Adult Intellectual Disabilities Operational Framework

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	November 2018

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Hayley Tarrant-Operational Manager & Lead Nurse Intellectual Disabilities

Circulated to the following for Consultation

Date	Role / Designation
November 2018	Consultant Psychiatrist Intellectual Disabilities
	Clinical Director Adult Mental Health
	Senior Management Team Mental Health
	Assistant Director of Nursing
	Team Leads Intellectual Disabilities Services
	Head of Occupational Therapy
	Head of Physiotherapy
	Head of Psychology
	Head of Speech and Language Therapy
	Clinical Behaviour Specialist
	Lead for complex and Unscheduled Care

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? • Mental Health Measure (2010) Wales • Mental Health Act 1983 (2007). • Mental Health Act 1983 Code of Practice for Wales. Welsh Assembly Government (2008) • All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults (2014) • Social Services and Well being (Wales) Act 2014 • Positive Behavioural Management. • NMC The Code for Nurses and Midwives - (NMC 2015) • General Data Protection Regulation (GDPR) (2018) • Framework for Restrictive Physical Intervention Policy and Practice. • Welsh Assembly Government (March 2007) • Health and Safety at Work Act 1974. • Safeguarding Vulnerable Groups Act 2006.

- Health and Care Standards 2015
- All Wales Strategy and "Fulfilling the Promise" (June 2011) framework
- The Foundation for People with Intellectual Disabilities 2003
- National Assembly for Wales 2001

Health and Care Standards 2015

Theme 1 Staying healthy
1.1 Health promotion, protection and improvement

Theme 2 Safe care
2.1 Managing risk and promoting health & safety
2.3 Falls prevention
2.5 Nutrition & hydration
2.6 Medicines management
2.7 Safeguarding children & adults at risk
2.9 Medical devices, equipment & diagnostic systems

Theme 3 Effective care
3.1 Safe & clinically effective care
3.2 Communicating effectively
3.3 Quality improvement, research & innovation
3.4 Information governance & communications technology
3.5 Record keeping

Theme 4 Dignified care
4.1 Dignified care
4.2 Patient information

Theme 5 Timely care
5.1 Timely access

IMPACT ASSESSMENTS

Equality Impact Assessment Summary

	No impact	Adverse	Differential	Positive	Statement
Age		x			Policy applicable to service users from the age of 18 who have an intellectual disability, commonly referred to as learning disabilities. PTHB does not routinely translate its policies and other written control documents into Welsh, there is an impact on staff and service users for whom, Welsh is their first language. Translation of this policy and procedure will be arranged if requested.
Disability		x			
Gender	x				
Race	x				
Religion/ Belief	x				
Sexual Orientation	x				
Welsh Language		x			
Human Rights	x				

Risk Assessment Summary

Have you identified any risks arising from the implementation of this policy / procedure / written control document?
No risks identified

Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?
The policy aims to adequately control these risks

Have you identified any training and / or resource implications as a result of implementing this?

No identified training or resource highlighted as result of implementation.

Policy Statement / Introduction

This policy is applicable to the Intellectual Disabilities Services provided by Powys Teaching Health Board (PTHB)
Powys Intellectual Disabilities Teams (CIDT) offer a specialist secondary Intellectual Disabilities service for individuals over the age of 18 years old.
This operational policy outlines the role and function of Powys CIDTs based on Welsh Government guidelines and the Social Services Wellbeing Act which will be subject to continuing review and development.
The team is committed to working in partnership with service users, carers, statutory, independent and voluntary agencies to deliver a range of high quality services which enable service users to exercise their full rights as citizens, realise their potential and live a valued lifestyle in the community.

2 Objective

Services for adults with an Intellectual Disability in Powys are commissioned and provided by two statutory bodies: Powys Teaching Health Board and Powys County Council.

This operational policy sets out the operating principles of the Learning Disability (LD) Health service and outlines how to access services provided by the community team for people with Learning Disabilities.

