Joint Working Protocol

Central Bedfordshire Council,
Bedford Borough Council,
East London Foundation Trust (ELFT)

Division & Service:	Adult Social Care		
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Owner	Central Bedfordshire Council, Bedford Borough Council, and East London Foundation Trust (ELFT)		
Final Validation by	Practice Governance Board		
Effective From:	01/08/2023	**Validation Date:**	26/07/2023
Next Review:	August 2025	**Version No.**	4.0

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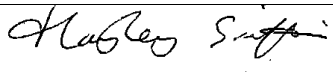
Hayley Griffin	AD, CS		Central Bedfordshire Council Childrens Services	24-10-23
			ELFT Adult Mental Health	
Linda Hurst	Interim Associate Director		ELFT CAMHS	07/08/2023

Version Control

Version no.	Date issued	Author	Change Reference	Issued to
1.0	08/01/2013	Ramone Nurse (CBC Policy Officer)	First Policy Version	ASC
2.0	11/11/2018	Nikki Kynoch (CBC) Paul Rix (ELFT)	Policy Review	ASC
3.0	04/06/2019	Caroline Tate (CBC) Nikki Kynoch	Policy Updated	NK/ ORG
3.1 (draft)	26/01/2023	Helen Hammond (CBC) Sarah Cavill (ELFT)	Policy Updated	HDT
3.2	12/04/2023	Helen Hammond (CBC) Sarah Cavill (ELFT)	Rename document due to purpose change	HDT/PGB
4.0	28/06/2023	Helen Hammond (CBC) Caroline Tate (CBC)	Formatted for validation	PGB
4.1	26/09/2023	Caroline Tate	Removed Luton Borough Council	HDT

This document is not controlled when printed.

It is the responsibility of every individual to ensure that they are working to the most current version of this document.

Contents

1. Introduction

1.1 This Protocol has been developed to improve work across service boundaries in Central Bedfordshire, and Bedford. This covers young people transitioning between Children's and Adult Services, as well as people transferring between Social Care and Community Mental Health Services.

1.2 The aim of the Protocol is to ensure sound procedures are in place for referring, allocating and transferring individuals so that people are not left unsupported because of uncertainty, or disputes between teams about roles and responsibilities.

1.3 Central Bedfordshire Council, Bedford Borough Council, and East London Foundation Trust (ELFT via S75 agreement) share responsibility for the delivery of the adult social care services under the Care Act 2014. It is therefore vital that clear pathways are established between Children's Services, Adult Social Care and ELFT.

1.4 This Protocol describes the principles and guidance to be applied in any circumstance where people may need support from more than one team or where the responsibility of the team is not clear. It also includes clear principles and guidance to be applied where there is uncertainty about whether a young person should transition into Adult Social Care or Community Mental Health Services.

1.5 All operational decisions must be recorded and must be consistent with the principles and standards set out in this Protocol; particularly in demonstrating responsiveness to care and support based on the needs of the person.

2. Scope and Purpose of the Protocol and Regulatory Framework

2.1 The Protocol aims to improve the delivery of social care services across organisational boundaries in Central Bedfordshire, and Bedford.

2.2 The Protocol recognises the difficulties people may experience identifying and/or navigating services. This Protocol encourages staff to assist people irrespective of whether they have contacted the wrong team or service, by carrying out the initial assessment at the first point of contact.

2.3 The Protocol contains procedures for transferring individuals between Local Authorities and ELFT so that people are not left unsupported because of uncertainty or disputes between teams about roles and responsibilities. The same principles apply to young people transitioning; the service that receives the referral should carry out an initial assessment to ascertain which service would best meet their needs.

2.4 The Protocol aims to reduce the potential risk to people where service boundaries may not always be clear, and gaps may emerge; particularly in relation to people whose social care and health needs do not fall neatly into one service area.

2.5 This Protocol aims to ensure that:

- Vulnerable people who need an assessment and/or the provision of care and support do not fall through gaps, and are denied a service, or get caught up in disputes about organisational responsibilities.

- The Local Authority continues to meet all its legal obligations towards people in need of social care and their carers, despite the dispersal of its social services functions across organisations.
- Systems exist to ensure that risk information about a person is passed across service boundaries in an effective way, whenever there is a need to know.

