

PROCEDURE FOR JOINT WORKING AND THE PROVISION OF MENTAL HEALTH SERVICES TO INDIVIDUALS WITH A LEARNING DISABILITY WITHIN SOUTH ESSEX

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PROCEDURE SUMMARY		
<p>This procedural guideline relates as to how the mainstream mental health and specialist learning disability services work together in the South Essex part of Essex Partnership University NHS Foundation Trust particularly with regards to referral and assessment, case management, transfer between services, acute mental illness and arbitration.</p> <p>The North Essex part of the Trust receives services from the Hertfordshire Partnership University NHS Foundation Trust, EPUT community Services and ACE for people with learning disabilities as covered by the document “Responding to People who have Learning Disability and need Mental Health Care and Treatment 2017”.</p>		
The Trust monitors the implementation of and compliance with this procedure in the following ways;		
All services, clinical directorates and specialist teams are responsible for implementing this policy and the associated procedural guidelines.		
Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	Not North Essex
CHS		

**The Director responsible for monitoring and reviewing this procedure is
Executive Chief Operating Officer**

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Assurance Statement

These procedures seek to clarify responsibility between the Learning Disability, Adult and Older Age Mental Health Services, Health and Social Care for the provision of services to adults aged 18 and over who have both mental health and learning disability needs.

These procedures aim to help decision-making and enhance support planning and case management to the benefit of individuals with both a learning disability and mental health needs and clinicians/practitioners alike in line with “Valuing People”, “Valuing People Now” and the Green Light Toolkit.

1.0 INTRODUCTION

- 1.1 These procedures outline good practice that aims to improve the continuity and collaboration between services enabling seamless care.
- 1.2 These procedures should be read in conjunction with EPUT’s Care Programme Approach Policy and Handbook and the Learning Disability (LD) Operational Policies.
- 1.3 The principles underpinning these procedures are as follows:
 - The care received by a service user should be based on the needs of the individual. Some individuals’ needs do not fit neatly into specialist service categories. The onus is on a service to collaborate with others to meet the individual’s need.
 - An individual who has a learning disability who also has mental health problems may have their needs met best by either the learning disability or mental health services. In either case, the other service should remain available should their expertise, support and joint working be required.
 - The needs of an individual with a learning disability who has a mental health problem will be assessed in a person centred approach, using the shared expertise from learning disability and mental health, in collaboration with other agencies.
 - Where a person with a learning disability has concurrent mental health needs which warrant application of CPA a Care Co-ordinator from a mainstream mental health team, if this seems most appropriate under

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the principles of Green Light For Mental Health, or Intensive Support Team must be clearly identified to ensure effective co-ordination of care between services. In this instance the Care Programme Approach will be followed in assessing, care planning, risk managing and reviewing a person's care. For all other people with a learning disability the Non CPA Policy and Procedures and LD Operational Policy and Pathway will be followed.

- Wherever possible, services should be developed locally to meet the needs. In general it would be expected that the learning disability teams would have the skills to provide treatment for the mental health problems of their service users.
- It is recognised that there are some people e.g. some people with Autism or Asperger's Syndrome, who do not fit the definition of learning disability but still require a service, this is not currently provided through the learning disability Service.
- The definition of learning disability in Essex is set out in the jointly agreed Learning Disability Eligibility criteria.
- The individual's opportunities and strengths referred to in the care plan should support the key principles outlined in "Valuing People" and "Valuing People Now" of rights, independence, choice and inclusion and be in line with the principles within Green Light for Mental Health.
- If both the mental health and learning disability teams are involved with members of the same family they will work collaboratively.
- Nursing and Therapy staff on mainstream mental health inpatient wards should be supported by Nursing and Therapy staff from learning disability services if a learning disabled patient is admitted.

2.0 REFERRAL & ASSESSMENT

- 2.1 Referrals to services for people who have a learning disability will be co-ordinated through [REDACTED] or [REDACTED] and then RAM. The Local Authority social workers will process new referrals through their duty systems.
- 2.2 The referral is allocated at the RAM following discussion with regard to the most appropriate service to meet the needs identified in the referral.
- 2.3 If it appears the individual would benefit from a joint assessment, contact will be made with the appropriate mainstream mental health team in order to facilitate a joint visit as soon as possible.

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- 2.4 Following assessment it will be agreed which service is best placed to meet the needs of the individual and the overall support planning and Care Co-ordination of the case will rest with the appropriate team. In reaching this decision it may be necessary for each team to discuss the case together involving the respective Consultant in both the MH and LD service.
- 2.5 It may be necessary for both MH and LD services to jointly work with an individual in order to meet their overall needs. The arrangements and responsibilities of each party must be clearly identified in the agreed Support/ CPA care plan and clearly communicated to the individual service user. A copy of the agreed care plan will be held by all those involved in the delivery of care.

