NHS
Yorkshire and Humber
Learning Disability and Autism
Operational Delivery Network
Hosted by
South West Yorkshire Partnership NHS Foundation Trust

DRAFT Protocol for the Provision of Specialist Community Health Services for People with Learning Disabilities placed in 'Out of Area' placements within Yorkshire & Humber

July 2019 (review biennially)

Parties to the Protocol:

- *Bradford District Care NHS Foundation Trust*
- *Humber NHS Foundation Trust*
- *Leeds & York Partnership NHS Foundation Trust*
- *Rotherham, Doncaster and South Humber NHS Foundation Trust*
- *Sheffield Health & Social Care NHS Foundation Trust*
- *South West Yorkshire Partnership NHS Foundation Trust*
- *Tees, Esk & Wear Valleys NHS Foundation Trust*

1. BACKGROUND:

Despite long-standing aspirations and commitments that, wherever possible, people with learning disabilities should be supported to live within their own homes and local communities, a significant number of people continue to be accommodated and supported in places other than the communities they call *'home'*. Typically the rationale given for this is that the nature of some people's '*complex needs'* means that they require '*specialist'* provision that is not available within their local areas.

The term '*complex needs'* is widely used but often poorly defined. Typically though it is used in relation to people with learning disabilities, as a descriptor when someone also presents with:

- Behaviours which services find challenging due to their frequency, severity and/or duration.
- Forensic support needs which pose a risk to the general public.
- Long-term mental health needs which are resistant to common treatments.
- Autism which is particularly sensitive and requires significant environmental control.
- Profound and multiple disabilities – usually including significant physical health needs.

Placements which do not fall within the curtilage of an individual's funding authority are called *'Out of Area Placements'* and refer to formally commissioned services which provide accommodation and support to meet a person's assessed needs. These can be commissioned and funded by Clinical Commissioning Groups and/or Local Authorities.

Where *'out of area placements'* are in registered hospitals, specialist health provision in relation to a person's learning disability is usually included as part of that commissioned service. Where *'out of area'* placements are commissioned in *'community'* settings (typically residential care homes) there is usually an expectation that local community learning disability teams will provide any specialist health input. Oftentimes however, there is little to no communication with local health services prior to a person being placed in a new area and sometimes suitable provision is not available.

Despite it being widely acknowledged that '*out of area'* placements are often not in the best interests of individuals or their families[1], the prevalence of out of area community placements in Yorkshire & Humber has increased in recent years, largely in response to the national *'Transforming Care Programme'* as CCGs and local authority commissioners seek to identify community based services for people previously supported in hospitals. We have seen population demographics in some of our regions alter significantly as people with learning disabilities and *'complex needs'* migrate to places where there is availability of specialist community placements – often where care providers have disproportionately developed new residential services. This movement of people with learning disabilities and *'complex needs'* has led to increased concerns about the quality of some service provision available to people with high support needs (particularly if they are unknown to local services) and has significantly changed the demands placed on some local specialist community health services, which in some cases they are unequipped and/or not resourced to meet.

[1] Studies have found that people in out of area placements report generally poorer experiences of care, poorer quality of life, have poorer health and wellbeing outcomes and are at increased risk of abuse and mistreatment (REF)

2. KEY ISSUES TO BE ADDRESSED:

People receiving care in *'out of area'* placements, are likely to be in very vulnerable circumstances; acutely unwell and/or distressed, and losing previous sources of support. Outcomes are typically poorer for people in *'out of area'* placements and there are examples where individuals' needs have not been adequately met, experiencing distress and negative outcomes (e.g. hospital admission, involvement of criminal justice services, placement breakdown) as a consequence of being far from home, in unfamiliar environments and without the support of people who know them well.

For many people placed in '*out of area'* community placements, the complexity of their needs and the fact that they will be apart from their familial, social and professional support networks makes them highly dependent on the quality of care provided in the new place. In addition to concerns relating to the quality and suitability of some '*out of area'* placements[2], many providers are also concerned about the existing arrangements relating to the transfer of care responsibilities between specialist learning disability health services (typically between existing care teams and community learning disability teams in the receiving area) when people move between different localities. Poor transfers of care can lead to gaps in the provision of needed health services, lack of adequate care planning and relapse prevention plans, and loss of important clinical and risk related information. There are occasions when people have moved from one failed placement to another (often in multiple different areas) experiencing further and multiple transfers of care, exacerbating the distress experienced by service-users & families and resulting in further loss of knowledge about the person's needs and how best to meet them.