2.6 The key objectives of the Protocol are:

- To help identify where Care Act responsibility for individuals who are / may be eligible for social care should be in situations where this may not be obvious.
- To ensure that there are sound procedures in place for transferring individuals between Local Authorities and ELFT so that people are not left unsupported because of uncertainty or disputes between teams about roles and responsibilities.
- To provide documentation to support the referral/ transfer of a person between organisations/ departments.
- To outline areas of responsibility for each service area, including clarification of transition arrangements and financial responsibility.
- To outline a process for dispute resolution and the monitoring mechanisms for the Protocol.

3. Principles of the Policy

3.1 The outcome for the person must be the primary consideration in all cross-team negotiations and decisions.

3.2 If a person appears to have social care needs which legally entitle them to receive an assessment and / or social care and support, the fact that they do not appear to fit readily within the usual remit of any one team must not be used to deny or delay access to help.

3.3 Decisions about which team or service should accept responsibility for people should be based on which team or service is most likely to be able to access the skills and resources needed to assess and respond to the combination of the individual's needs.

3.4 No one will be denied access to the professional skills and service resources that best meet their needs on the grounds of their age, gender, sexuality, race, religion, diagnosis, or type of disability (or any protected characteristic).

3.5 It is essential that people do not wait while issues of responsibility are being resolved. Disputes relating to funding or responsibility must be dealt with promptly by managers and must not involve the person or be allowed to impact on their health and wellbeing.

3.6 The team the person first accesses should undertake the initial assessment of their needs. If it is assessed that the person would be better supported by another team, then the pertinent information should be transferred using the organisations referral procedures.

3.7 The person should be informed that discussions are being held with another service who it is felt may better meet their needs. This should include assurance that support will continue in

the meantime and that, where appropriate, there will be a joint meeting/appointment if support is to be handed over.

4. The Social Care Eligibility Framework for Adults

4.1 All authorities with statutory responsibilities for delivering adult social care services, including ELFT, are required to do so in line with the Care Act 2014.

4.2 The National Eligibility Criteria for Adult Social Care is now set firmly within the context of the Care Act 2014.

4.3 The Care Act 2014 sets out in one place Local Authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

4.4 Under the Care Act 2014 Local Authorities must be proactive about putting in place arrangements to ensure that they do not unfairly discriminate against individuals on the grounds of their protected characteristics. Equality should be integral to the way in which any support is prioritised and delivered

- Carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care.
- Focus the assessment on the person's needs and how they impact on their wellbeing and the outcomes they want to achieve.
- Involve the person in the assessment and, where appropriate, their carer or someone else they nominate.
- Provide access to an independent advocate to support the person's involvement in the assessment if required.
- Consider other things besides paid support services that can contribute to the desired outcomes (e.g., preventive services, universal support from mainstream services or support from friends or family).
- Use the Care Act eligibility criteria to judge eligibility for publicly funded care and support.

5. Service Responsibility - Initial Assessment

5.1 In most situations it is clear which service should undertake the assessment, however this is not always the case and the team receiving a referral may feel that it does not 'belong' to them and should be directed to another area.

5.2 It is vital that such uncertainty does not lead to the person being denied access to the assessment to which they are entitled. To prevent this happening, responsibility needs to be clearly located at each step of the process.

5.3 Responsibility for an individual remains with the team to whom the initial referral is made until another team accepts responsibility. Transfer of responsibility between teams must be agreed and acceptance of responsibility confirmed in writing (or by email) by the receiving team. It is unacceptable for a worker to change the key team field on organisations respective databases without the prior agreement of the receiving Team.

5.4 If there is a question whether the person is Ordinarily Resident in Central Bedfordshire or Bedford, the team holding lead responsibility at the time will continue on a 'without prejudice' basis. This would include paying without prejudice pending resolution. If the decision is the other authority is responsible payment would be backdated. The worker should consult their line manager and address this issue with the relevant other Local Authority, taking legal advice if necessary.

5.5 It is important that no person be denied timely access to assessment or safeguarding because of a question or dispute over the responsible Local Authority.

5.6 When a team receives a referral for assessment, responsibility for responding to the referral will remain with that team unless one of the following happens:

a. The referred person refuses an assessment, and they have mental capacity, or.

b. A negotiation has taken place and the relevant manager in another team has agreed (in writing within 2 working days) to accept the referral and takes over responsibility for undertaking the initial assessment.

