Commissioning Specialised Services – Placing Patients Outside Natural Clinical Flows (Mental Health, Learning Disability and Autism Services)

Standard Operating Procedure

NHS England and NHS Improvement

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Standard Operating Procedure (SOP)

Version number:

1.0 22/04/20
1.1 23/04/20
1.2 15/05/20
1.3 02/06/20
1.4 11/06/20 – Final version, agreed by Specialised Commissioning SMT

Updated: new SOP – replaces arrangements agreed by Specialised Commissioning Senior Management Team, December 2017

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1. Purpose and Principles

1.1. Purpose

In respect of specialised commissioned Mental Health (MH), Learning Disability (LD) and Autism (A) services, this Standard Operating Procedure (SOP) has been developed to support the placement of patients of all ages into services which are outside of established and agreed natural clinical flows, where this is required.

It is important that this process is followed in a timely and efficient way to ensure patients access the appropriate service when they need to.

1.2. Overarching Principles

Patients should be able to access the right type of service, as close to home as possible, in the least restrictive environment. In some instances, this may not always be possible or appropriate. Where a patient does need to be placed outside the natural clinical flow this must be clinically appropriate, proportionate to any risk presented and local ownership and involvement must be maintained from a clinical and commissioning perspective. Where possible a placing team should look to neighbouring geographical areas when considering placements outside natural clinical flows, this will minimise distance from home and ensure that local involvement is facilitated more easily and effectively. There may be the opportunity for reciprocal arrangements for neighbouring regions to accommodate these arrangements.

1.3 Natural Clinical Flows (NCFs)

What are NCFs and how are they defined?

NCFs define the expanse in which patients from a given geographical area would generally utilise a particular service or group of services.

NCFs are not catchment areas – i.e. they do not presuppose boundaries outside of which patients should not be admitted, nor within which only patients from that area should be admitted.

All Specialised MHLDA services must have NCFs defined.

- NCFs are defined at the individual service level by Regional Specialised Commissioning Teams and NHS-led Provider Collaboratives (where these are in place) for specific services.
- NCFs are specific to the type of service and local specialised commissioning geography.
- NCFs may differ across and within service specialisms, e.g. in relation to varying sizes of geographical footprints on which specialised MH/LD/A services are planned and commissioned, which may reflect the degree of specialism of the service.

Placements outside NCFs – "appropriate" and "inappropriate"?

The Five Year Forward View for Mental Health and NHSE/I Long Term Plan use the terminology "Out of Area" (OOA) in setting out the ambition to eliminate inappropriate OOA placements. For specialised MHLDA services, we prefer to use the terminology outside of NCF in place of OOA, as this is more reflective of the nature of specialised services, which provide for relatively smaller numbers of patients across wider geographies.

At times clinically urgent situations will necessitate placements outside of NCF. Patient safety, the least restrictive environment and clinical need remains paramount in these situations. Where placements outside of NCF result in any way from constraints on or a deficit in capacity of local services, the placement will be described as an inappropriate placement outside NCF. However, it is crucial to note that this does not in any way imply that the placement is clinically inappropriate.

Identifying inappropriate placements outside of NCF in this way will support commissioners to make the case for change in local capacity to more adequately provide for their populations.

Equally, individual patient circumstances may also necessitate placements outside of NCF which would be deemed appropriate. There is an agreed broad list of reasons why a particular placement outside of NCF may be appropriate, including:

- Patient, family or carer choice
- Placement is closer to family or carer(s)
- Safeguarding reasons
- Offending restrictions in place
- Requires more specialised provision or specific clinical intervention that can only be offered on a larger geographical footprint.

1.4 Prohibition on ring fencing of capacity

Ring fencing of capacity refers to reserving capacity (beds in this instance) for the admission of local patients, such that this results in refusals to admit non-local patients into services where there are beds available.

It is acknowledged nationally that clinically urgent placements may be made outside of NCFs while commissioners continue to implement strategic plans to ensure the appropriate capacity is in place locally to meet local need and demand.

Accepting that both appropriate and inappropriate placements outside of NCF will continue in the short term, the ring fencing of capacity for local populations is not supported at the current time.

This may be revisited when the national position is that all local capacity issues have been appropriately addressed. Please note, it is unlikely that ring fencing of capacity for any more specialist services which are part of national networks (e.g. Secure CAMHS, Deaf secure MH services, Mother and Baby Units) would be supported at any point in the future.

These principles are in line with existing SOPs, including the Strategic (De) commissioning SOP.

2. Process

Where patients are being placed **outside of NCF**, the following process must be followed. This applies for all patients moving into new services, regardless of whether this is the first time the patient is being placed in a specialised service or whether the patient is transferring across different specialised services.