The key issue to be addressed by the current proposals is to ensure that any future arrangements for supporting people in 'out of area' placements better ensures the safety and wellbeing of the people being placed away from their previous sources of support and the places they call 'home'. In order to achieve this, future arrangements must ensure that the identified providers of specialist health services are those which are best placed to meet the person's needs at a particular time and are adequately equipped to be able to provide safe and effective support to those people placed into the communities they serve from outside of the local area. The main elements required to achieve this are:

A. **A CLEAR & CONSISTENT APPROACH TO THE PROVISION OF SPECIALIST HEALTH SERVICES TO PEOPLE PLACED IN OUT OF AREA PLACEMENTS:** There is currently a lack of clarity and consistency in regard to how transfers of care should be managed between specialist health services for people with learning disabilities. Services often develop their own local 'rules' for this, which do not interface with each other and can leave service-users with sub-optimal support and gaps or delays in service provision. We propose a single approach is agreed and employed by specialist health providers throughout the Yorkshire & Humber region.

[2] NOTE: Whilst significant concerns have been noted regarding the rigour and quality assurance applied when 'out of area' placements are commissioned and procured, we are aware there is already a significant amount of guidance and further development work happening in relation to this. This protocol will therefore focus on the arrangements and responsibilities of providers of specialist community health services to people with learning disabilities.

B. **BETTER PROCESSES FOR ENSURING THE SUITABILITY OF 'OUT OF AREA' PLACEMENTS TO MEET PEOPLE'S IDENTIFIED NEEDS**[2]**:** It is felt that people with learning disabilities are often placed in provision outside of their place of origin without sufficient assurance being sought in respect to the suitability of the chosen placement provider to meet the person's needs. This sets conditions in which people's needs are unlikely to be met irrespective of the level of support provided by local specialist services. We propose greater communication occurs between placement commissioners and services local to the proposed placement before *'out of area'* placements are agreed.

C. **GREATER FOCUS ON THE SUPPORT REQUIRED BY PEOPLE DURING THE 'SETTLING-IN' PERIOD IMMEDIATELY FOLLOWING COMMENCEMENT OF AN 'OUT OF AREA' PLACEMENT AND CONSIDERATION OF WHICH SERVICE IS BEST PLACED TO PROVIDE THIS:** It is felt that insufficient attention is currently given to the support provided to people (and placement providers) in the initial period after a person moves into an 'out of area' placement. We propose that clear expectations are set about the roles and responsibilities of specialist service providers in supporting people to settle in to new placements, especially when these are far away from previous sources of support.

D. **ENSURE LOCAL SERVICES ARE AWARE OF PEOPLE MOVING INTO THEIR LOCAL AREA WHO MAY REQUIRE SUPPORT:** Inadequate communication between health-providers has meant that community services have often been unaware a person with complex care needs has moved into their local area until their placement starts to break down and urgent support is requested. Local management in these circumstances is often challenged by a lack of knowledge about the person and their recommended or preferred treatment/support plans. We propose that communication between existing and future specialist health service providers starts well before care is transferred between clinical teams.

E. **IMPROVE THE QUALITY OF CLINICAL HANDOVER BETWEEN SPECIALIST HEALTH PROVIDERS:** Often the sharing of information about a person moving into an 'out of area' placement between clinical teams has been inadequate and resulted in the loss of important clinical and risk information. We propose a formal, documented process of handover between current and future clinical teams, which shares relevant history, assessments and care-plans.

F. **ENSURE SPECIALIST COMMUNITY HEALTH SERVICES ARE ADEQUATELY RESOURCED TO MEET THE NEEDS OF THE LOCAL POPULATION INCLUDING THOSE PLACED FROM OTHER AREAS.** Specialist community learning disability teams are typically commissioned and resourced based on the population for whom the local CCG is responsible. Where significant numbers of people are placed into an area from outside the locality, demand and capacity for local services can become unbalanced and in some cases insufficient to meet the needs of the people referred. In some cases inaccurate assumptions about the availability of local specialist clinical services have been made and left people in '*out of area'* placements without access to appropriate services (e.g. Personality Disorder Treatments & SOTPs). We propose that CCG's formally acknowledge the additional resources required by specialist health services in order to meet the needs of people placed from outside the local area, including by funding the care provided by specialist community learning disability teams.

