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Learning Disability and Autism – Host Commissioner Guidance

Quality oversight of CCG-commissioned inpatient care for people with a learning disability and autistic people

January 2021

Host Commissioner Guidance: Minimum expectations during the COVID-19 pandemic

- Host commissioners should continue to maintain their responsibilities for keeping an oversight of concerns in relation to the provision in their areas.
- We do not expect host commissioners to visit provider settings during this period, but we do expect them to continue to oversee and accept any concerns raised with them and to follow the agreed process for raising this with the region and if necessary, through the agreed safeguarding processes.
- All placing commissioners need to make contact with the relevant Host Commissioners for inpatient services where they have an individual placed.
- Host Commissioners may be in the first instance in a better position to visit their allocated inpatient services rather than placing commissioners due to geographic constraints and on a risk-based approach

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Introduction

1. The Long Term Plan made a commitment to improve the quality of care within an inpatient setting for people with a learning disability, autism or both. We need to have robust and effective systems in place to identify and address concerns relating to quality of care and safety at the earliest opportunity.

2. Where inpatient services are commissioned by clinical commissioning groups (CCGs) and spot purchased, this can lead to care for individuals being commissioned by multiple and dispersed CCGs or by multiple transforming care partnerships (TCPs), sustainability and transformation partnerships (STPs), integrated care systems (ICSs) and even regions.

   Responsibility and oversight for individuals' care are held by placing commissioners. However, there is rarely an opportunity to share intelligence between commissioners about care quality or concerns, or to triangulate any issues identified.

3. For this reason, Minister of State for Care Caroline Dinenage, announced in May 2019 that there would be new responsibilities for the host CCG to oversee and monitor the quality of care:

"Where it is essential that someone is supported at distance from home, we will make sure that those arrangements are adequately supervised. We cannot have people out of sight and out of mind. That is why we are introducing stronger oversight arrangements.

"Where someone with a learning disability or an autistic person is an inpatient out of area, they will [be] visited every six weeks if they are a child and every eight weeks if they are an adult, on site.

"The host clinical commissioning group will also be given new responsibilities to oversee and monitor the quality of care."

4. This guidance has been designed to help CCGs, TCPs and Regional teams put host commissioner arrangements into place. Where the document refers to the 'regional lead for learning disability and autism', the list of these contacts is provided within Appendix 1.

Defining the role of the host CCG

5. The key roles of the host CCG, in respect of inpatient care commissioned for people with a learning disability, autism or both, are to:

   - be the point of contact for commissioners and for the Care Quality Commission (CQC) for issues relating to quality and safety for units where inpatient care is delivered
   - ensure that placing commissioners are aware of the key contact in the host CCG should they become aware of issues of concern
   - establish a mechanism for sharing intelligence between commissioners who are placing individuals (or considering placing individuals) with a learning disability, autism or both within the service
   - ensure there is an interface with the relevant local authority adult social care safeguarding service, and also with the local safeguarding adult board (SAB) and with local partners so that any identified actual or potential safeguarding concerns are raised with the host local authority and dealt with as appropriate
   - work with colleagues in contracting and quality teams and be the key point of contact with the provider for issues relating to quality and safety, including those that impact multiple commissioners
   - work with the provider and with colleagues in contracting and quality teams to develop actions that will deliver required quality improvements, and seek assurance that necessary improvements have been made
   - work in conjunction with local, regional and national quality surveillance group (QSG) arrangements, taking a lead role in co-ordinating the response required if there are serious and/or multiple concerns identified. Ensure the QSG has strong and formal links with the local SAB, so that concerns discussed at QSG can also be discussed with SAB chairs.

6. The host CCG does not:

   - replace the role of an individual's placing commissioner, who is responsible for:

- commissioning and overseeing the individual's placement and pathway of care back into the community
- undertaking regular commissioning reviews of the individual, including new commissioning oversight visits, as described in section 72

- take responsibility for the quality of care afforded to individuals

- have responsibility for individuals' care plans or discharge planning.

Identifying units which require a host commissioner

7. Any specialist mental health inpatient unit which provides care commissioned by CCGs to people with a learning disability, autism or both, will need to have an identified host CCG. This includes assessment and treatment units, long-term rehabilitation units, and other specialist inpatient units (including those delivering care to individuals with complex needs and/or mental illness). This includes both NHS and independent sector provision.

