Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
INTENSIVE SUPPORT TEAM

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VALIDITY – All local SOPS should be accessed via the Trust intranet

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Contents

1. Introduction 3
2. Scope 4
   2.1. Hours of operation 4
   2.2. Service Coverage 4
   2.3. Staffing 4
3. Duties and Responsibilities 5
4. Procedures 5
   4.1. Referrals and Initial Assessment 5
   4.2. Eligibility Criteria 5
   4.3. IST risk rating 6
   4.4. Management of Routine referrals 6
   4.5. Management of New crisis and urgent referrals 6
   4.6. When a client open to IST requires crisis or urgent support 7
   4.7. Management of referrals to IST allied health professionals 7
   4.8. Out of Area liaison 8
   4.9. Consultation and pathways with other services 9
      4.9.1. Consultation with CTLD (see Appendix 2) 9
      4.9.2. Consultation with FOLS 9
      4.9.3. Liaison with Townend Court Assessment and Treatment Unit 10
      4.9.4. Liaison with Psychiatry 10
      4.9.5. Liaison with the Admissions Avoidance Hub 10
      4.9.6. Liaison with Mental Health Services 10
      4.9.7. Liaison with other Services 10
   4.10. Service Model 11
   4.11. Current service objectives 11
   4.12. Service User/ Carer Involvement 12
   4.13. Audit 13
5. References 13

Appendix 1: Risk Rating Form 14

Appendix 2: Pathway document 15

1. Introduction

This document provides operational guidance for staff, patients and others working or accessing services in the Intensive Support Team at Townend Court for adults with Learning Disabilities. This service sits within the Humber Teaching NHS Foundation trust (HTFT) Care Group Directorate for Primary Care, Children's Community & Learning Disability Services.

The Standard Operational Policy aims to establish a consistent approach to delivering high quality person centred care within the community. Promoting and delivering safe, evidence based interventions aligned to NICE guidance.

The Intensive Support Team offers a multi-disciplinary proactive and comprehensive service to people with a learning disability who experience significant levels of behavioural distress and or mental health problems and require intensive support to prevent a further escalation in distress, placement breakdown or hospital admission.

The staff within the Intensive support team follow the recommendations of the STOMP programme. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP is about helping people to stay well and have a good quality of life.

The services provided are guided by the national agenda of the Transforming Care for people with a Learning Disability and the local Humber Transforming Care in Partnership Plan. The Intensive Support Team delivers individualised care/management plans to support complex individuals to remain in their own environment. When a hospital admission is appropriate the admissions are underpinned by the nine principles of 'Building the Right support'. This includes signposting and facilitating for some individuals access to appropriate mainstream support including adult mental health services through frameworks such as the Green Light Tool Kit. In accordance with the provisions of the Equality Act 2010.This enables people with learning disability and or autism who need to be admitted to hospital to be assessed and treated in mainstream inpatient services whenever this is appropriate and benefits the individual.

The Learning Disability Services are responsive and adaptable to changing demands, the national drivers and the guidance from bodies such as NHS England and NICE

Links to the Trust Vision (Caring, Learning, Growing)
The Humber Teaching NHS Foundation Trust are reinforcing their commitment to creating a culture of caring. This extends beyond caring for our patients and service users / carers to caring for each other, and to staff feeling that the Trust cares about them.

The new staff charter sets out the Trusts mission and vision along with three new values, Caring, Learning and Growing

The Learning Disability Service embraces these principles and will begin to underpin service delivery plans with the trust vision:

- *Caring:* Our shared commitment to patient centred care, providing dignity and respect through our high quality and patient safety culture.

- *Learning:* Our shared commitment to actively engage, listen, and learn from our people and empower them to use evidence based teaching approaches.

- *Growing:* Our shared commitment to be an organisation that is accountable and which seeks collaborative work with others to support and grow health and social care systems.

- *Trust Mission*: to be a multi-specialty healthcare and teaching provider committed to caring, learning and growing.

Trust vision: To be a leading provider of integrated health services recognised for the care, compassion and commitment of our staff, and known as a great employer and valued partner. The Learning Disability Services are committed to working in partnership and delivering integrated services whilst being recognised as a local lead provider of quality care to people with a learning disability and their families /carers.

2. Scope

2.1. Hours of operation

The Intensive Support Team has a team of nurses and healthcare assistants that operate 8am – 8.15pm, 7 days a week. The model also includes an MDT of other core staff covering the hours of 8-5 Monday-Friday. This includes an operational team leader, lead nurse, Psychology, Occupational Therapy, Speech and Language Therapy and care-coordinators.

2.2. Service Coverage

The service provides a multi-disciplinary pro-active and comprehensive service to people with a learning disability who have registered GPs in Hull and East Riding. The team also has some liaison with individuals previously from these areas who are placed in out of area placements or hospital settings and on the local Transforming Care Register.

