touching account about her illness, the importance of receiving the right care at the right time and what the care and support she received within a specialist perinatal unit meant to her and her family. The effect of Jo's presentation and her honesty about her illness had a significant impact upon all in the room. It reminded everyone of the importance of ensuring that women who need perinatal specialist provision that met the necessary quality and Royal College standards, should be able to do so in a timely and effective manner.

38. The morning moved into presentations by Dr Margaret Oates on the National and East Midlands Perinatal standards for both inpatient and community provision, followed by clinicians from the Mother and Baby units in Derby and Nottingham about the Inpatient Pathway and the importance of working with Community Perinatal Community Services.

39. Finally, before the round table discussions the way forward without the 3 beds being available after April in Leicester was discussed. The group then broke into round table discussions with a feedback session, opportunity to consider the next steps and have an open discussion.

40. The 'Round Table Discussions' session gave a chance to attendees to list 'What needs to happen to make access to inpatient services for work for Leicestershire patients?'. Each group was asked to feedback the top 3 issues from the discussion on each table.

41. The group discussion produced the following issues and resolves:

Potential Difficulties Faced:

- Staffing within the community team in Leicestershire
- Emergency team
- Distance of travel
- Impact on the whole region
- Not enough data collection
- Wider communication systems were needed
- Community team needed with involvement with patients
- Not enough time mobilise teams
- Need robust information sharing systems
- Child protection concerns and lack of data transfer systems
- Practicality of transfer - ambulance services? Costs of this?
- Limited or little community information
- Delays in access to units
- Bed capacity - stresses involved
- Crisis support - access to specialist support

What needs to be put in place?

- Need a complete pathway for perinatal to postnatal care
- Jointly commissioned service standards
- National bed management system
- Better training with wider breadth to include GPs, HV, and hospital staff
- Enhanced community perinatal service provision
- Mirror development pathways
- Need to alert wider pathway and model to all those involved with pregnant and new mothers
- Revisit thresholds for community teams
- Collaborative working between providers and commissioners
- Care of relatives as well as the patient
- Translation services for patients that do not speak English
- One regional service specification

How?

- Specialist service specification for perinatal services
- Finance
- Task and finish groups
- Oversight scrutiny groups
- Recruitment and development drive
- Use of technology i.e. Skype/ sure start/ communication between distances for patients
- Review process from the onset - to look at whether it's working
- GP engagement
- Consultations between LPT and commissioners
- Contract minimum data set
- Discharge maternity beds recording
- Set up working groups

42. One of the key outcomes from the event was the agreement that the East Midlands should adopt a regionally agreed service specification for CCG Community Perinatal Services. The East Midlands Perinatal Network had written a community service specification that would meet national and royal college guidelines. It would also ensure that any woman and baby requiring a specialist inpatient bed would have an effective and efficient smooth pathway to and from inpatient provision.

43. A meeting was held in January with representatives from the CCG, UHL and NHS England. This meeting discussed the outcome of the engagement event and identified a number of key actions to be addressed. These included:

- NHS England to email LPT to confirm that there has been no change in the provider's position about ceasing the service on 30 April 2014.
- NHS England Clinical Network to write to CCG Mental Health Leads requesting that locally adopted data monitoring is undertaken to identify pregnant women accessing adult mental health inpatient beds and IAPT provision.
- Leicestershire, Northamptonshire and Milton Keynes CCG Mental Health Leads asked to confirm whether they have comments on the regional perinatal community service specification.
- Confirmation of regional perinatal community service specification version.
- Task group established to develop clinical protocol guidance for referrals for perinatal inpatient admissions and two meetings held by end of February. Involving LPT; community nurses; GP; obstetric and other associated representation and focus group input.
- Patient focus group established to assist with above.

44. The Strategic Clinical Network for NHS England is running the focus groups to assist with the clinical protocol guidance for referrals with women who have used both Leicester inpatient and community services and some who had gone out of area which will be completed by the end of March.

45. During this time, the three CCG across Leicester Leicestershire and Rutland have also been reviewing the current community provision. This review has acknowledged that the current community service required improvements and in view of this commissioners have worked with clinicians to develop a new model.

46. The proposed new model is based on national recommendations and aims to increase the current capacity.

47. This team would work in conjunction with regional in-patient Mother and Baby Units to provide alternatives to admission and to provide treatment and support for women following discharge after an in-patient stay.

48. This proposal is being discussed as part of the contract negotiations with LPT.

49. It is hoped that the new model will be phases in from 1st April and work is now underway to agree local and regional clinical referral pathways.

50. NHS England will automatically direct any request for an inpatient perinatal bed to the two regional perinatal units in the East Midlands until the community referral pathway is finalised and in circulation.

Officer to Contact

Tina Smith
Mental Health Commissioning Manager
NHS England Leicestershire and Lincolnshire Area Team

This page is intentionally left blank