Determining the host CCG

8. It is important that the host commissioner model is considered alongside NHS contracting arrangements so that there is an appropriate framework for the host CCG to work with the provider and on behalf of individual CCGs.

9. We recognise there will be different scenarios in which these arrangements are implemented. For example, a CCG may hold a contract for the unit in its area, and could be the only CCG to place individuals in that unit. Alternatively, a unit may have no block contract in place, and individuals could be placed by multiple and dispersed commissioners on spot contracts.

10. The **default position** will be that the host commissioner will be the CCG in whose geographic patch the inpatient unit is located.

11. It may be deemed more appropriate that if the unit has an NHS contract in place that is held by a CCG – i.e as identified lead commissioner for contracting purposes – then that CCG should be the host commissioner. Even if CCG and provider are not located in the same geographic area, this will ensure a consistent approach to quality oversight, and grant the CCG the authority to work with the provider on any required actions.

12. In such circumstances, if there is a predictable and consistent flow of activity from other CCGs it is recommended that a co-ordinating commissioner arrangement be put in place (if this has not been done already). This will provide a framework for the host commissioner to act on behalf of the other CCGs – who would be associates to the lead provider contract – if any actions are required with the provider following quality concerns raised.[1]

13. Arrangements will need to be determined on a case-by-case basis, with the regional lead for learning disability and autism taking overall responsibility for ensuring the most appropriate host CCG is identified (see Appendix 1 for details of regional leads).

    Where commissioners disagree about the host CCG, the **default position** is that the CCG in whose geographic patch the specialist inpatient unit is located is the host commissioner and fulfils the role as described within this guidance.

14. The final list of identified host CCGs will need to be agreed with the NHS England and NHS Improvement regional lead for learning disability and autism (Appendix 1) and shared with the national team. Any disputes will be mediated by the regional lead, or a nominated person within their team.

    They will take into account the local arrangements in place for quality oversight, and which commissioning organisation is best placed to carry out the roles and responsibilities described within this guidance. In the rare occasion when disputes cannot be resolved at a regional level, these should be escalated to the national learning disability and autism programme team.

15. Irrespective of which CCG is identified as host, the relevant local SAB (and therefore, the relevant local authority and other partners such as Health Watch and emergency services representatives) will be those where the unit is geographically located.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/03/8-NHS-Standard-Contract-Technical-Guidance-1920-v1.pdf. Section 13 of this guidance provides further information relating to collaborative commissioning arrangements.

Establishing key commissioning and provider relationships

16. The host CCG will need to **ensure there is corporate knowledge of which units it is the host CCG for**, and it is recommended that this is identified at least annually to its board in writing.

    16.1 As set out above, the default position will be that the CCG in whose geographic patch the unit is located is the host commissioner

    16.2 Host commissioners must ensure they are aware of any specialist mental health inpatient units delivering care to people with a learning disability, autism or both within their boundary. To fulfil this role each regional lead for learning disability and autism will need to establish links with its local CQC service relationship owner and ensure that they are notified of any facilities registered within their boundaries. This will allow responsibility for the host commissioner to be determined.

    Arrangements are being put in place for notification of any newly registered units falling within the scope of this guidance to come from the CQC directly to regional leads for learning disability and autism in the first instance. These leads will then have responsibility for cascading to host commissioners.

    16.3 There may be a unit within a CCG's area that is dual registered to provide both mental health and learning disability services, but which currently does not have any inpatients with a learning disability or autism.

    A host CCG and commissioner should still be identified for such units, and relationships should still be made within local partners, including the provider. However, there will be no requirement for the host commissioner to undertake routine quality surveillance until someone with a learning disability or autism is admitted to that unit.

17. **The host CCG must identify a named individual within the CCG who can act as the host commissioner, and undertake the responsibilities described within this document.**

    17.1 This individual should be of sufficient seniority that they are someone to whom issues may be escalated. They should also be able to liaise with

senior management within provider units and other CCGs and local authorities, and with regional and national teams as appropriate.

It will be for individual CCGs to determine who this individual should be, but it is suggested that this could be a director with responsibility for quality and/or nursing.