3.0 CASE MANAGEMENT

- 3.1 An individual who has learning disability with mental health problems, whose needs are best met by the learning disability service, will remain with that service with appropriate advice and support from the respective mental health team. There will be reciprocal advice and support arrangements where someone's primary needs are mental health difficulties.
- 3.2 Clear clinical/practical leadership is important to give clarity of care and decision making. For individuals subject to CPA a Care Co-ordinator will be allocated and be responsible to ensure this happens. For service users not being supported on CPA a named nurse/practitioner will be allocated to oversee the agreed care/support plan.
- 3.3 The Care Co-ordinator and or named practitioner must ensure the following occurs when an individual's care plan is based on collaboration between services;
- Discussions with service users as early as possible about their continuing support and care needs.
 - Consultation with family and carers where appropriate.
 - Discussions with the receiving team to consider options/possible alternatives – recorded in written support / care plan with agreed review date.
 - Comprehensive assessment, care planning, risk assessment and management plan, and a scheduled review to include assessment of the carer's needs and a suitable carer's support plan.
- 3.4 Copy of the support / care plan to be agreed and shared with the service user and relevant other team/service providers.
- 3.5 Future transition points between workers and services should be recognised and planned for as soon as possible to ensure they are successfully navigated.

4.0 TRANSFER BETWEEN LD AND MH SERVICES

- 4.1 The mainstream mental health service is contracted to work with adults who have severe and enduring mental health needs, whilst the learning disability service works to the Learning Disability Eligibility Criteria. It is the responsibility of the current worker to make the appropriate arrangements for referral and possible transfer to the other service where this is thought appropriate.
- 4.2 Where the current worker believes that transition of care to the other service is necessary a referral should be made to the relevant Community Team Manager. The referral should include a comprehensive report on the client. The Community Team Manager will arrange for a joint case or CPA review within 7 working days of receipt of the referral. If the predominant need is mental health, and the service user would seem most appropriate for that service under Green Light For Mental Health principles a mainstream mental health team will be the responsible team.
- 4.3 If, following this case review it is agreed that the service user should be accepted by the other service, the transition should be planned on the basis of a care plan prepared by the service user (and their family where appropriate) and appropriate staff from learning disability and mental health services. It may be appropriate to consider a period of joint work or consultation spanning the period where responsibility is transferred. Copies of all records relating to the service user should be transferred as part of this process. The current worker should ensure that the service user's GP and any other agencies involved are fully informed about the plans and timescale for the transfer of responsibility.
- 4.4 If, following joint assessment, it is agreed that the referral is not appropriate the service user, their family, and all other professionals and agencies involved should be informed as soon as possible outlining the reasons why.
- 4.5 If agreement cannot be reached, the Arbitration Process in Section 6 should be used.

5.0 ACUTE MENTAL ILLNESS

- 5.1 It is recognised a small number of service users will require in-patient mental health provision while suffering acute mental illness. This should only occur when all community provision has been exhausted and risk assessment indicates admission to a mental health in-patient facility is necessary. Choice of in-patient facility should be based on the persons' primary need. A patient with learning disabilities will be subject to a Care and Treatment Review or "blue light" meeting prior to in-patient admission to explore alternatives.

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- 5.2 Once admitted the LD Consultant will take the role of Responsible Clinician and visit weekly to review, working with the ward doctors.
- 5.3 In exceptional cases, this can be reviewed by the Medical Director.
- 5.4 During their in-patient treatment, the Community Team, in some cases from both specialisms, will give support and be involved with the delivery of the care plan. This will involve attendance at CPA Review and Discharge planning meetings as well as working as an advisory member of the in-patient team. Nursing and Therapy staff on mainstream mental health wards should be supported by Nursing and Therapy staff from learning disability services if a learning disabled patient is admitted and should work collaboratively supporting and learning from each other in providing shifts caring for the patient and jointly writing care plans.
- 5.5 The Community Teams should be referred to where possible prior to admission and on discharge in accordance with agreed local criteria for the service, if there has not been ongoing involvement throughout the in-patient treatment.
- 5.6 Following admission of someone not known to EPUT services, as soon as practicably possible a case review involving the full multi-disciplinary team will be convened to agree responsibility, a care plan and discharge arrangements. This will be monitored and developed throughout the in-patient stay.

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6.0 ARBITRATION

- 6.1 It is expected that senior clinicians and managers will work in a flexible and cooperative manner and in the best interest of the service user. This process should be expedited by all involved to avoid undue delays in resolving issues and reaching a concluded way forward. In all cases, the current lead agency will retain that role until the resolution is achieved, and ensure that services continue to be delivered.
- 6.2 Any disagreement about the management of a case should be resolved at the earliest opportunity. The levels of escalation are as follows:

Stages of process	Mental Health	Learning Disability
First stage	Team Manager	Team Manager
Second Stage	Associate Director and Clinical Director	Associate Director and Clinical Director
Third stage	Director of Mental Health and Mental Health Commissioner	Director of Specialist Services and Learning Disability Commissioner

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Pathway for Joint Working