3. GUIDING PRINCIPLES & PRACTICE GUIDANCE:

The right to receive NHS Care:

- All UK citizens have the right to receive appropriate care & treatment from the NHS. The NHS Constitution directs that the NHS provides a comprehensive service, available to all and free at the point of delivery.
- Every person in the UK is legally entitled to receive NHS care in their local area in an emergency (but not follow-up treatment), to receive treatment for certain communicable diseases, and if they need compulsory psychiatric treatment under the MHA.
- People should usually register with a local GP as soon as they move into a new area.

It is the responsibility of NHS Providers and commissioners to collectively ensure continuity of service provision to meet the needs of each person in an 'out of area' placement.

Any service related challenges/pressures which arise from this should be addressed as a secondary issue (through discussion with responsible CCGs) rather than becoming a barrier to individual patients' care pathways or an attempt to protect services from anticipated difficulties.

Guidance relating to '*Transfers of Care'*:

- Transfers of care between services are generally considered to contribute to poorer patient outcomes and experience; increasing the risks of treatment breakdown, loss of information, disruption in care delivery and errors in delivering care-plans.
- Transfers of care should be avoided wherever possible. Where necessary, transfers of care should be carried out safely and with confidence in any future care arrangements.
- Transfers of care should only occur when patients are 'settled & stable'. It is not advised that care responsibility is transferred between (equivalent) clinical teams whilst someone is acutely unwell, unusually distressed or presenting significantly differently to usual (their baseline).
- Transfers of care between clinical teams should take place separately to other significant life changes so that people are challenged by only one change in circumstances at a time.

Transfers of care should be avoided and minimised wherever possible. Where transfers are deemed necessary and beneficial to the person, this should be facilitated safely; identifying the optimum time (for the individual) for transfer of care responsibility to occur, and ensuring handover of relevant information to the new clinical team occurs and is recorded.

Transfers of care between clinical teams should occur separately and at a different time to changes in placement provider/place of residence.

'Settled & Stable':

- Practice guidance advises that where possible, transfers of care between clinical teams should occur when people are *'settled and stable'.*
- *'Settled'* relates to the likely permanency of the person's current circumstances and is considered important to ensure that transfers of care occur in a way which promotes continuity in future care arrangements and preserves knowledge of individuals histories and circumstances.
- 'Ordinary Residence' guidance (& case-law), and the Care Act (2014) refer to a term of 6-months living in the same place as predictive of a person's on-going place of residency.
- *'Stable'* relates to the degree to which the person's current presentation is typical for them. This is important in ensuring that during times of particular distress people are supported by clinicians who know them well and are best placed to provide support and continuity.
- Clinical studies often identify a person's presentation as *'stable'* if the frequency, severity & duration of identified behaviours are relatively consistent over a period of 12-weeks.

Transfers of care between specialist community learning disability health providers should occur only when services are confident that the person involved is presenting in a manner which is typical for them – they are not acutely unwell or unusually distressed – and that they are likely to continue residing in their current place for the foreseeable future.

'Who Pays?' Guidance & Commissioning Arrangements:

- The *'Who Pays?'* guidance sets out the framework for establishing responsibility for commissioning an individual's care within the NHS and determining who pays for their care.
- *'Who Pays?'* doesn't provide explicit guidance around which services should ***provide*** NHS care to people in *'out of area'* placements, but typically when someone registers with a local GP they become the responsibility of the local CCG and are expected to receive NHS services commissioned by that CCG. An exception to this is when people are entitled to aftercare under section 117 of the Mental Health Act (1983).
- Where people entitled to aftercare under s117 are placed in 'out of area' placements, the 2016 amendments to 'Who Pays?' directs that the responsible CCG should fund the provision of any (non-emergency) specialist community health services provided to that person.