While there will need to be a single, named person identified as the host commissioner, it is important to note that this commissioner works as part of a system (which is both health and social care) and not in isolation. As such, appropriate arrangements should be put in place to provide resilience and timely action as required.

18. **The host CCG must ensure it has a full list of which individuals with a learning disability, autism or both are placed in any units for which it has host commissioner responsibility, and which CCGs or commissioners are responsible for those individuals.**

18.1 The national team will provide a list of which CCGs are currently commissioning inpatient care for people with a learning disability, autism or both at individual units. Each regional team will provide a list of commissioner contacts for each CCG.

The host commissioner should cross-reference this with the provider to ensure that all individuals with a learning disability, autism or both have been captured. This exercise must NOT include patient identifiable information; rather, a pseudonymised identifier for the individual should be used.

18.2 The national team will not be able to provide details of individuals placed by commissioners outside of England – e.g in Wales or Scotland as they will not be captured within the national Assuring Transformation system. This should be identified when lists of individuals are cross-referenced.

For any individuals from outside of England, if the provider is unable to provide contact details for the relevant commissioner, the host CCG should contact their regional lead for learning disability and autism for assistance.

18.3 Placing CCGs have a responsibility to notify the host commissioner if the individual is discharged, and if they no longer have any individuals placed at that unit. Similarly placing commissioners have a responsibility

to contact the host commissioner for an individual with a learning disability or autism.

19. **The host CCG commissioner must contact each of the placing commissioners so that they are aware of the host CCG, and provide their contact details and the duty on call number for the host CCG in case of emergency (i.e if there is an immediate risk to individual safety which would require other placing commissioners to be notified).**

20. **The host CCG must inform the regional lead for learning disability and autism of the details of the senior officer who will act as the host commissioner.**

    20.1 The regional lead for learning disability and autism will need to ensure there is a named host CCG and commissioner (including e-mail address and telephone number) for all specialist inpatient units delivering care to people with a learning disability, autism or both within its region. This must be confirmed to the national team by the regional leads for learning disability and autism.

    20.2 The regional lead for learning disability and autism must also establish a mechanism for keeping an up-to-date register of this information, refreshing this on at least a quarterly basis.

Establishing local and relevant stakeholders

21. The host commissioner should ensure they are aware of the local stakeholders who will play a role in ensuring the quality and safety of care for people with a learning disability, autism, or both. These will include:

- Local CQC service relationship owners
- Local authority heads of service for learning disability and autism (sometimes joint NHS/social care posts), adult safeguarding leads – this will be the local authority where the unit is based
- CCG designated professionals for adult safeguarding
- Local Healthwatch representatives
- Representative from local emergency services.

Identifying relevant specialised commissioning contacts

22. Within specialised commissioning, at the time of writing, specific regions have responsibility for oversight of national multi-site independent sector providers as follows:

- North West – Cygnet Healthcare Limited
- Midlands – St. Andrew's Healthcare, The Huntercombe Group
- East of England – Priory Group Limited (including services formerly under Partnerships in Care)
- South East – Elysium Healthcare Limited

23. As such, they will play a similar role to the CCG host commissioner – triangulating intelligence received and ensuring that this is acted upon.

24. Regional leads for learning disability and autism are responsible for ensuring there is a mechanism for receiving and sharing intelligence from host commissioners and between regions (including with regional leads for specialised commissioning), relating to multi-site independent sector providers.

25. Further detail is provided in sections 62–63 on sharing intelligence and taking action in a way that is proportionate and appropriate to the intelligence received.

Identifying relevant contacts outside of England

26. There are individuals from outside England placed within English units. These are likely to be isolated cases, and the priority will be for placing commissioners to maintain oversight of their individuals and ensuring continued quality of care.

    However, there are certain units in Wales where there is a small but consistent flow of individuals, particularly from CCGs within the North West, West Midlands and South West regions of England. These CCGs will take a lead role in liaising with the units and relevant Welsh commissioners to provide a single point of contact. They will ensure co-ordination of individual concerns is undertaken in the same way as for a unit located in England.

27. The regional leads will work with the national team to ensure appropriate communication with national counterparts within NHS Wales.

Acting as the central point for concerns relating to quality of care to be raised

28. One of the key responsibilities of the host commissioner is to act as a central point to receive any issues relating to quality and safety that are escalated from individual commissioners, individuals or family members or carers.