3 Definitions

- **PTHB** – Powys Teaching Health Board
- **CHC** - Continuing health Care
- **CILD –** Community Intellectual Disability Team
- **LD** - Learning Disability

4 Responsibilities(Mandatory Heading)

	4.1 Staff Group or Specific Role (for example only please complete as required)
	4.2 Other staff

5 Other Headings (for example only please complete headings as required for your document)

	5.1 Sub heading layout (for example only please complete headings as required for your document)

6 Monitoring Compliance, Audit & Review

Description of how monitoring compliance with your policy will be undertaken.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise. *(standard statement that can be amended to fit if your document is to be reviewed earlier)*

This policy will be reviewed every three years.

7 References / Bibliography

If you include a PTHB document please ensure you have the document code and correct title.

If you need to add more headings than given you can highlight the rows, copy and paste or copy and insert where you need them.

Please contact the Corporate Governance Officer (ext. 2933) if you require assistance.

The table outlines will be removed from the document before it is published to the intranet or internet.

Community Intellectual Disabilities-Operational Policy.

Team Purpose

Relevant to: This policy is applicable to the Intellectual Disabilities Services provided by Powys Teaching Health Board (PTHB)

Introduction:

The terms used to describe people who have a learning disability have changed over time. Nurses in the UK identify as learning disability nurses and the policies and legislation related to people with learning disabilities also use this definition when referring to this service user group. In the academic community internationally, the term Intellectual Disability is used when referring to people with learning disabilities.

Services for adults with an Intellectual Disability in Powys are commissioned and provided by two statutory bodies: Powys Teaching Health Board and Powys County Council.

This operational policy sets out the operating principles of the Intellectual Disability service and outlines how to access health services provided by the community team for people with Intellectual Disabilities.

Statement of intent

The team is committed to working in partnership with service users, carers, statutory, independent and voluntary agencies to deliver a range of high quality services which enable service users to exercise their full rights as citizens, realize their potential and live a valued lifestyle in the community.

Principle

The Intellectual Disabilities Service follows the principles of the "All Wales Strategy" and "Fulfilling the Promise" (June 2011) framework.

In practice this means having exactly the same expectations of decent health, education, housing, safety and financial security, protection from harm, positive social relations and roles within family and community, employment opportunities, personal development, emotional well-being and civic rights as the non disabled population.

People with Intellectual Disabilities have a right to decide for themselves and to join in all decision-making which affect their lives, with support if necessary.

People with Intellectual Disabilities have access to the support of their families and the communities, of which they are part, and to general and specialist public services to improve their chosen quality of life.

Service Objectives

Provide and facilitate a good quality health service which:
Promotes choice and control through person-centered approaches and respects the viewpoints of families.

Focuses on the quality of the staff relationships with the person with an Intellectual Disability.

Sustains and monitors the package of care based on assessed needs of the individual.

Promote the use of reasonable adjustments across all health services so that they adequately support the needs of people with Intellectual Disabilities

Provide a collaborative service approach with Social Care, accommodation, education and leisure colleagues as needed

Comply with the key performance indicators outlined in the IMTP and the Joint Commissioning Framework.

Develop and expand the capacity of local services for people with Intellectual Disabilities to better understand and respond to behaviours which challenge.

To provide specialist services under tier 2 framework which will support primary mainstream practice as well as directly serve a small number of people with the most challenging needs

Provide and facilitate support for the person's general health and wellbeing using mainstream primary care services.

Epidemiological information

The prevalence of Intellectual Disability is probably between 1% and 3%, depending on the definition used (Whitaker, 2004). If the definition is based on IQ alone then the rate may be nearer to 3%, while if the

criterion of deficits in adaptive behaviour is also used, then the rate may be nearer to 1%.

There is clear evidence that due to medical advancements there has been a dramatic increase in the survival rates and life expectancies of those individuals with severe and complex Intellectual Disabilities. For example, the number of people 16-64 years and 65 years and over on learning disability registers in Wales have increased by 20% and 39% respectively since 1990 (Felce, Kerr, Perry, Hastings, Northway and Allen, 2005).