Simple extrapolation of 'Who Pays?' guidance to link local NHS provider services to their responsible CCG's often leads to conclusions which contradict clinical practice guidance which recommends a more individualised (person-centred) approach to identifying the most appropriate clinical teams. This guidance recommends that care is provided by those services best placed to meet the needs of the patient at a specific time and that clinical handover occurs at a point which best serves the patient. The 2016 amendments advise that responsible CCG's should pay for specialist community services provided to people entitled to s117 aftercare arrangements in 'out of area' placements (see Section 6 for details)

4. PROPOSALS:

A. PRIOR TO COMMENCEMENT OF AN *'OUT OF AREA'* PLACEMENT:

i. Before agreeing an placement, the responsible commissioner should discuss its suitability to meet the needs of the individual with local health services and/or commissioners (who will likely have a greater awareness of a local care provider's history of service delivery.

ii. Once an *'out of area'* placement is confirmed, the responsible commissioner should inform local service providers (CLDTs) and commissioners (CCG &/or LA) of their intention to place someone with *'complex needs'* in their area[3].

iii. The person's existing clinical team should make referrals to local health services as required and ensure that any specialist clinical services are available in the proposed area.
NOTE: Referrals should be made at least 18-weeks before care responsibility is expected to transfer

B. AT THE POINT OF SOMEONE MOVING INTO AN *'OUT OF AREA'* PLACEMENT:

i. The responsible commissioner &/or existing clinical team should inform local learning disability health services and commissioners that a person with *'complex needs'* is moving into their local area.

ii. The existing clinical team are responsible for sharing relevant information about the person's needs with local health services (background history, clinical & risk assessments, care plans etc.).

iii. The local specialist LD health service should start to review the information and plan for accepting care responsibility once the person is settled and stable in their new placement (approximately 12-weeks).

iv. If the person is entitled to section 117 aftercare, then funding arrangements should be agreed between the local specialist community team and the responsible commissioner in anticipation of future transfer of care responsibility (see Appendix 2 for an example of this).

[3] The proposals relating to responsible commissioners liaising closely with the CCG local to the *'out of area'* placement are taken directly from The National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare) (NHS England, 2012). There are templates for communicating with local CCGs included within that Protocol.

C. INITIAL PERIOD FOLLOWING MOVE TO *'OUT OF AREA'* PLACEMENT: *(Minimum 12-wks)*

i. Following someone moving into an *'out of* area' placement, the existing clinical team are responsible for supporting the individual and the placement provider in the initial period (until the person is '*settled & stable'*).

ii. The existing clinical team retain responsibility for provision of any specialist learning disability health services.

iii. Any emergency health services required will be provided by local service providers.

iv. Transfer of care to local specialist LD health services should only occur once the person is 'settled & stable' in the new placement and the placement provider is confident of their continued ability to meet the person's needs.

v. The existing clinical team should regularly review the person in an *'out of area'* placement and **monitor the frequency, severity and duration** of any behavioural indicators of distress/disorder (suggested weekly review).

vi. During this period, local services should attend any formal meetings held as part of planning for transfer of care (e.g. CPA meetings).

D. ONCE THE PERSON IS *'SETTLED & STABLE'* IN THE NEW PLACEMENT:

i. If the regular monitoring and review of the person in the '*out of area*' placement indicates a consistent behavioural presentation over a period of 12-weeks or more, **and** the placement provider is confident they are able to continue to offer a placement to the person for the foreseeable future, then responsibility for specialist learning disability health services should be transferred to local services at a point which best serves the person being transferred.

ii. Local services should accept case-responsibility and allocate the case immediately and there should not be a gap in service provision. The case should be treated as a 'transfer of care' and not considered to be a 'new referral'.

iii. If the person is entitled to section 117 aftercare, then the responsible CCG (and local CCG) should be informed that the funding arrangements agreed previously with the local specialist community team (see B.iv) are commencing.