    It is vital that any professional sharing information relating to an individual (as opposed to the overall environment, for example) does so in line with Caldicott Principles and General Data Processing Regulations (GDPR), gaining the individual's consent wherever possible. Therefore, commissioners should not share personal identifiable information unless there is a clear need to do so that is in the person's best interest. If so, this should be logged within the Caldicott Guardian log of the CCG responsible for the individual (that is, the placing CCG).

29. In most circumstances, it will be sufficient to share pseudonymised information relating to individuals. This should be the default unless there is a legitimate reason why more information should be shared.

30. The host CCG will need to establish and use a system to log individual issues raised in line with its usual practice and governance. Although it will contain

pseudonymised data, the host CCG will need to make every effort to protect the security and integrity of this information. The host CCG should seek advice if there is any doubt as to what can and cannot be shared.[2]

It is important to note that placing commissioners will continue to retain responsibility for individuals in an inpatient setting. Therefore, they also retain responsibility for oversight of that inpatient placement; for ensuring that the care being provided is reviewed; and for ensuring that intelligence is shared appropriately. The role of the host commissioner is not to replace this; rather, to act as a single point of escalation for a particular unit and to ensure that intelligence is shared across the relevant system.

31. The placing commissioner should use their professional judgement in determining what to escalate to the host commissioner, and use a range of sources of intelligence, such as:

- care (education) and treatment reviews (CTRs)
- care programme approach (CPA) meetings
- commissioner oversight visits
- complaints, or individual or family feedback
- advocacy feedback
- serious incidents – including deaths in service
- Healthwatch reports.

32. Intelligence shared should include:

- use of restrictive practice outside national policy
- concerns about lack of application of Liberty Protection Safeguards;
- concerns relating to staffing ratios
- concerns relating to treatment of individuals by individual or multiple staff and a lack of person-centred care
- repeated failure to deliver agreed actions as part of CTRs or CPA
- poor use of documentation (e.g care planning), failure to personalise care, or to involve the individual or their family in the care planning process

[2] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/information-governance-resources/information-sharing-resources

- concerns regarding the inpatient environment, e.g health and safety and medication concerns
- concerns of immediate risk of harm to individuals or staff which **must** also be escalated to local authority safeguarding services
- death of an inpatient
- lack of involvement of families or of incidences where families are regularly being excluded from units
- concerns in relation to whether an individual's human rights are being upheld (see useful information for health and social care professionals on human rights in healthcare from the British Institute of Human rights here).

33. This list is by no means exhaustive, and the placing commissioner will need to use their professional judgement to determine what is appropriate to share with the host commissioner.

34. Beyond this, the placing commissioner also has their own responsibility – and duty of care – to take appropriate and proportionate action. This will depend on, and be relative to, the concerns they identify – e.g raising issues with the provider or making a safeguarding referral.

Taking a proportionate and appropriate response to quality/safety issues raised

Routine quality surveillance

35. The host commissioner should put arrangements in place for routine quality surveillance. This is an opportunity to speak to commissioners with individuals placed within the unit, as well as other local partners including community health providers and families. This will ensure all quality and safety concerns have been escalated as appropriate, and safeguarding concerns appropriately referred.

36. The host commissioner will need to determine arrangements for routine quality surveillance as locally appropriate. This should take account of factors such as the number of placing commissioners, and current arrangements already in place to oversee quality of care. Arrangements put in place should ensure there is the mechanism for intelligence to be shared on a regular basis and including the following organisations:

- placing commissioners
- local authority head of service and/or adult safeguarding lead – this is the local authority where the unit is located
- host CCG adult safeguarding leads
- local CQC service relationship owner
- local emergency services representatives
- representative from the provider
- experts by experience
- Healthwatch.

37. This list is not exhaustive, and the host commissioner may wish to invite other relevant individuals.

38. The host commissioner should develop a good understanding of the care being delivered at the provider. This should include visiting the unit as well as information gained from other methods.

39. The views of the individual and their family/carers must always be taken into account when considering the quality of care provided. The host commissioner should have mechanisms in place to ensure that this takes place.

40. Families and carers who have concerns regarding the quality of care provided in an inpatient setting should raise these with the placing commissioner in the first instance. Equally, placing commissioners have a responsibility to ensure that they communicate openly and transparently with families and carers of those placed in inpatient care.