When considering those individuals in Powys who have a learning disability a significant proportion may not need to access the specialized Community Intellectual Disability Team or may only need to occasionally. Their needs in general can be met by generic primary, secondary and tertiary health services.

However, some individuals with an Intellectual Disability have specialist healthcare needs over and above those which can be met from generic/core health services.

Although not an exhaustive list such individuals may have needs that relate to:

Behaviour which challenges e.g. aggression, self-injury, destruction to property,

Difficulties associated with complex mental health issues or personality Disorders

Difficulties associated with offending behaviour

Difficulties associated with a diagnosis of Autistic Spectrum Disorder and Intellectual Disability

Difficulties associated with adverse life events e.g. complex bereavement reactions, or abuse

Significant difficulties that arise from complex health issues such as deficits in communication, sensory processing and adaptive functioning, multiple or complex physical health problems.

Epilepsy disorders

It is these individuals with specialist health needs who receive support from the health professionals within the team.

When considering national figures regarding the prevalence of specialist health needs studies suggest that between 12-17% of individuals with a learning disability engage in challenging behaviour (e.g. physical aggression, self-injury, destructive-ness towards the environment) and 40-60% of those will show more severe problems (National Assembly for Wales, 2001). It has been highlighted that between 25 - 40% of individuals with a learning disability will have mental health problems at some point in their life in comparison to about 25% of the general population (The Foundation for People with Intellectual Disabilities, 2003). 14-24% of individuals with a learning disability have a diagnosis of epilepsy (National Assembly for Wales, 2001).

Team Membership and Roles

Community Intellectual Disabilities Nurse

The role of the CIDN can be split into 3 distinct areas: clinical, educational and strategic, (Teasdale & Comber 2005)
The core clinical elements of the CIDN's role concentrates on health promotion and developing individual care plans that are intended to meet the service user's needs in a number of key clinical areas these being:

- Behaviour which challenges, including Autism,
- Epilepsy,
- Mental Health, including Dementia – Referrals are managed by Clinical Care Pathways
- Complex Health

Advising and educating other service providers, individuals and carers to meet the healthcare needs of people with Intellectual Disabilities.

Facilitating the provision of health care that is beyond the scope of generic primary services.

Providing training in areas including Positive Behaviour Support, Positive Behaviour Management, Epilepsy Training.

Issues associated with ageing i.e. Dementia, transition into adulthood.

Working with individuals and their families to cope with adverse life events.

Creating positive images for people who have a learning disability.

Influencing positive outcomes for service users in all aspects of health care.

Educating and supporting Primary services of the needs of people with an Intellectual Disability.

Team Leader
The role involves working with complex cases and managing the team members operationally day to day and providing clinical supervision to nurses within the team.

Health Care Assistant
The role of the Health Care assistant is supporting people with their goals based within their home environments or local community. Activities of support vary from daily living skills, teaching of independent life skills to assistance with accessing community, supporting completion of the "traffic lights" documentation. It is the HCA who will implement any intervention prescribed by the Registered Nurse and who will monitor under supervision.

Complex Care Practitioner
The role of the Complex Care Practitioner is to

Support the (CHC) designated care coordinators in the assessment of people who could be eligible for health funding from a variety of funding streams.

Undertake training of Health and Social Care staff in the Primary need approach (National CHC framework) and other locally agreed pathways that are identified to secure funding.

Chair MDT meetings to complete Decision Support Tool.

Monitor and review patients in receipt of Health Funding.

Undertake relevant checks of possible placements.

Participate in Commissioning activities as part of the All Wales arrangements.