1. The placing commissioner/case manager must contact the host geographical area in which the prospective service (i.e. identified potential placement for patient) is situated to inform them of the intention to place.

2. The contact for the host geographical area may be the relevant Regional Specialised Commissioning Team (RSCT) or the host Lead Provider for the relevant NHS-led Provider Collaborative.

   The point of contact should be determined by the relevant RCST and articulated against each specialist service type in order to sign post to the most appropriate person – see Appendix 2 for relevant regional arrangements and contacts.

3. The identified contacts are responsible for the identification of a deputy in the event they are unavailable. This should be clearly articulated in any electronic automated out of office message.

4. The placing commissioner/case manager must explain the reasons for the placement, intended outcomes, timescales associated and arrangements for monitoring the patient's pathway and placement.

5. Commissioners must work with providers to ensure that all referrals and admissions are considered based on clinical presentation and urgency, including referrals and admissions from outside NCF.

6. Information pertaining to the reasons for the placement and other relevant communication must be documented on the National Case Management System as described in the NHSE/I Case Management SOP, for all services in scope of the case management SOP.

7. Where there may be an issue with the placement from the host area's perspective, this must be clearly explained to enable an alternative placement to be considered, this must be documented clearly on the national case management system. Issues may include where a service is restricted or closed to admissions temporarily, this could be for a variety of reasons.

8. This process must be implemented in conjunction with the agreed Out of Country Placement Process (Feb 2017). See Appendix 3.

This process emphasises national expectations for communicating about and placing patients outside NCF and should be read in complement to existing arrangements specific to regions or particular service types.

Where patients are moving into new placements that are **within NCF but out of region**, elements of this process which relate to communication across commissioners and providers remain relevant, though it is acknowledged that the host commissioning team may not be contacted prospectively given that the placement is within NCF.

3. Appendices

Appendix 1 – Terms and Definitions

1.1 Glossary of terms

SOP- Standard Operating Procedure
RSCT – Regional Specialised Commissioning Team
MH – Mental Health
LD- Learning Disability
A – Autism
NCF – Natural Clinical Flow
OOA – Out of Area
CM – Case Management

1.2 Definitions

NHS-led Provider Collaborative – A group of providers taking collective responsibility for a specific type (or group) of service specialism(s), through a Lead Provider for their originating population. They manage the pathway and budget for their population and have responsibilities for quality assurance and service improvement. They are accountable to NHS England and NHS Improvement for decisions made and the quality of care**.** Provider Collaboratives have specific delegated commissioning responsibilities.
Lead Provider – Within a Provider Collaborative (PC), the Lead Provider is a designated/agreed NHS provider organisation who will oversee the delivery of all services under the contract. Lead providers engage with all other providers within and outside of the Provider Collaborative, will sub-contract elements of the contracted services and ensure consistency and quality of services delivered. The lead provider is accountable to NHS England and NHS Improvement on behalf of the Provider Collaborative.
Commissioning – The continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment. (Ref: NHS England definition)
Commissioner and Commissioning Team – The individuals, groups and organisations involved in carrying out commissioning processes, as defined above. This includes an NHS-led Provider Collaborative. The use of the term *commissioner* in this document does not relate to the strict legal interpretation of the term *responsible commissioner*.

Case Manager - Professionally and/or clinically qualified member of staff who provides credible oversight and facilitates the care of patients in Specialised MH, Learning Disability and Autism services. CMs support commissioning functions by monitoring and reviewing of the quality of care by observing providers in practice. CMs also monitor and review quality information and local intelligence. CMs play a vital role within Specialised Commissioned services. CMs can be directly employed by NHS E/I or by NHS Led Provider Collaboratives
Geographical host – The NHS England Specialised Commissioning Region where a given service (unit) is geographically situated. This is determined based on the CCG footprint which incorporates the unit postcode, and the CCG-to-Region mapping. Geographical host arrangements may also be defined in terms of CCG-to-Hub, or CCG-to Provider Collaborative mapping.
Host team – The commissioning team operating within the geographical host area (Region or Provider Collaborative geographical footprint) for a given service (unit), which has specific responsibilities with respect to quality oversight and input towards the strategic management of the service.
Placing team – The commissioning team with responsibility for the patient population which originates from the given area (region or Provider Collaborative), which may be specific to the given service specialism. The placing commissioning team may also be referred to as the 'originating team', specifically in such context where a distinction is being made between a patient's originating (placing) team and the host team.