41. Placing commissioners should make family members and carers aware of the role of the host commissioner and how they can be contacted to raise any concerns.

42. Regional leads for learning disability and autism should ensure that the role and contact details of the host commissioner is promoted and made available to families and carers, for the purposes of raising concerns regarding the quality of care.

43. Should any family member or carer contact a host commissioner regarding an individual in a unit, it is important that:

- the host commissioner takes the time to listen to and acknowledge concerns raised, and follows local safeguarding processes as applicable
- patient identifiable information is only shared in line with GDPR and with the consent of the individual where this is possible
- concerns are recorded, as per section 33 above, and in line with GDPR
- family members and carers are encouraged to discuss concerns with the placing commissioner if they have not already done so
- family members and carers are made aware that any concerns will be discussed by the host commissioner with the placing commissioner.

44. The host commissioner should note that the Winterbourne View Concordat[3] highlighted the importance of robust safeguarding arrangements, and the role of local SABs in ensuring the safety of vulnerable individuals. There is significant interface between the role of the host commissioner and the role of the local SAB in respect of safeguarding vulnerable adults. It is important that respective responsibilities are well understood to avoid duplication, and/or important intelligence being missed through miscommunication.

45. All health professionals have a duty of care to individuals/service users. Should they suspect a safeguarding concern, they should raise this via the relevant local authority – in line with the Care Act 2014 – and with the host commissioner. The chair of the local SAB should include the host commissioner as a partner when the board investigates any concerns that have been raised.

46. The following is taken from the Care Act 2014, S43 and S42(1) and clarifies the role of the local SAB:

"When adults who have care and support needs are experiencing or are at risk of abuse and neglect, and because of their needs are unable to protect themselves, local SABs are responsible for co-ordinating and seeking assurance on and supporting the effectiveness of what partner agencies do."

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213217/Concordat.pdf

47. Host commissioners must ensure they are familiar with local adult safeguarding referral processes, and that there are defined routes for regular liaison with CCG and local authority safeguarding leads regarding care provided at the specialist inpatient unit.

Enhanced quality surveillance

48. . There may be concerns are of such a scale or nature that it is deemed necessary to take further action. These issues should be escalated to the local quality surveillance group (QSG).

49. The local QSG guidance[4] sets out how the QSG will assess the risks to quality and either seek further information, or put in place enhanced quality surveillance as appropriate. It is likely that the host commissioner will be required to play a lead/co-ordinating role in undertaking any actions agreed by the QSG.