6. Joint Assessments

6.1 When it appears from the referral information (and perhaps from previous history) that a person's needs would be best met by two service areas, it is good practice to agree to undertake a joint assessment with a worker from the other team. However, the responsibility for arranging and progressing the assessment remains with the original receiving team. This also applies to young people transitioning into adult services, the expectation is that the referring Children's service will work alongside Adult Social Care and ELFT to ensure a smooth transition. However, the receiving team should remain responsible for coordinating support and updating the Children's worker and relevant family members/ carers.

7. The Assessment

7.1 The purpose of the Assessment is to ensure that people receive appropriate, effective, and timely responses to their health and social care needs and that professional resources are used effectively.

7.2 The assessment should ensure that the scale and depth of assessment is kept in proportion to an individual's needs, that agencies do not duplicate each other's assessments, and professionals contribute to assessments in the most effective way.

7.3 Assessments will be carried out by either Health or Social Care staff based on the principles of the Care Act 2014.

7.4 The assessment should be coordinated and integrated across local agencies relevant to the person concerned. Agencies should work together to ensure that information from assessment and agreed outcomes is shared with the person and among professionals - with due regard to data protection - in such a way that duplication of assessment is minimised for people and the professionals involved. In coordinating assessments, agencies should maintain an emphasis on outcomes rather than functions or services.

8. Identifying Responsibility for Service Provision

8.1 In the vast majority of situations, the team which has undertaken the initial assessment and found the person eligible for care and support is also likely to be the appropriate team to accept any ongoing case responsibility. However, there will be some situations where even though the person's eligibility is not in doubt, information gathered during the assessment suggests that the nature and combination of the person's needs mean that it would be more appropriate for support to be undertaken by a different team.

8.2 Sometimes different needs may emerge at a later stage, which may indicate the need for an additional referral to another team or possibly a full transfer.

8.3 It is essential that staff work together to meet the best outcome for the person to ensure they are not left without support following an assessment. The following guidelines aim to address this risk by providing a robust framework within which local teams can negotiate and agree responsibility.

8.4 All negotiations about transferring individuals should be undertaken by the relevant workers involved. If no resolution is agreed within 2 working days, the issue needs to be escalated to line managers from both organisations for discussion. If no resolution can be achieved within 1 working day, the line manager should escalate to their line manager. Where there are safeguarding concerns identified, the worker/ manager needs to escalate issues to their line manager immediately. In some instances, issues may need to be escalated to the Assistant Director or Director(s).

8.5 Once a person has been assessed as eligible for social care that person remains with the assessing team until either the need for service ceases and involvement can be closed or a transfer to another team has been negotiated and agreed. The person can be allocated in line with the team's normal prioritisation processes, but the important point is that at any given time it is clear where responsibility lies. For teams receiving a request to accept a transfer, it should be noted that inability to allocate a person is not a valid reason to refuse to accept a person which is otherwise appropriate, although the fact that there may be a delay needs to be understood.

8.6 When transfer of responsibility between teams has been agreed, the team handing over responsibility is required to provide a handover summary of work completed, full details of any outstanding issues and commitments, and access to all relevant documentation.

8.7 For an established situation all outstanding assessments and reviews must be fully documented, and the respective organisation's database records must be up to date and complete.

8.8 Where a new referral is being re-directed to a more appropriate team a full set of documentation will not have been completed but handover information must include records of all contacts and work to date. Again, it is important that the team receiving the original referral remains responsible for the person, until the re-directed referral has been accepted by the other team in writing. This should take no more than 2 working days (2 working days) after receiving the information.

8.9 Should a Care Act Assessment deem that a person is not eligible for support this should be communicated to the person and referring team. Where this is disputed the relevant authority's appeals process should be used.

9. Joint Working Between Teams / Services

9.1 All services will from time to time need to call on the services of another area to meet the needs of a particular person. It is therefore in everyone's interests to respond to such requests in a positive way that keeps the person's needs at the heart of any discussion.

9.2 The type of service requested may include:

- An informal consultation.
- A request for attendance at a case conference / professionals / strategy meeting.
- A request for an additional worker to undertake a specialist assessment.
- A formal referral to the service of an adult at risk.
- A request to discuss transfer.
- Support for safeguarding vulnerable people.

9.3 It is important that there is clarity about what type of assistance is being requested, and why.

9.4 If agreed, the organisations referral procedures must be undertaken to obtain this support. If agreement cannot be reached, the allocated worker will liaise with their manager to initiate further discussions between the organisations managers.