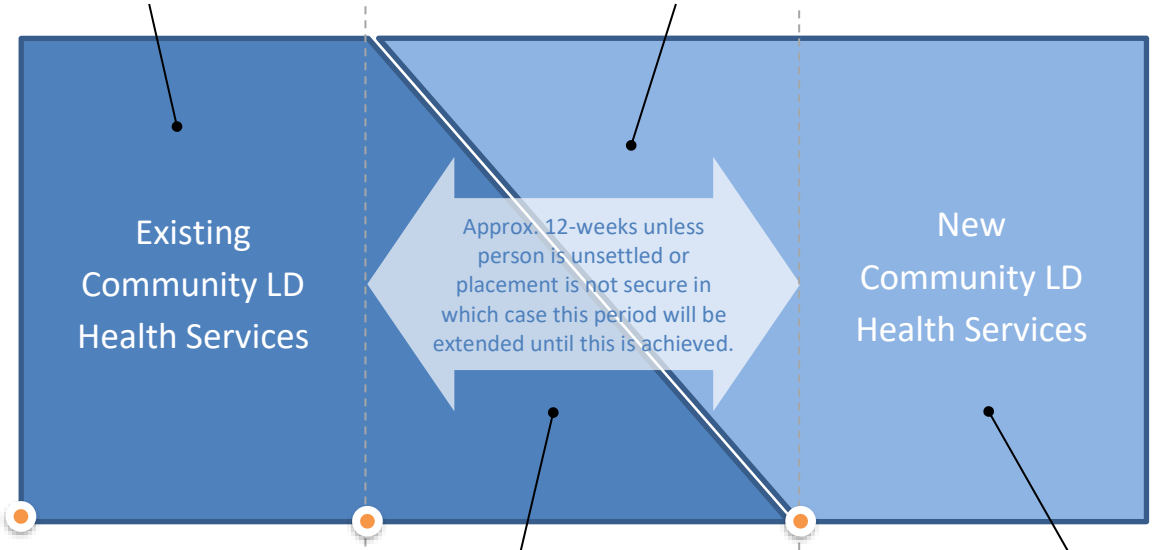
iv. The transfer of care between the existing clinical team and local services should involve a formal (documented) handover, usually involving a meeting between the current and future clinical teams (e.g. a CPA meeting or equivalent), in which relevant clinical and rsk related information is shared and arrangements in event the person requires admission to hospital are confirmed.

v. Following transfer of care responsibility, the previous clinical team should continue to provide information to assist the new clinical team in supporting the person as required.

5. SUMMARY OF RESPONSIBILITIES:

Responsible commissioner and existing care team discuss suitability of proposed OOA placement with local services and commissioners.

Local services review assessments & care-plans received from previous health team and begin liaising with service-user and placement provider to ensure person's needs are known



Potential 'Out of Area' Placement Identified

'Out of Area' Placement Commences

Transfer of responsibility from originating team to local services

Local community LD services take over responsibility for provision of specialist health services.

Existing specialist health provider supports the person to settle into the new placement and shares relevant information (assessments & care plans) with local learning disability health services.

Existing clinical team regularly reviews the person placed *'out of area'* (e.g. weekly) to ensure the placement is meeting the person's needs and gathers information about the frequency, severity and duration of known behaviours to evidence this.

There should be a formal, documented handover of care between the 2 clinical teams (e.g. MDT/CPA meeting) which acknowledges receipt of clinical & risk information and agrees responsibilities & procedures in the event of placement breakdown or need for hospital admission

6. FUNDING IMPLICATIONS:

With reference to the April 2016 amendment to the 'Who Pays' guidance (2013):

"The responsible CCG should be established by the usual means (see paragraph 1) for their typical secondary healthcare. However, if a patient who is resident in one area (CCG A) is discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to jointly work with CCG A, who will retain the responsibility to pay for their aftercare under section 117 of the Act as agreed with the appropriate local authority. The purpose of this is to ensure that the person has access to local clinical support and advice in the area they will be moving to (CCG B), whilst remaining the commissioning responsibility of the original CCG (CCG A)."

It is proposed that where a person entitled to section 117 aftercare, moves into an 'Out of Area' placement and requires input from local specialist community learning disabilities, then the CCG with s117 responsibility will pay the local provider of Community Learning Disability Health Services in the receiving area in line with the following tariffs[4]:

- **Community Nursing input:** **£150 per episode[5]**
- **Allied Health Professional input:** **£150 per episode[5]**
- **Health Care Support Worker input:** **£80 per episode[5]**
- **Clinical Psychology input:** **£240 per episode[5]**
- **Psychiatry input:** **£430 per episode[5]**

Noting also the guidance that:

"If a detained person who has been discharged, and is in receipt of services provided under section 117 of the Mental Health Act, is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, the responsible CCG will continue to be the CCG that is currently responsible for funding the aftercare under section 117 (except where the admission is into specialised commissioned services).