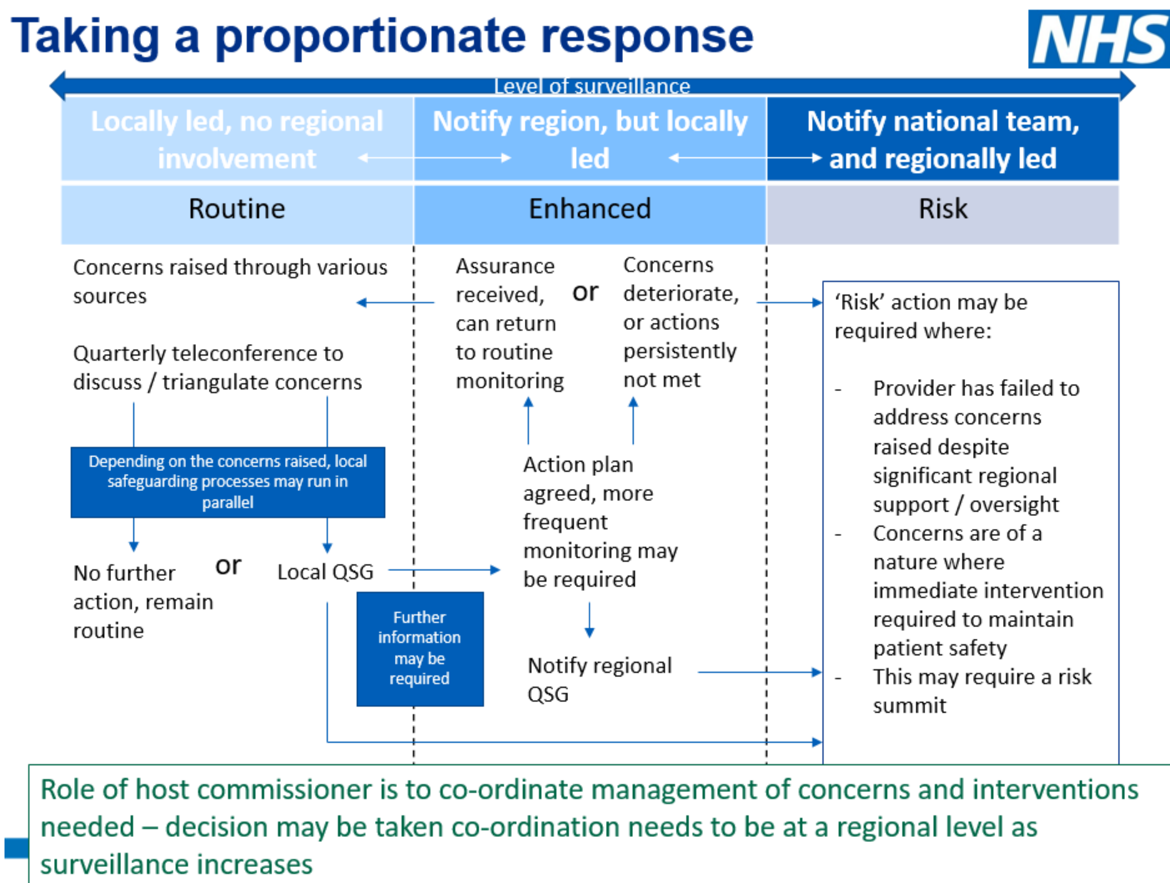
50. Depending on the concerns raised, local adult safeguarding processes may run alongside actions initiated by the host commissioner and partners to review and address any quality concerns highlighted.

51. As per the national QSG guidance, the QSG will determine at what point a provider is ready to be stepped back into routine quality surveillance.

52. See figure 1 below for guidance on levels of quality surveillance:

[4] https://www.england.nhs.uk/wp-content/uploads/2017/07/quality-surveillance-groups-guidance-july-2017.pdf

Figure 1: Levels of quality surveillance



Communication and engagement while overseeing quality concerns

53. The host commissioner will play a vital role in ensuring local stakeholders are involved in and kept up-to-date with any surveillance or actions being undertaken with a provider.

54. Regional leads for learning disability and autism are responsible for ensuring a mechanism is in place to allow host commissioners within their area to communicate regularly.

55. Regional leads for learning disability and autism must also ensure that they communicate at a regional and national level regarding any units that are placed in enhanced quality surveillance, or where there is management of serious risk of harm to individual or staff.

56. In certain circumstances, it is particularly important that intelligence is shared between regional leads. These include where a unit is in enhanced quality surveillance, or where there is management of serious risks of harm, and the unit is provided by a multi-site independent sector provider (see section 22).

    As well as sharing intelligence between regional leads, they should also include their counterparts within specialised commissioning and in NHS-led provider collaboratives, who have oversight for these units.

57. Appendix 2 contains a scenario that sets out the roles and responsibilities of each commissioner within the new commissioning landscape. It takes into account provider collaboratives and the introduction of the host commissioner arrangement.

58. Communication should be proportionate and appropriate to the level of quality surveillance in place. Those sharing intelligence with other regional leads should also consider GDPR – particularly when sharing information regarding individuals, or where it is possible to identify an individual due to high profile.

Having an ongoing awareness of the inpatient population

59. It is the responsibility of all commissioners to ensure they know who the host CCG and commissioner are for any specialist inpatient unit where they are planning to admit an individual. Before a placing commissioner places an individual into a unit out of area, they are advised to contact the host commissioner to understand any current concerns or issues associated with that provider. The only exceptions to this may be in exceptional emergency circumstances, or placements made outside office hours.

60. If a placement is made, placing commissioners will be required to notify the host commissioner by email within 48 hours of any admission. This should contain the pseudonymised patient identifier and contact details of the responsible/placing commissioner. This must not contain any patient identifiable information. The host commissioner will then be able to ensure that they include that commissioner in any communication regarding individual quality or safety at that unit.

