‘Blue Light’ Protocol

Introduction

A “Care and Treatment Review” (CTR) approach has been developed as part of NHS England’s commitment to improving the care of people with learning disabilities and with the aim of reducing admissions and unnecessarily lengthy stays in hospitals.

CTRs bring together those responsible for commissioning and procuring services for individuals who are at risk of admission or who are inpatients in specialist mental health or learning disability hospitals, with independent clinical opinion and the lived experience of people with learning disabilities and their families.

The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the treatment and support needs of the individual and their families are met and that barriers to progress are challenged and overcome.

In circumstances where an admission is unplanned it is recognised that a CTR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action.

The aim of the ‘Blue Light’ Protocol therefore is to provide the commissioner with a set of prompts and questions to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds.

It is also intended to help identify barriers to supporting the individual to remain in the community and to make clear and constructive recommendations as to how these could be overcome by working together & using resources creatively.

The blue light protocol is subject to CTR Policy exemplar standard 11 as follows
“CTRs and any related recording or disclosure of personal information will be with the express consent of the individual (or when appropriate someone with parental responsibility for them), or if they lack capacity, assessed to be in their best interests applying the Mental Capacity Act 2005 and its Code of Practice.”

Moreover, confidential information can be recorded and shared when a child under 18 is or may be at risk of harm, or when an adult is or may be at risk of offending or of suffering harm from offending. The information recorded and shared should be in proportion to the risk in each case.

The format of the ‘Blue Light’ meeting is most likely to be a secure teleconference to allow people to participate at short notice, although it can be a face to face meeting and must make every effort to involve the person with learning disabilities or their representative/advocate and family to gain their views on what would help to avoid admission into hospital.

This protocol describes when this response is needed, and suggests who should attend and what discussions should take place.

Organisations need to sign up to this protocol locally to support prioritising of their time and resource to respond both flexibly and at short notice to a request for a ‘Blue Light’ meeting.

For NHS England specialist commissioned services, a referral for an ACCESS assessment may happen alongside this ‘Blue Light’ protocol if it is felt that the individual may need admission to secure services or Child and Adolescent Mental Health Services (CAMHS).

‘Blue Light’ process

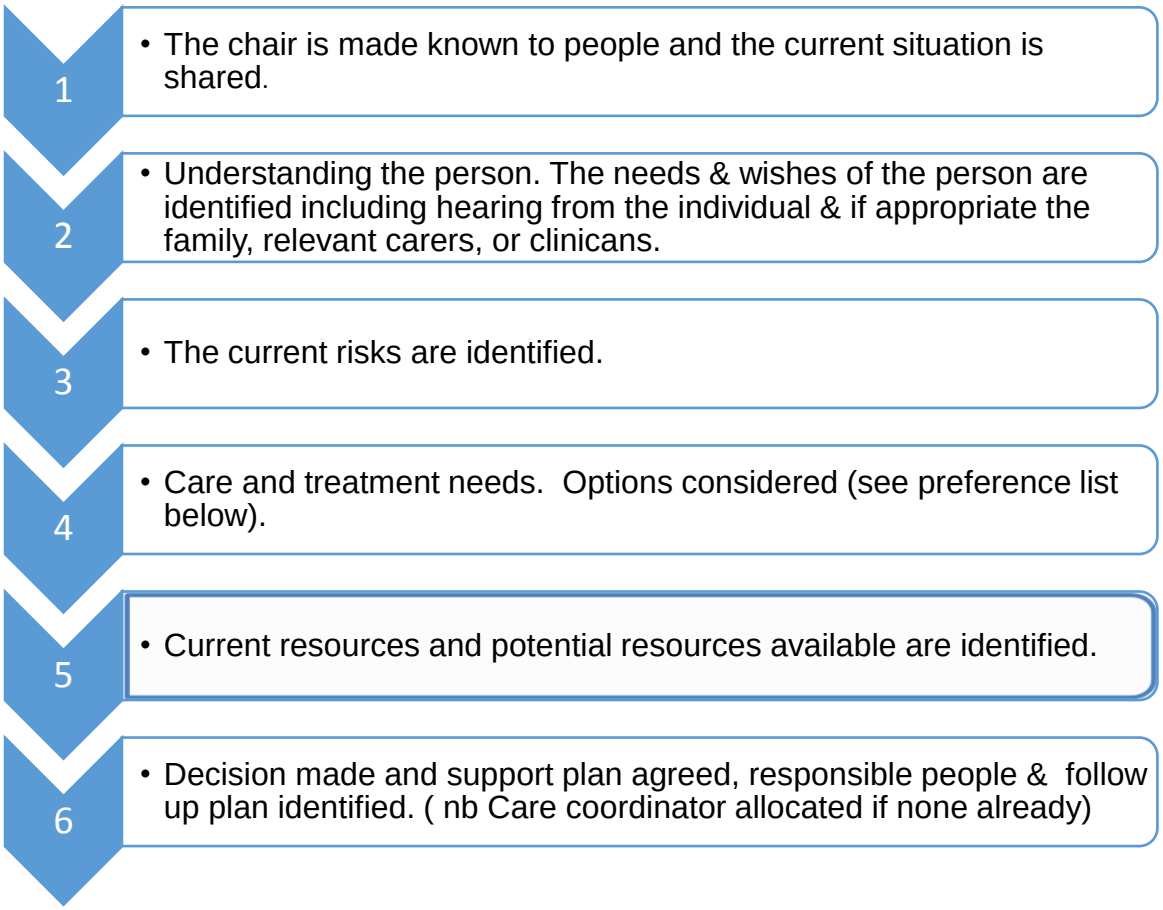
Anyone involved in the care of a person with learning disabilities and / or autism can raise concerns about an individual who is at risk of being admitted to hospital
(Note: The ‘Blue Light’ protocol is to be used where there is neither prior knowledge of the escalating risk of admission nor the time to set up or hold a CTR.)