2.3. Staffing

Discipline	Band	WTE
Team Lead	7	1.00
Lead Nurse	7	1.00
Specialist Nurses	6	4.60
Staff Nurses	5	3.00
Clinical Psychologist	8b	1.00
Clinical Psychologist	7	0.60
Occupational Therapist	6	1.00
Associate Practitioner for Occupational Therapy	4	1.00
Speech and Language Therapist	6	0.60
Associate Practitioner for Speech and Language Therapy	4	0.60
Care Co-ordinators (both social workers)	6	2.00
Family Support Worker	4	1
Healthcare Assistants	3	6.40
Administrator	2	1.00

The team also work in collaboration with Consultant Psychiatrists, the family therapy service and Physiotherapists as and when required. It also works in close liaison with Townend Court inpatient service.

3. Duties and Responsibilities

Clinical Care Group Director/ Care Group Leads / Service Manager / Modern Matron and Clinical Leads ensure the dissemination of this Standard Operating Procedure.

All staff involved in delivery of clinical care must ensure compliance with the requirements of the Mental Capacity Act of Practice, associated Trust policies and Standard operating procedures.

The Clinical leads to ensure implementation of Standard Operating procedure

The whole staff team to follow the Standard Operating Procedure

4. Procedures

4.1. Referrals and Initial Assessment

Referrals can be made to the team from any external agency as well as self-referrals and internal referrals from within LD services. Referrals are actioned and directed to the LD-IST at the weekly CTLD meetings or the weekly service Referral and Allocation Meeting (RAM). If a referral is identified as urgent or which may require prompt IST support, these are sent to the team outside of these meetings for review by team leads or other senior clinical staff.

Following receipt of a referral to the LD-IST MDT, it is reviewed, and the degree of urgency is decided upon by a member of the IST leadership team or senior nurse on shift. Referrals that are deemed as crisis and urgent are offered an assessment within 24 hours. Other referrals are offered an assessment within 7 days. An initial IST screening assessment is completed by two qualified members of the MDT to determine whether the case requires input from the team, and if so, what input may be required.

IST assessments include gathering information relating to a person's relevant background and historical information, information regarding the person's current difficulties, presentation, risk, previous interventions, communication, sensory difficulties and mental health.

4.2. Eligibility Criteria

The IST initial assessment aims to gather information to establish if a client meets the following eligibility criteria for the IST. The information from the assessment is discussed at the MDT and it is an MDT decision as to whether the person meets the criteria. If the person meets any of the criteria below, they should be eligible to receive a service from the IST.

- Does the person's behaviour (e.g. self-harm/harm to others, destruction of property, absconding etc) present with such frequency, intensity and/or duration that it warrants intensive support to prevent placement breakdown or admission to hospital. If this support is currently been provided by another health service and its deemed by both services to be

most clinically appropriate for them to continue, consolation work from IST should be considered. *Provide evidence*

- Does the person require a consistent and intensive multi-agency approach but has otherwise disengaged from therapeutic interventions and/or services? *provide details*

- Is the person not under FOLS, but is under a forensic restriction (e.g. section 37/41), under MAPPA or do they pose a significant risk of offending and therefore require a longer-term piece of preventative work. If the person meets this criteria and is not currently open to FOLS, a discussion with required first to ensure that they cannot offer support. *Provide evidence*

4.3. IST risk rating

The IST use a rag rating system to rate and review risk. The team support a small number of cases rated as 'green' and are considered a lower risk of placement breakdown and/or hospital admission, though require an ongoing level of consistent support to maintain this. Most cases however, are rated as Amber or Red, which reflects a higher level of risk and the potential for more intensive input from the MDT. Everybody open to the IST is rated using this system and this is logged on Lorenzo. It is expected that the risk rating will change over time, and it is hoped that those rated as Red or Amber will reduce as interventions are delivered. This risk assessment and review process is completed alongside formal FACE risk assessments for all clients open to the team.

See Appendix 1 for the risk rating form.

4.4. Management of Routine referrals

Routine referrals will be either internal from the CTLD or external that will come through the RAM. These referrals are triaged as presenting with risks which can be assessed safely within 7 days.

The Intensive Support Team assessment is carried out by 2 members of staff and assesses whether the person meets the criteria for the service. It ensures that physical health has been ruled out as a cause for the behaviour and will include an initial risk assessment (FACE). This assessment will then be discussed at the weekly team meeting. A decision will be made as to whether the person will be accepted by the team, discharged or signposted. The team may also offer some consultation in the short term to outside agencies or the CTLD if this would prevent the person needing the team. There is a separate pathway detailing the process of the consultation model (see appendix 2).

If the person is accepted by the team, they will follow the IST care pathway, which includes assessment, formulation, evaluation and the potential of discharge using a PBS framework (see appendix 2 for further details on the specifics of the pathway).

4.5. Management of New crisis and urgent referrals

If an urgent referral comes in, the person who takes the call/referral will then triage the referral using a 'decision making triage tool'. The referrals will be seen as either:

- 'Very high risk' (an immediate risk of harm) and will require a response of within 4 hours
- 'High risk' and will require a response of between 24-48 hours

If a crisis referral comes in it may need to be actioned before the RAM and so will bypass this process initially. The RAM will be informed of the outcome afterwards.

The initial gathering of information from the IST will formulate an initial risk assessment. Following the assessment, an initial plan ***may*** include:

- The deployment of staff to offer intensive support
- Development of an initial, clear care plan focused on stabilising and where possible reducing the current risk.
- Linking with other agencies such as Mental Health services, Police, Social care agencies, FOLS
- Liaison with Psychiatry services
- Liaison with inpatient services
- Risk assessment/formulation and behaviour plans being developed in line with the person's presenting needs.
- Completion of risk rating.
- Request a LEAP or a CTR
- Referral to the dynamic support register (DSR).