Support for the host commissioner

61. We are aware that this will create an additional set of responsibilities for CCGs and individuals assigned as the host commissioner. Support will be led through each regional team, and we will be producing materials to enable regional leads to support local areas to implement this guidance.

62. By the end of March 2021, we expect each region to have held discussions with all relevant stakeholders to finalise how the guidance will be implemented in practice. This should include local adult safeguarding leads, host commissioners, CQC local service relationship owners and representatives from the provider units. The guidance should be fully implemented by the end of March 2021.

Interdependencies and helpful documents

63. The role of the host commissioner is one that will exist amongst several other national, regional and local initiatives already designed to ensure oversight of quality and safety for people in inpatient care with a learning disability, autism or both.

64. It is therefore important that the host commissioner familiarises themselves with existing structures and processes in place locally. In particular, any existing forums established to share intelligence or to bring local partners together for the purposes of quality assurance. Care should be taken to ensure that the role of the host commissioner and their responsibilities can be aligned with existing local processes – where these are working well – wherever possible.

65. In addition, there are national processes in place that will interface with the role of the host commissioner:

    - **Commissioner oversight visits:** The placing commissioner has a responsibility to ensure that any adult with a learning disability, autism or both, who is placed in an inpatient setting commissioned by a CCG out of area, receives a visit from their placing commissioner at least every eight weeks. (At least every six weeks for children and young people.)

This will guarantee continued oversight of the individual and ensure any concerns relating to quality or individual safety can be identified and escalated at the earliest opportunity.

The commissioner who undertakes this visit must ensure that any intelligence requiring escalation is passed to the host commissioner and any other agency as required, eg local adult safeguarding.

- **Care (Education) and Treatment Reviews [C(E)TRs] and Care Programme Approach (CPA):** Both C(E)TRs and CPA meetings are an important vehicle for the placing commissioner to identify concerns relating to the care provided to an individual within the inpatient setting.

  Following each C(E)TR and CPA meeting, the placing commissioner should reflect on whether there is any intelligence they feel should be shared with the host commissioner relating to the care delivered by the provider.

Review of the host commissioner model

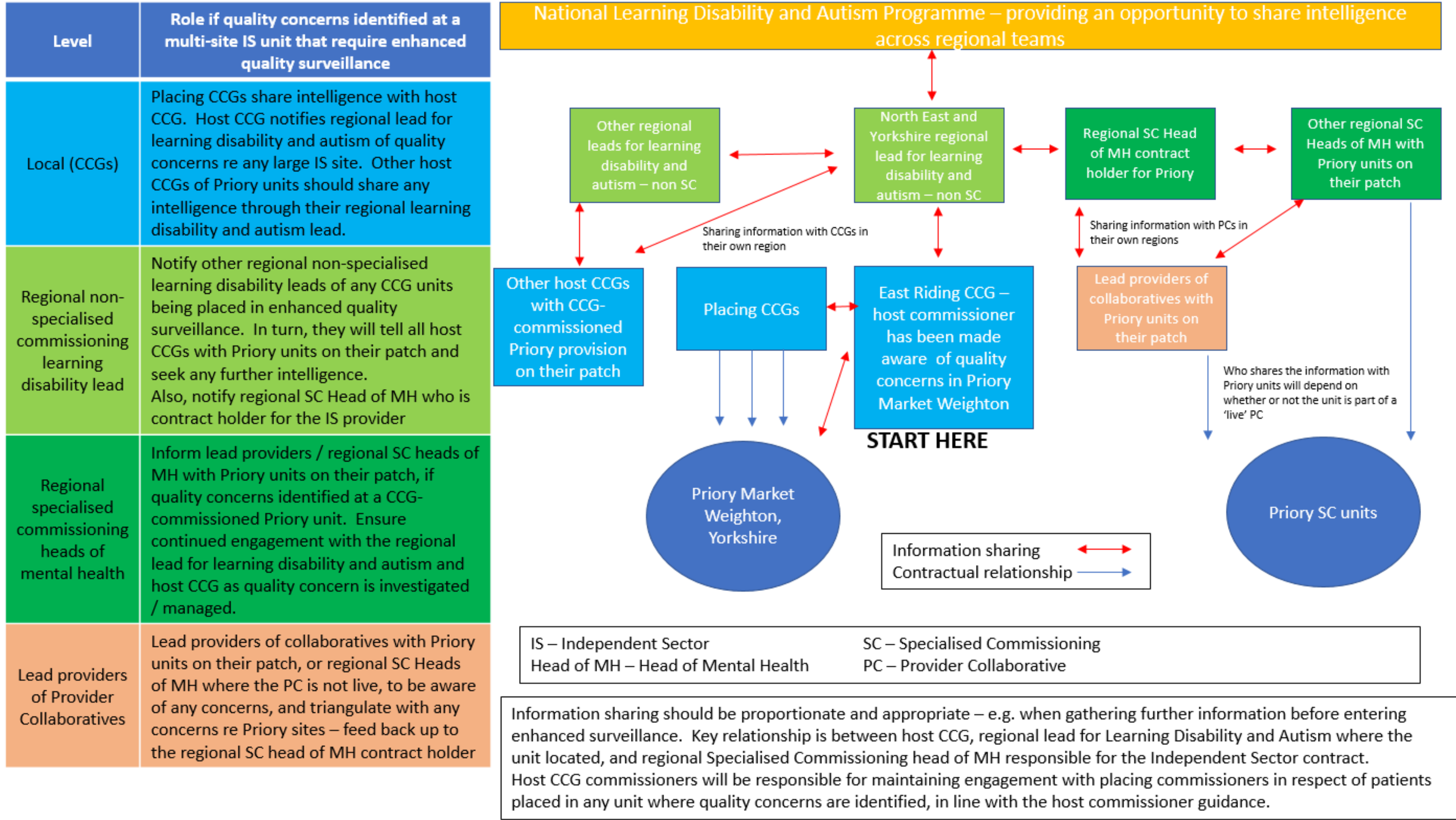
66. .We will undertake a review of this model within 12 months of the publication of this guidance, to identify any refinements or improvements. We will share the outcome of this review.