Ongoing joint working

9.5 If workers from more than one service are involved either with a person or with a family, particular attention must be given to how these various inputs are coordinated, and an appropriate lead professional/team agreed.

9.6 Responsibility for ensuring that workers meet and agree a coherent plan is with the lead team. If agreement to a coordinated approach cannot be reached between workers, support should be sought from line managers so further discussions can take place and a resolution can be agreed (within 2 working days). If no resolution can be achieved, this should be escalated to the relevant line manager(s)

9.7 Service coordination is best achieved by joint care planning and, if involvement is ongoing, joint review meetings at regular intervals. These offer the opportunity to take a holistic view of the person's / family's situation, to clarify roles and responsibilities, and to ensure all who need to be are aware of and signed up to the current care plans.

9.8 If a worker at any time becomes aware of a significant change in the situation or a new or increased risk, they must inform the other worker(s) immediately.

9.9 If one service is planning to cease its involvement it must contact the other service before doing so in order that relevant and up to date information can be exchanged, care plans adjusted, if necessary, and any differences of opinion about closure dealt with.

9.10 Where a person is receiving services from more than one member of a multi-disciplinary team (for instance from a psychiatrist and a social worker in a CMHT) it is important that any proposed cessation or transfer of service by one professional is first discussed with any other person providing services in the team. This is so that the implications for the person and their impact on the other service can be fully considered.

10. Resolving Disputes

10.1 In working across organisational / service boundaries situations may arise where there is disagreement over such issues as who should take responsibility, whether an additional worker can be provided and what information should be shared. In recognising this fact, the following guidelines should be followed to facilitate resolution of disputes.

10.2 If there is disagreement between two or more teams, attempts should always be made to reach an agreement as soon as possible at a local level, using this document as a reference point. All teams will sometimes have to accept responsibility for a person who workers believe is not appropriate for their service area. It is essential this responsibility is accepted as there is an overriding legal responsibility for the Local Authority to meet assessed Care and Support needs.

10.3 Whilst most disagreements should be resolved through negotiation between workers, if this is not possible, it is essential that further steps are taken without delay. Leaving such matters unresolved can be very damaging to people and their carers. Workers should alert Team Managers to the problem within 2 working days, and it then becomes the latter's responsibility to ensure further effective action is taken to resolve the dispute.

10.4 An Operational Manager or Service Manager will undertake discussions within 2 working days to try and agree actions and ensure appropriate support for the person. Discussions should always focus on identifying and agreeing the specific care needs of the individual in question before moving on to consider questions of service provision. It is essential that each potentially relevant service is represented by someone with sufficient management authority to make the necessary decisions.

10.5 If agreement still cannot be reached, the Operations Manager or Service Manager of the team currently responsible for the person should refer the matter to their line manager for formal determination. It may be necessary to consider including a legal view at this stage.

10.6 On rare occasions that a dispute cannot be resolved it may be necessary to refer to relevant (Assistant) Directors.

10.7 Where it is necessary to commission services before a determination has been made, budget holders in teams disputing responsibility should agree which team will fund on a 'without prejudice' basis, this will usually be the team who is currently supporting the person. Both teams will need to agree that the proposed package of care is an appropriate response to the assessed needs and will be required to accept the responsibility for funding the care package if the eventual determination is for them to hold responsibility. Shared funding should be considered where appropriate.

10.8 It is not acceptable for a manager to refuse responsibility for a care package on the basis that they have not commissioned it themselves, nor is it acceptable for a care commitment to be

made on behalf of another team who have not yet accepted responsibility without consulting them and obtaining agreement to the proposed package prior to entering the commitment.

11. Monitoring Implementation of the Protocol

11.1 The Assistant Director(s) in each organisation have lead responsibility. Responsibilities include ensuring staff awareness, effective implementation, ongoing monitoring, and practice development.

12. Equality and Diversity

12.1 All SCHH policies are accompanied by an EIA (where applicable) and an implementation plan that sets out monitoring and reporting arrangements available in relation to this policy.

12.2 The Council is proactive about putting in place arrangements to ensure that they do not unfairly discriminate against individuals on the grounds of their protected characteristics. Equality should be integral to the way in which any support is prioritised and delivered.

13. Evaluation and Review

13.1 The Joint Protocol will be reviewed after 2 years.

14. Appendices

- **Appendix 1:** Referral Dispute Resolution Flowchart

Appendix 1: Dispute Resolution Flowchart