(Please see appendix 2 for further details around the IST pathways)

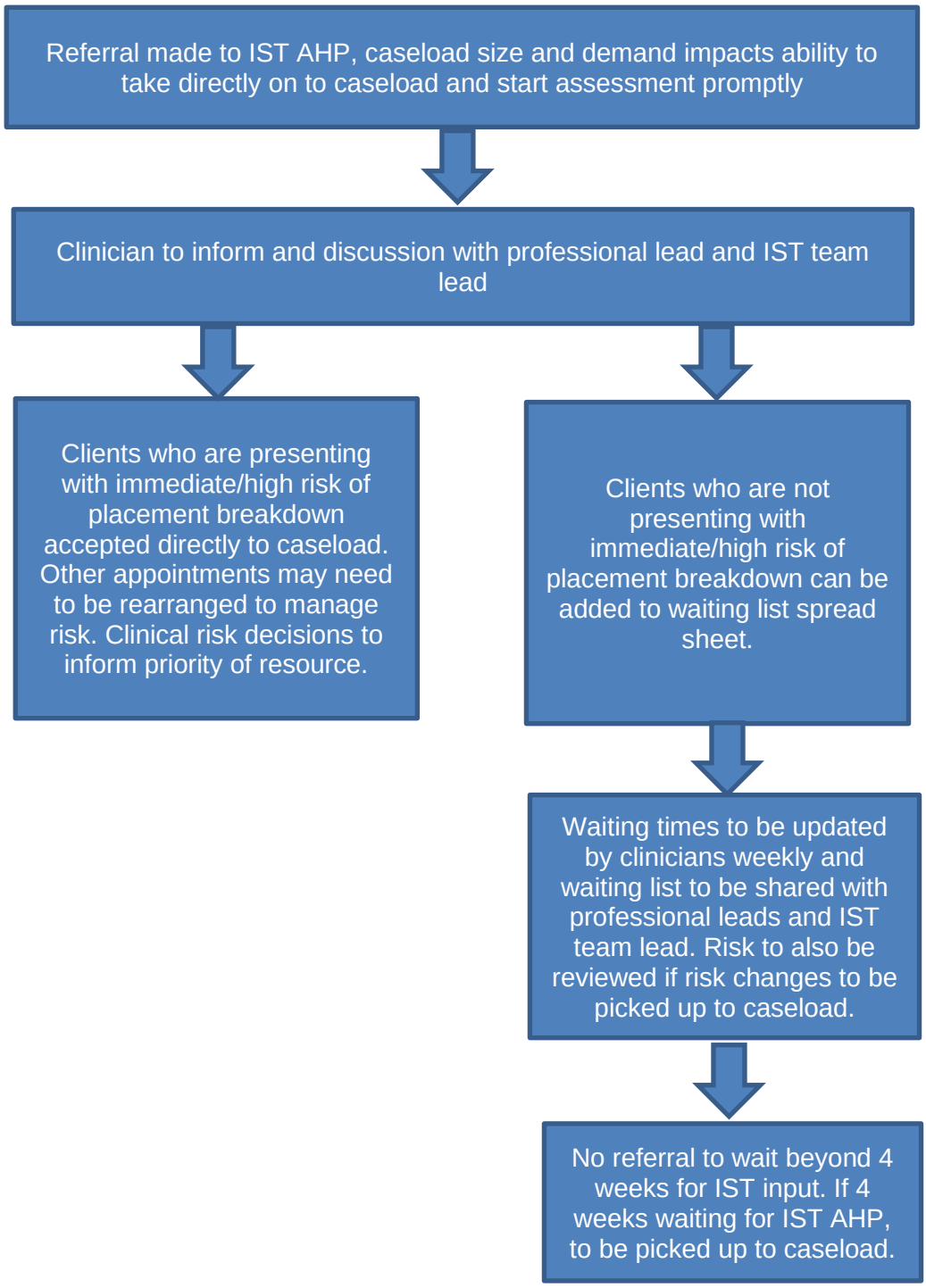
4.6. When a client open to IST requires crisis or urgent support

When a client open to the team requires urgent support due to increased risk the team will discuss at the daily morning meeting and an initial plan formulated. This may include:

- The risk assessment and risk management plan updated as needed
- A formulation meeting
- Liaison with funding social services and ICM
- Liaison with the inpatient unit where appropriate.
- Discussions with Psychiatry
- Update initial outcome measures
- Refer to DSR
- Request a LEAP or a CTR where appropriate
- Once risk has subsided, the case would again be discussed at the weekly team meeting and any changes to the treatment plan would be determined.
- Consider if CPA is needed.

4.7. Management of referrals to IST allied health professionals

There are at times of high clinical acuity when referrals to AHP's (Occupational Therapy, Speech and Language Therapy and Psychology) in IST outweigh the resource. When this happens, the following will be utilised to ensure clinical safety is maintained and ensure the most urgent interventions are provided.