67. Any feedback regarding implementation of the model in practice should be passed to the relevant regional lead in the first instance (see Appendix 1).

Appendix 1: Regional leads for learning disability and autism

Region	Lead	email
North East and Yorkshire	Claire Swithenbank	Claire.Swithenbank@nhs.net
North West	Claire Swithenbank	Claire.Swithenbank@nhs.net
East of England	Sue Fox	Susan.Fox11@nhs.net
Midlands	Robert Ferris-Rogers	R.Ferris-Rogers@nhs.net
South East	Alison Leather	Alison.Leather4@nhs.net
South West	Kevin Elliott	Kevin.Elliott@nhs.net
London	Heidi Peakman	H.Peakman@nhs.net

Appendix 2: Interface between NHS England and NHS Improvement, provider collaboratives and CCGs in the host commissioner model



Level	Role if quality concerns identified at a multi-site IS unit that require enhanced quality surveillance
Local (CCGs)	Placing CCGs share intelligence with host CCG. Host CCG notifies regional lead for learning disability and autism of quality concerns re any large IS site. Other host CCGs of Priory units should share any intelligence through their regional learning disability and autism lead.
Regional non-specialised commissioning learning disability lead	Notify other regional non-specialised learning disability leads of any CCG units being placed in enhanced quality surveillance. In turn, they will tell all host CCGs with Priory units on their patch and seek any further intelligence. Also, notify regional SC Head of MH who is contract holder for the IS provider
Regional specialised commissioning heads of mental health	Inform lead providers / regional SC heads of MH with Priory units on their patch, if quality concerns identified at a CCG-commissioned Priory unit. Ensure continued engagement with the regional lead for learning disability and autism and host CCG as quality concern is investigated / managed.
Lead providers of Provider Collaboratives	Lead providers of collaboratives with Priory units on their patch, or regional SC Heads of MH where the PC is not live, to be aware of any concerns, and triangulate with any concerns re Priory sites – feed back up to the regional SC head of MH contract holder

Information sharing should be proportionate and appropriate – e.g. when gathering further information before entering enhanced surveillance. Key relationship is between host CCG, regional lead for Learning Disability and Autism where the unit located, and regional Specialised Commissioning head of MH responsible for the Independent Sector contract.
Host CCG commissioners will be responsible for maintaining engagement with placing commissioners in respect of patients placed in any unit where quality concerns are identified, in line with the host commissioner guidance.

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