If a detained person who was registered with a GP in one area (CCG A) is discharged to another area (CCG B) and is in receipt of services provided under section 117 of the Mental Health Act) is subsequently readmitted or recalled to hospital for assessment or treatment of their mental disorder, ***it is the responsibility of CCG A to arrange and fund the admission to hospital*** *(except where the admission is into specialised commissioned services). Furthermore, the originating CCG (CCG A) would remain responsible for the NHS contribution to their subsequent aftercare under S117 MHA, even where the person changes their GP practice (and associated CCG)."*

[4] Calculations are based on typical agency/locum costs to provide additional multi-disciplinary staff, with 15% supplement to cover administrative and associated costs incurred by provider Trusts.
[5] An episode is classified as anything up to a half-day of programmed activity (3.75hrs)

7. CONTINGENCY ARRANGEMENTS

- It is impossible to plan for every eventuality and permutation of placement and transfer of care between providers of different types and location.
- We anticipate there will be circumstances where people being placed in '*out of area'* placements do not have an existing community team supporting them, or where an inpatient team is unable to provide support once the person is discharged.
- In some cases, long distances between the place of origin and the new *'out of area'* placement may make it impractical for existing community services to provide support even in the initial 'settling in' period following someone moving into an 'out of area' placement.
- In these circumstances it is proposed that NHS services work collectively to ensure that each person's needs are safely met and that in the absence of any identified specialist health service provider, ***local*** services to the person should take responsibility for ensuring their safety and wellbeing.
- It is acknowledged that this can put a significant pressure on services in areas which host a high number of *'out of area'* placements, and it is proposed that wherever possible responsible CCGs should fund any additional work undertaken by specialist community services as a result of supporting people in 'out of area' placements.

The 'acid test' in determining which community team should provide support to someone in an out of area placement is to consider what is in the best interests of the service user. If it is to be supported by their existing clinical team and this is possible (at least in the initial 'settling-in' period), then services should work flexibly to accommodate this. If it is necessary and appropriate to transfer clinical responsibility to local services then this should be facilitated safely and at a point in time which is least disruptive to the person being supported.

QUICK REFERENCE GUIDE:

- Commissioners should liaise with local services before commissioning an *'out of area'* placement and inform local services when placing someone in a new area.
- Wherever possible, the existing clinical team should retain responsibility for service provision & resettlement in the period immediately following a move and until the person is demonstrably 'settled & stable' in their new placement (minimum 12-weeks).
- Transfer to a new team should primarily consider the needs of the person being transferred.
- Services should ensure there is no gap in provision – timely referral by existing clinical teams and early engagement from receiving services. 'Transfer' not 'New Referral'.
- There should be a formal (documented) handover of care responsibility which ensures relevant information (history, clinical & risk assessments, care-plans) is shared with the new team and confirms arrangements in the event the person requires admission to hospital.
- If the person is entitled to s117 aftercare arrangements, then the responsible CCG should fund the provision of local specialist community learning disability (in addition to the placement) and is responsible for arranging and funding any future admission to hospital if required.
- In the event that there is no identified existing clinical team or the existing clinical team is unable to support a person in their '*out of area'* placement, NHS services should work together to ensure the person's needs are met under the NHS constitution.
- Agreement should be reached with responsible CCGs to fund any additional work undertaken by specialist community services as a result of supporting people in *'out of area'* placements.

Transfer Type

Local Community Placement	Out of Area Community Placement	Existing clinical team supports the person to settle into their new placement until 'settled and stable' (minimum 12-weeks). Following formal handover of care and sharing of all clinical & risk related information. 'out of area' team accepts referral.
Distant Community Placement	Out of Area Community Placement	Existing clinical team develops appropriate care plans to support the person in the out of area placement and shares with 'out of area' team. Out of area team agrees funding to provide agreed level of support with responsible CCG.
Local Hospital Placement	Out of Area Community Placement	Local community team works in partnership with the inpatient team to identify appropriate community care & support plans. Local community team supports the person to settle into the new placement before handing over to 'out of area team'.
Distant Hospital Placement	Out of Area Community Placement	Responsible CCG liaises with 'out of area' CCG and local provider Trust to commission 'out of area' community team to develop (with existing inpatient team) and deliver appropriate care plans to support the person in an 'out of area' placement.