4.8. Out of Area liaison

Due to the complex presentation of some individuals and the lack of appropriate local service, a small minority of individual's live out-of-area. The IST will have involvement with these clients if they are on the Transforming Care Register. If the person is in an out of area hospital they will be allocated to somebody in the IST who will maintain links with the placement (e.g. arrange and attend CPA meetings). The IST will have more involvement with discharge planning and transition back to the community when there is a clear plan that the person will be moving back into area within 6-12 months. If a person is in an out of area residential home, ordinarily the IST will only become involved when the person has a clear plan to be moving back into area within 6-12 months. If a person is moved from an out of area hospital to an out of area short term placement (e.g. an 18 month personality disorder service) then the IST will remain involved and will attend CPA meetings for the

duration of the placement. The purpose of this involvement is to ensure links between the person's placement and their place of origin as part of the Transforming Care Agenda.

This patient group are reviewed at monthly Transforming Care Meetings, one for Hull and one for East Riding. There are ongoing discussions, reviews and assessments for clients moving back to area under the Transforming Care Agenda.

Should a patient move out of area to an ISL/ residential service, IST will remain involved for a period of 6 weeks. This is based on the principles of a hospital discharge (4.9.3). During this period, IST will attend meetings, share relevant information and make contact with the person/ provider to assist with the transition prior to discharge.

4.9. Consultation and pathways with other services

The LD-IST provides consultation and support across the LD services in Hull and East Yorkshire.

4.9.1. Consultation with CTLD (see Appendix 2)

Some referrals to the LD-IST from the CTLD will not quite meet the criteria for the team, though there may be an increase in distress or a concern about placement breakdown that the CTLD worker requires some further support with. In this case, where appropriate the LD-IST work with the CTLD in a consultation model and support the case holder in the CTLD. The aim of this work is to prevent risk increases and potential placement breakdown as well as providing specialist behavioural support advice in the short term while maintaining therapeutic relationships the client may already have established with their CTLD worker.

Referrals from the CTLD and/or requests for consultation will be discussed at the weekly LD-IST meeting and allocated to an IST clinician to complete a joint LD-IST initial assessment with CTLD clinician. The purpose of this is to ensure open communication between the two teams and to ensure that a decision is agreed upon by both teams in the best interest of the client. From this assessment, the client will either be accepted for support with the IST, the referral will be rejected, or consultation will be offered.

When consultation work is agreed, a joint care plan will be agreed between the IST clinician and CTLD clinician detailing which team will do what. Timeframes for consultation will also be agreed. The CTLD clinician will maintain case holder responsibility during the consultation period though the client will be open to both clinicians via a Lorenzo.

If the risks are deemed to be significantly high, the LD-IST may accept the referral from CTLD for a transfer of care. For clients who have ongoing physical health needs, it may be determined that they should remain open to CTLD as well as IST to ensure that they receive the correct support for their needs.

Alternatively, if clients under the care of IST's risk becomes stabilised and it is felt they have ongoing physical health or needs lower behavioural needs, then a discussion will take place with CTLD leads to discuss transfer of care from IST to CTLD. (Further details can be found in appendix 2)

4.9.2. Consultation with FOLS

Clients involved within the criminal justice system or at a high risk of offending may be under the care of FOLS team. Where appropriate the LD-IST may also provide support and intervention to

these clients. Clients must meet the criteria for the LD-IST and require an intervention or professional input which is not provided within FOLS. Where this is provided by FOLS they should be directed back to FOLS. Clients will be discharged from the LD-IST when they no longer need support.

4.9.3. Liaison with Townend Court Assessment and Treatment Unit

If the LD-IST feels that a client may require an inpatient admission or be at high risk of an admission their case will be discussed with inpatient managers and psychiatry as soon as a concern is raised. The client will also be referred to the DSR and a LEAP or CTR will be requested depending on the situation.

All clients from Hull and East Riding the are admitted to the unit will be allocated a co-ordinator from IST. If the client is known to the LD-IST at the time of admission, their named nurse will continue with this role. If clients are not known, they will be referred to the IST and a co-ordinator allocated. IST will attend care planning meetings and be involved in discharge planning. Where possible the IST will endeavour to attend the weekly ward round for their named individual, however this may not be possible, and feedback will be sought by the IST (further details in appendix 2). Following discharge from Townend Court, IST will remain involved for a 6 week follow up. During the 6 week period IST will make regular contact with the patient/ service and attend professionals meetings if required.

4.9.4. Liaison with Psychiatry

Clients under the care of the LD-IST may require a referral to Learning Disability Specialist Psychiatry. An internal referral will be completed and discussion with the psychiatry team. The LD-IST will support clients to attend appointments, where possible and appropriate.

In urgent and crisis cases the LD-IST may request an urgent psychiatric assessment and/ or review of medication.

LD-IST will consider the Green Light Tool Kit and SOP to determine if referrals should be made to mainstream mental health psychiatry or Learning Disability Psychiatry.

4.9.5. Liaison with the Admissions Avoidance Hub

If a client in IST is at risk of admission to a specialist learning disability or mental health hospital, at risk of coming into contact with the criminal justice system, or at risk of admission to an acute care hospital for complex physical health conditions, then a discussion will be had at the weekly MDT to determine if a referral to the Dynamic Support Register (DSR) is necessary. From this, the admissions avoidance hub may request a LEAP or a CTR depending on the likelihood of the person requiring a hospital bed quickly. Furthermore, if an IST client's risk changes and it is felt that a hospital placement may be needed imminently, then contact will be made with the admissions avoidance hub to request a LEAP or CTR.