Appendix 2 – Contacts

2.1 Regional Contacts for Placing Patients Outside NCF

Region or Sub-Region	Service Area	Contact Point for Placing Patients Outside of NCF	Spec Comm Mental Health Lead	Spec Comm Learning Disability and Autism Lead
North West	All specialised MHLDA services	[I/S] @nhs.net		
North East	All specialised MHLDA services	[I/S] @nhs.net		
Yorks & Humber	All specialised MHLDA services	[I/S] @nhs.net		
East Midlands	CAMHS Tier 4	[I/S] @nhs.net	[I/S] @nhs.net (Deputy) [I/S] @nhs.net (Head)	[I/S] @nhs.net
	Mother & Baby Units, Adult Eating Disorder Services	[I/S] 3@nhs.net		
	Adult Low-Med Secure services	[I/S] @nhs.net [I/S] @nhs.net		
	Other specialised MHLDA services	[I/S] @nhs.net		
West Midlands	Adult Low-Med Secure services	[I/S] @nhs.net	[I/S] @nhs.net (Deputy) [I/S] @nhs.net (Head)	
	Other specialised MHLDA services	[I/S] @nhs.net		
East of England	All specialised MHLDA services	[I/S] @nhs.net	[I/S] @nhs.net	[I/S] @nhs.net
London	Adult Low-Med Secure services	[I/S] @nhs.net	[I/S] @nhs.net	[I/S] @nhs.net
	CAMHS Tier 4, Mother & Baby Units	[I/S] @nhs.net		
	Other specialised MHLDA services	[I/S] @nhs.net		
South East	Adult Low-Med Secure services	[I/S] @nhs.net	[I/S] @nhs.net	[I/S] @nhs.net
	CAMHS Tier 4 services	[I/S] @nhs.net		
	Mother & Baby Units	[I/S] @nhs.net		
	Other specialised MHLDA services	[I/S] @nhs.net		
South West	Other specialised MHLDA services	[I/S] @nhs.net		[I/S] @nhs.net

Appendix 3 – Out of Country Referral Process

OUT OF COUNTRY REFERRALS FOR SPECIALISED MENTAL HEALTH/LEARNING DISABILITY SERVICES – GOVERNANCE FRAMEWORK (FEBRUARY 2017)

The basic premise is that we should be planning our in–patient capacity such that the specialised mental health, learning disability and autism services (all ages) provided in England can meet the needs of the English population.

The core principles are as follows:

- NHS England, specialised commissioners will plan in-patient service capacity to meet the needs of the English population. It is recognised that there may be some planned exceptions to this around particular borders e.g. North East/Scotland; North West/North Wales.
- Any cross-border exception to this principle will be where there is a routinely commissioned clinical pathway which has taken in to account: patient experience, regular clinical links with local services, travel time, travel distances. This cross-border arrangement should be supported by a contract to ensure clear accountability and service monitoring of activity, finance and quality.
- Emergency referrals outside planned routine clinical flows, due to capacity reasons, will need prior commissioner approval.
- Each specialised commissioning regional team will need a clear escalation process to enable speedy decision making at a senior level.

In reaching a decision there will be a need to consider secondary issues:

- Distance to be travelled; is the out of country placement closer to home than other “in country” alternatives.
- Gaps in current service provision, particularly at the more specialist end of the service spectrum e.g. low secure services for adolescents.
- Patient/carer choice – where it is absolutely clear that this is a critical aspect of improving the patient’s well-being and all the potentially detrimental circumstances associated with an out of country placement have been considered by the carer/patient e.g. length of stay, distances to be travelled for visitors, integration with the local team to support discharge.

The steps in the escalation process would be as follows:

- The local clinical team would follow the usual national referral process to identify a suitable bed within commissioned capacity/services.
- Where no bed can be found, case managers support the locally responsible clinical team and local commissioner to exhaust all options in contracted capacity nationally and to keep a track of the process, what services have been tried and reasons for refusal. (This evidence will be important in any decision making around an out of country referral).
- First point of internal escalation – MH senior commissioners and case managers to explore all options– this may include direct intervention in discussions with providers, local commissioners and other regional MH Leads/teams.
- Case manager/ local team formulate a plan to underpin a request for admission out of the country – clear identification of rationale needed and likely length of stay i.e. evidence that there is a plan to repatriate.

- Senior commissioner will need to see evidence of efforts made to identify an appropriate bed to assure themselves that all options have been explored and discounted.
- In the event that no bed can be found and there is no other clinically appropriate choice and the senior commissioner is in agreement a case should be made to RDoSC (need to agree other Directors) for final approval prior to admission.
- If the decision is made to refer out of country a clear package of care and costs need to be agreed with the provider.