The lead commissioner will be responsible for ensuring that a pre-admission (unplanned) ‘Blue Light’ meeting is organised and chaired.

Role	**Involvement**
Person being considered for admission	To give a first-hand account of issues & what would help. Listening to the individual is essential & should be prioritised and facilitated
Family member/s	If appropriate to give additional information. As above, listening to the family views, ideas and wishes should also be prioritised and facilitated
Psychiatrist	To provide feedback on assessed clinical needs and risks. Role in MHA processes.
Named Nurse	Care management and coordinating role, provider of clinical information.
Social worker	Care manager, involvement in assessment and care planning.
IMHA/IMCA	As required.
Commissioner	To provide support to fund alternatives to institutional care.
GP	To ensure effective support around health needs as required.
Advocate	To support the individual.

It is important for all involved to sign up to a 'no blame' principle, in order to give individuals or services the confidence to speak up should they face difficulties fulfilling their contracted role/s.

The chair should manage the conversation using the format below:



The following questions will help to focus the discussions:

1.	Gather a pen picture. "Understanding me".
2.	What are my and my family's / carers' views of the current situation?
3.	What are my symptoms including my physical health? Do any of these diagnoses mean I need to be in hospital? Have I had an annual health check & do I have a health action plan?
4.	What are the current issues and risks and how can I stay safe and keep others around me safe?
5.	What's working well / what doesn't work? (Everyone's views, including what has helped me before).

6.	What support has been/can be put in place so I that can stay in the community?
7.	What treatment do I get including drugs, therapy, diet and care that keep me safe and well?
8.	Can the care and treatment I need be given in a community setting?
9.	What additional support is needed to keep me/others safe in the community?
10.	What resources are available/can be created or used in a different way to support me?
11.	What additional support is needed for my family/ carers? Has there been a carers assessment?
12.	Do I need advocacy to support me to understand my care & treatment?
13.	What is the reason for considering inpatient admission?
14.	What would the outcomes be for me from an admission?
15.	What would the impact of admission be on me and others around me? (For example, moving away from home & the people I know, to a new environment).
16	Do I have a personal budget, personal health budget or integrated personal budget, and would this help meet my needs better?

The outcomes of this conference call should be recorded as per local policy and lead to an updated CPA care plan and risk assessment (or EHCP)

Preference list

No placement should take place out of area without the agreement of the commissioner. The preference of support arrangements are as follows:

1st preference	Support the person at home with the relevant help taking place there. Additional support packages will be considered favourably by commissioners.
2nd preference	The person is supported in a local non inpatient unit, using residential, or short breaks services.
3rd preference	A local inpatient service in the CCG area. Please note that mental health needs should be met in acute mental health services and underlying physical health needs in acute hospitals. Inpatient LD units should not be unnecessarily used.

Out of area placements should be avoided at all costs. If an out of area placement is suggested it needs to be approved by the commissioner in line with the contracting process and would only ever be considered when the move is justified by clinical need and / or risk management and all other avenues have been exhausted. Where it is agreed, it should be time limited. Any gaps in local delivery should be reported to the relevant commissioner if needs cannot be met locally.

Follow up

If an individual is at risk of admission and they are not part of the Care Programme Approach pathway, it is likely that they now meet the criteria for CPA and a care co-ordinator is to be allocated to follow up the agreed care plan. For an under 18 year old, this may trigger a review of their Education, Health and Care Plan.(ECHP) and education should be involved in discussions.

The revised care plan will require regular review in line with the CPA Policy by the care coordinator to ascertain effectiveness and quality. The individual will now be placed on the ‘at risk of admission’ register if they are not already on it.

Should admission take place following a ‘Blue Light meeting’ a full CTR will need to take place within ten working days.