4.9.6. Liaison with Mental Health Services

The need for local mental health services will be considered on a case by case basis using principals of the Greenlight Toolkit and following the Greenlight SOP. The need for involvement will be discussed between the LD-IST and appropriate mental health services as per the SOP. Mental health Act assessments will be discussed and requested from the mental health response service.

4.9.7. Liaison with other Services

IST will provide liaison with the following services as and when needed:

- Social care
- National Probation Service
- Police
- Local and Specialist commissioning
- Forensic inpatient services
- Other CTLD/ IST services

4.10. Service Model

A critical feature of the IST's service delivery is that of a collaborative team approach. All team members are aware and involved in individual treatment plans which provide continuity and a proactive approach to client need.

The team approach commences from the initial assessment, moving on to the engagement process, developing an in depth comprehensive assessment of needs and strengths and this leads to the planning, implementation and evaluation of care.

Some clients will be registered on the Care Programme Approach. In these cases, one person will be allocated as care-coordinator, and this could be any professional in the team band 5 and above. This person will specifically hold the lead role for ensuring the agreed programme of care is delivered by the team. Clients who do not fall under CPA will be allocated a case holder within the team who would also coordinate the person's care while they are open to the intensive support team.

A daily morning handover (safety huddle) is used to ensure effective and consistent communication about care delivery and provides a systematic assessment of the day-to-day progress and status of at risk clients.

A weekly MDT meeting is used to discuss and allocate new referrals, to review risk and to support a multi-disciplinary discussion about clients (e.g. to discuss formulation, to devise care plans and ensure an MDT understanding of the client's presentation to ensure consistency with response).

A weekly formulation meeting is used to discuss a smaller number of cases in more depth, and to devise or revise a formulation to support the team to understand the client's presentation and to provide safe and consistent care.

A monthly operational model is used to discuss operational matters such as supervision/training compliance, to discuss feedback from working groups that have been developed to ensure up to date and effective processes within the team and to update staff on matters from meetings such as clinical network.

4.11. Current service objectives

- To provide a 7 day week access to a specialist multi-disciplinary learning disability team that can provide advice and interventions in a responsive and timely manner that supports individuals within their usual community setting.
- To maintain an internal RAG rating system of risk based on a number of factors including risk of harm to self and/or others, risk of placement breakdown, risk of hospital admission. The team use a risk form that is maintained on Lorenzo. Every person open to the IST is rated using this form, and clients who are perceived as having a greater risk and thus rated as 'red' are discussed on a weekly basis at the team meeting. Discussions around these clients include what is maintaining the person's risk, what the team are endeavoring to do to reduce this risk and if any changes are required to the care plans. If a person is at risk of placement

breakdown or hospital admission due to their risks, a discussion will also be had as to whether a referral is needed to the admission avoidance team.

- Staff in the IST follow the lone working policy and lone visits are risk assessed. A number of clients that are supported by the IST require joint visits to ensure staff and/or client safety and this is clearly identified in care and support plans.
- To provide intensive support to reduce inpatient admissions and to facilitate prompt discharge and reintegration into the community.
- To support the discharge process from hospital by providing support around discharge planning and intensive support around the transition into the community.
- To provide preventative interventions to reduce the likelihood of a crisis happening. This includes work such as PBS plans, therapeutic groups such as and when deemed useful. In the past this has included the Skillful Minds Group and individual work such as anger or anxiety management.
- To reduce rates of re-admissions within 12 months of previous discharge.
- To ensure through effective gatekeeping that all least restrictive options and alternatives to a hospital admission have been considered, including the requirements of Care Treatment reviews.
- To signpost to most appropriate services including mainstream mental health services where necessary. This is in line with the recommendations from the Green Light Toolkit.
- To monitor delivery of service impact through an agreed set of Key Performance Indicators and Quality measures
- Promote the client's participation in their own treatment plan.
- Work in collaboration with other statutory agencies and carers/families as well as the service user at all times.
- Community forensic skills are integrated within the team to support people who have come into contact with or are at risk of coming into contact with the criminal justice system with a mix of early intervention and prevention work, a monitoring and support role, providing advice and support to other services and teams and working in conjunction with the FOLS team when the client is open to both teams.
- Capacity to maintain a longer term relationship with people with forensic needs to maintain their safety in the community and continued engagement in therapies and support.
- To support the inpatient service when necessary, including the use of staff when this is needed to ensure a safe running of the inpatient service.

4.12. Service User/ Carer Involvement

Service users and carers are invited to attend regular meetings, contribute and provide feedback to service development and improvements.

The service encourages and supports the input from advocates and any legal representation to ensure service users are actively informed, engaged and involved as much as possible.

Information is also provided in accessible formats with support provided by Speech and Language Therapists.

Service Users are invited and supported to their review meetings/ CPA/ CTR and Care Plan reviews

Family members and Carers invited and supported to their review meetings/ CPA/ CTR and Care Plan reviews

Service Users are supported by the Advocacy Service as and when required to facilitate improved engagement and understanding

All compliments, concerns and complaints are reviewed.