APPPENDIX 1:

NHS
Yorkshire and Humber
Learning Disability and Autism
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OUT OF AREA TRANSFER OF CARE CHECKLIST:

		Signed: (Designation)	Date:	☑
1.	Suitability of proposed placement discussed with local OOA services prior to placement being commissioned	Responsible Commissioner		☐
2.	Local CCG & Learning Disability health services informed of pending OOA placement in their area	Responsible Commissioner		☐
3.	Referrals made to local learning disability health services as required (At least 18-weeks prior to expected transfer of care)	Existing Clinical Team		☐
3.	Clinical & risk information/care-plans shared with local services	Existing Clinical Team		☐
4.	Person is deemed clinically settled and stable in new placement. (Minimum 12-weeks after moving into new placement)	Existing Clinical Team		☐
5.	Formal handover of care completed – including sharing of assessments & care-plans and agreement of contingency arrangements in event of placement breakdown or need for hospital admission. This checklist shared with local services as a record.	Existing Clinical Team		☐
		New Clinical Team		☐

APPPENDIX 2:

NHS
Yorkshire and Humber
Learning Disability and Autism
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South West Yorkshire Partnership NHS Foundation Trust

AGREEMENT TO FUND SPECIALIST COMMUNITY LEARNING DISABILITY HEALTH SERVICES FOR PEOPLE PLACED IN *'OUT OF AREA'* PLACEMENTS ENTITLED TO AFTERCARE UNDER SECTION 117

SERVICE USER NAME:	
D.O.B:	
NHS NO:	
OUT OF AREA PLACEMENT PROVIDER:	
PLACEMENT ADDRESS:	
RESPONSIBLE CCG:	
LOCAL SPECIALIST LEARNING DISABILITY HEALTH SERVICE:	

In line with the April 2016 amendments of the 'Who Pays?' guidance (2013), I agree to pay for any specialist learning disability health services provided to the above named person in line with the pricing schedule below:

- **Community Nursing input:** **£150 per episode[6]**
- **Allied Health Professional input:** **£150 per episode[5]**
- **Health Care Support Worker input:** **£80 per episode[5]**
- **Clinical Psychology input:** **£240 per episode[5]**
- **Psychiatry input:** **£430 per episode[5]**

I also acknowledge that in the event that the above named person requires admission to hospital for assessment or treatment of their mental disorder that it is the responsibility of the CCG with section117 responsibility to arrange and fund the admission to hospital (except where the admission is into specialised commissioned services).

NAME:		
JOB TITLE:		
ON BEHALF OF (CCG):		
SIGNATURE:		**DATE**

[6] An episode is classified as anything up to a half-day of programmed activity (3.75hrs)

APPPENDIX 3: OUTSTANDING RISK & ISSUE LOG

REF.	*Risk/Issue Description*	*Potential Impact*	*RAG Rating*	*Action Required*	*Date for Completion*
OOA/001	**Lack of clarity with respect to transfers from hospital/prison where no existing community team is involved.**	Delayed discharges into OOA placements. Lack of appropriate input from specialist LD health services.		Further discussion with CCGs/SCG regarding potential to contract with OOA community health providers to address lack of provision during initial transition period.	September 2019
OOA/002	**Some provider Trusts in Y&H provide care coordination for OOA placements whilst others do not. Care Co-ordination responsibilities (CPA) requires a consistently commissioned approach – only some services are commissioned to continue to provide this for OOA cases.**	Lack of clarity with regard to care-coordination arrangements for people in OOA placements & differing expectations in different places. Potential gaps in service, conflict between teams or delay in transferring care responsibilities		Further discussion with CCGs and SCG to try and identify a consistent approach to Care-Coordination responsibilities for people placed in OOA placements	September 2019
OOA/003	**Some health teams are becoming overwhelmed with influx of complex OOA cases to their local areas.**	Protocol doesn't address lack of resources to meet demand as current 'population based' commissioning often fails to acknowledge OOA demand.		Further discussions regarding potential for funding specialist health input to OOA placements. Clarify 'specialist vs universal health services' definitions with NHSE/I	September 2019
OOA/005	**MHA/MoJ; CTO, s17, s37/41 responsibility should sit with the local clinical supervisor or local RC. Is proposal for person to remain under RC in place of origin for 12-week period permissible?**	The protocol could be in contravention of MHA/MoJ guidance which stipulates a 'local clinical supervisor' or local 'RC'		Further legal advice required	September 2019
OOA/006	**Potential need for a forum for negotiating areas of conflict/discord in relation to this policy**	Gaps in proposal are not sufficiently covered by 'contingency arrangements' and leads to conflict between placements and delay/barriers to people receiving care and support.		Consider ODN having a mediation role in supporting providers in Y&H to resolve issues relating to this protocol.	September 2019