4.13. Audit

Clinical audit is one of the key components of clinical governance. The IST lead nurse completes a record keeping audit every month, looking at 5 random cases. The results of the audit are fed back to the monthly clinical network meetings.

It is essential that teams incorporate the learning from Serious Incidents (SI's), complaints and audits into clinical practise. The team manager will oversee the application of learning outcomes in consultation with Trust structures e.g. The Clinical Governance Networks and Risk Management Team.

The service will monitor performance against agreed Key Performance Indicators and these will be reported on a regular basis allowing for ongoing audit in relation to performance and outcomes.

In addition, the service will also align with Humber Teaching NHS Foundation Trust's Friends and Family Dashboard to allow clients the opportunity to provide regular feedback in relation to their experience of services.

5. References

This document compliments the Business Continuity Plan for Community Learning Disability Team. This document should be read in conjunction with all relevant Trust policies and procedures

Appendix 1: Risk Rating Form

Risk Rating Scale	Green (Low Risk)	Amber (Medium Risk)	Red (High Risk)
Risk to Self	Green – No active self-harm or suicidal feelings/attempts	Amber – History of significant self-harm/suicidal feelings/attempts in recent past	Red – Current thoughts of self-harm/suicidal
Risk to others	Green – no current behaviours that pose a risk to others	Amber – Serious risk to others in the recent past and/or actively displaying low level of physical aggression	Red – current recurrent risk behaviour towards others that has the potential to cause serious harm
Risk to Property	Green – no current risk to property	Amber – Behaviour that has caused significant damage to property in the recent past, or current levels of aggression	Red – current recurrent distressed behaviours that has the potential to seriously damage property and make the property uninhabitable (arson should be considered here)
Risk of Offending	Green – no history or offending behaviour in past 12 months	Amber – History of involvement with the criminal justice service in the recent past or current behaviours at risk of escalating to offending behaviour	Red – actively engaging in serious offending behaviour or has had police involvement for offending behaviour in the past 3 months
Risk of Physical Health	Green – no current concerns about physical health	Amber – recent behaviours that may impact on the person's physical health without intervention (eg eating regularly, not having mediation regularly etc)	Red – Behaviour is having a serious impact on the person's physical health (e.g refusing medical intervention, not eating/drinking etc)
Risk of placement breakdown	Green – No risk of placement breakdown	Amber – Person's behaviour could put placement at risk without intervention to support this	Red – Person's placement is at imminent risk of breakdown (eg notice is likely to be or has already been served)

Appendix 2: Pathway document

The IST provides assessment, support and treatment to adults who have a learning disability and complex needs including behaviour that challenges, autism and mental health needs. The IST's main focus is to support people who are reaching crisis and may otherwise require an admission to hospital or are at risk of placement breakdown. However, the team also support people with the transition from hospital back into the community. The team work closely with the inpatient unit, the CTLD and community care services to support people with a learning disability who require additional support in the community. The IST was set up in line with Transforming Care and integrated working is a key component of the IST. It ensures that the person is at the centre of their care, promoting involvement in decisions making about their care and treatment.

Transforming care outlines four core functions that an IST should deliver:

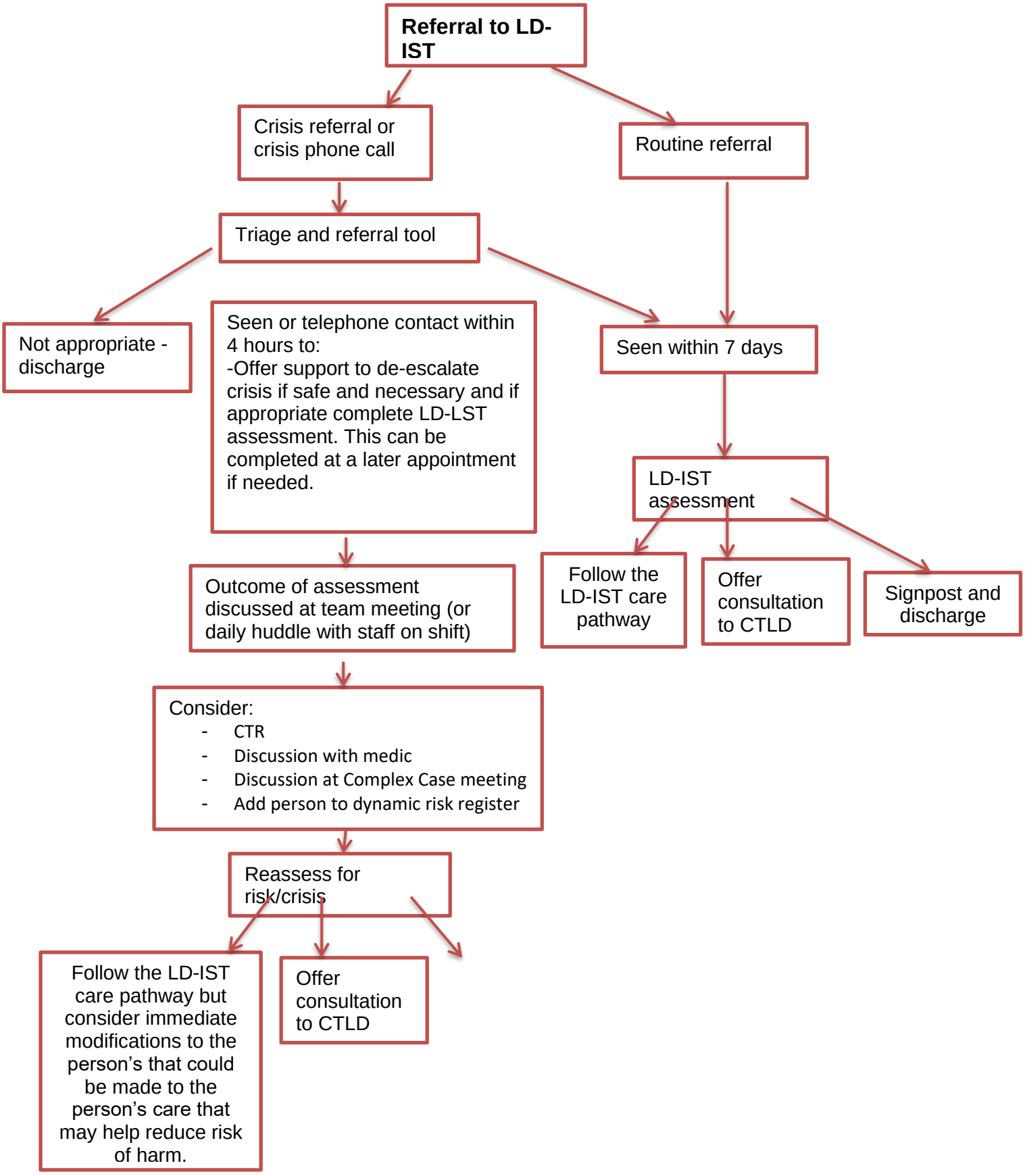
1) **Support and training** – This includes advising what suitable services should include to enhance their resilience, to create capable environments which do not rely on restrictive practices to manage behaviours. The team will also provide expert advice, training and support to those who support the person on a day-to-day basis. They will provide basic training and support to services on evidenced based approaches to supporting people who display behaviours that challenge, such as PBS and active support.

2) **Assessment, treatment and support** – This includes developing detailed assessments using a functional analysis approach in collaboration with all involved in the person's care. Following this behaviour support plans should be developed that may include a number of strategies such as environmental modifications, skills development, consistent response to behaviours. The person should be at the centre of this work and their hopes and aspirations recorded. The team may provide bespoke, person-focussed training to ensure that PBS plans are understood and implemented correctly, and to support and monitor effectiveness.

3) **Coordination of transitions from inpatient settings** – This includes local leadership and coordination across multiple agencies. It may involve direct case-management with individuals, or through advising and guiding others teams.

4) **Crisis response** - This includes direct and urgent support to a crisis that might otherwise lead to family/service breakdown or admission to hospital. The work will include rapid risk assessment and liaison with relevant services to ensure modifications to the person's care and support is put in place to reduce the risks.

Care pathway for referrals into IST



Care pathway for individuals supported by the LD-IST

Referral has gone to the LD-IST and an initial assessment by the team has highlighted the person's behaviour meets the criteria for the team. Person is added to IST risk register

6 week Assessment period

The assessment aims to aid formulation, inform treatment plan and help the person/people who support the person to understand the difficulties. Assessment may include but is not be limited to:

- Functional assessment/ collation of ABCs
- Attachment assessment
- Health assessments to rule out physical causes of distress
- Review of current and past interventions and outcomes of these
- Interviews with the individual/family/carer
- Review of historical notes to create timeline. (This is mandatory if the person has a forensic history)
- FACE risk assessment

MDT discussion to determine if the person still needs IST, what they need and what professions are needed

Transfer to other team or service

Offer consultation to CTLD

Discussion with professions involved in the case to develop care plan and basic formulation

All clients open to IST will follow the PBSP pathway unless it is evidenced why this is unnecessary.

Other interventions may include but are not limited to:
Further assessment (e.g. specific risk or forensic assessments, communication and/or sensory assessments
More detailed formulation/psychological thinking
Individual or group work (e.g. therapeutic work, OT, SALT, social groups)
Systemic intervention with the wider context (e.g. care coordination, supervision, support and training to families/care providers)

Group intervention

Care plan review (every 3 months)
Review Care plan and TOMS scores

Full review of IST intervention (6 monthly)

Outcome measures include:

- TOMs
- QoL plan (wheel of optimal living)
- Qualitative reports from person/carers/family
- Review of care plan
- Does the person continue to meet criteria for IST
- FACE risk assessment review

No evidence of change?

Review formulation, care plan and IST intervention. Is IST the best service to meet the needs of the person?

Discharge

Transfer to other team or service

Pathway from the CTLD to the IST – general referrals

Concerns about the client discussed at the nurses meeting/ CTLD meeting and/or with a band 7 community nurse. From this a decision will be made as to whether the client needs a referral to the IST. Where possible, the potential referral should be discussed with a member of the IST.

Referral discussed at IST meeting and allocated to an IST team member to arrange a joint IST assessment with the CTLD referrer.

The outcome of the assessment is discussed at the IST meeting. The CTLD referrer is welcome to attend this meeting.

Referral not accepted

Rationale discussed with the referrer
IST assessment paperwork attached to Lorenzo
Letter back to referrer, client and GP outlining the assessment and decision
Decision reviewed with referrer in 3 weeks to review the concerns. If it is felt that the risks have escalated then a decision will be taken as to whether the person should fit under IST or for consultation

Accepted by IST

Referral should follow IST care pathway.

Consultation

If the person does not meet the criteria for the IST but the one of the following criteria is met then consultation should be considered

- client requires a higher level of support to manage risk in the short term than the CTLD can offer
- the person is not at immediate risk of placement breakdown but if increased support is not put in place the placement will be at risk
- the person requires a functional assessment of behaviour as part of a PBSP

If somebody is taken on under consultation, the CTLD worker will be expected to have a clear understanding of what they are asking and a joint decision of what the work will entail should be written and recorded on Lorenzo on a joint care plan. The IST consultation care plan will be completed jointly and will outline the plan and time constraints.
The CTLD worker will remain involved though the person will also be allocated to a named IST worker and the person will be open to both clinicians for the duration of the consultation process.
The piece of work will be time limited and this will be discussed and agreed with the CTLD worker. Both workers should meet regularly to discuss progress
Consultation may include:

- IST HCAs doing observations to support a functional assessment
- Support for the CTLD worker to undertake a PBSP. The CTLD worker would be expected to contribute and take ownership of this work.
- Do additional visits to support the care plan that has already been completed by the CTLD worker
- Advice and guidance on complex presentations and support with management/support plans

If a CTLD client is admitted to a unit, CTLD should not discharge the client without a consultation with IST first. A joint care plan should be put in place to determine the input required from both teams currently and after the IST six month follow up plan.

Pathway from the CTLD to the IST – crisis referrals

Phone call or face to face conversation with IST to discuss the situation. If possible, there should be a conversation between the clinician and a band 7 from the CTLD first to discuss whether the situation cannot be dealt with immediately by CTLD.
The following paperwork is expected to be completed prior to IST involvement: up to date FACE up to date Care plan. If this paperwork is not complete, then the CTLD clinician is expected to give IST an overview of the risks and then complete the paperwork urgently. Lack of paperwork should not prevent IST intervention, though could be escalated afterwards.

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The conversation needs to establish whether the client needs a referral to IST, or an immediate response. If an immediate response is needed, the following things should be established:

- Has the CTLD duty worker been contacted, and can they support.
- Can a telephone contact suffice, or is a visit needed?
- If a visit is needed, has it been confirmed that a person unknown to the client help the situation rather than hinder it
- What is the aim of the visit (e.g., risk management)
- Can a joint visit between CTLD and IST be facilitated.
- The above points should be documented on Lorenzo.

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Outcome of visit

Referral to IST
CTLD clinician puts in referral form on Lorenzo
If the visit above was used as part of the IST assessment, then the paperwork should be uploaded onto lorenzo. If not, another visit should be arranged within 7 days. This assessment should be jointly completed with IST and CTLD

CTLD to continue to hold case
Consider writing a joint protocol for what would necessitate input from IST again in the future. This information should be added to the CTLD nursing care plan.

Consultation
If the person does not meet the criteria for the IST but the one of the following criteria is met, then consultation should be considered

- client requires a higher level of support to manage risk in the short term than the CTLD can offer
- the person is not at immediate risk of placement breakdown but if increased support is not put in place the placement will be at risk
- the person requires a functional assessment as part of a PBSP

If somebody is taken on under consultation, the CTLD worker will be expected to have a clear understanding of what they are asking and a joint decision of what the work will entail should be written and recorded on Lorenzo on a joint care plan. The IST consultation care plan will be completed jointly and will outline the plan and time constraints.
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Consultation may include:

- IST HCAs doing observations to support a FA
- Support for the CTLD worker to undertake a PBSP. The CTLD worker would be expected to contribute and take ownership of this work.
- Do additional visits to support the care plan that has already been completed by the CTLD worker
- Advice and guidance on complex presentations and support with management/support plans

Pathway from the IST to CTLD

Referral from the IST should happen if:

- The client does not meet the criteria for the IST any more
- All appropriate paperwork is up to date (e.g. FACE, PBSP)
- There is an identified health need that cannot be met by mainstream service

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Consultation from IST nurse or/and AHP with either band 7 CTLD nurse or/and AHP or at the CTLD team meeting prior to referral

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Discharge letters are to be sent to GP and relevant others to inform transfer of need before referral.

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Internal referral completed

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Referral accepted

Referral should be picked up as part of continuity of care.

A CTLD transfer care plan should be developed jointly between IST and CTLD to specify what CTLD's role will be in relation to the client, and what instances a re-referral to IST should take place. For example, if the client is being referred for 'medication management' then a deterioration in the person's behaviour that challenges may warrant a re-referral to the IST.

IST and CTLD joint transfer care plan needs to be clear on re-referral criteria. It will identify if a period of transition occurs to enable the person to be picked up by IST rather than re-referred. This is to be decided on the individual's person needs.

Care pathway to IST from inpatient services