Social Worker Disabilities Team.
Social Workers are trained to work with individuals, families, groups and communities, to help them secure their rights, promote their interests and combat social exclusion. The social workers in the Disability Team support adults not only with Intellectual Disabilities but people with a

physical disability and vulnerable adults who appear to have social needs.
Social workers in the Disability Team assess the needs of service users and their carers, organize service provision to meet the eligible needs, implement services where appropriate, monitor and review and amend person centered care plans as required.

Occupational Therapist/ Occupational Therapist Techniques
Occupational Therapists offer a range of specialist assessments and interventions in relation to the complex needs of people with Intellectual Disabilities, which includes: sensory integration disorder, autism, profound and multiple disabilities conditions associated with Intellectual Disabilities e.g. dementia, behaviours which challenge.

Referrals to the Intellectual Disability Team, allocated to the occupational therapist, will relate to the effect of the service user's disability upon their occupational performance. A therapist will assess the service user's motivation; their daily pattern of self-care, leisure and productivity; and the impact of the environment on their occupational performance.

Clinical Psychologist
The Clinical Psychologist within the team aims to alleviate Psychological distress and promote psychological well-being by working at a number of levels including;

Direct Clinical Work with Service Users, Families and Carers
Assessment for Eligibility
Advice, Consultation and Supervision to Other Professionals
Service Development
Teaching and Training

Assistant Psychologist
The Assistant Psychologist will assist a qualified Clinical Psychologist. They will be responsible for the psychological aspects of the multi-disciplinary/multi-agency care provided for adults, liaising with and providing an advisory service for a wide range of voluntary and statutory organisations.

Consultant Psychiatrist
Medical staff specialise in the assessment, diagnosis, and treatment of psychiatric and neuropsychiatry conditions which may include behavioural, emotional and psychological problems in people with an Intellectual Disability. Psychiatrist acts as the Community Responsible Medical Officer for individuals in the community. They also advise on

Epilepsy and can directly refer to the tertiary Epilepsy clinic if appropriate.

Clinical Behaviour Specialist
The Clinical Behavioural Specialist provides expertise in order to support people with an intellectual disability who engage in behaviours that challenge and may also present with mental health problems. Their clinical activities involve:

Co-coordinating, devising and implementing specialist multi-faceted assessments, formulations and support plans both pro-active and re-active.

Working in partnership with service users, carers and services to promote a seamless and holistic approach to meet the needs of the service users.

Provides support, advice, consultation and education for individuals, carers and service providers.

Provides specialist advice to practitioners on PBM ABMU model of preventing and responding to behaviours which challenge in order to improve knowledge and practice and reduce the reliance and use of restrictive interventions.

Co ordinates the delivery of PBM ABMU training throughout Powys for Intellectual Disability Services and maintains training records for audit.

Physiotherapy
The physiotherapists' role is management of long-term conditions. This involves education and close links with family and carers to understand the nature of the conditions. Advise on individual management programs.

On occasion the physiotherapist may recommend specific treatment sessions such as hydrotherapy, rebound therapy and movement techniques. Specialist Physiotherapists role is also to be actively involved in health promotion. This may include walking projects, gym sessions, swimming, cycling groups, horse riding etc. Many Physiotherapists are also involved in multi-disciplinary health screening to aid early detection and treatment of health problems.

Speech and Language Therapy
The Speech and Language therapist role is to assess, manage and treat clients with communication issues to promote independence, choice, inclusion and rights.

Assess, manage and advice clients with eating and drinking issues to reduce risks of aspiration, hospital admissions, potential fatality.

SLTs work in partnership with clients, carers, other health and social care professionals. Service can be delivered directly and indirectly and involves education and training to promote health, well being and inclusion of people with Intellectual Disabilities.

Team Administration
An administration team supports all administrative and secretarial aspects of the CLDT.

Usual hours of operation
The CLDT health services are available Monday to Friday 9:00am – 5:00pm
Outside normal office hours, emergency assistance should be sought via the Primary Health Care Team, or via the Social Services out of hours service.

Eligibility Criteria
Eligibility for specialist health services are dependent upon a diagnosis of Intellectual Disability.

The criteria for a diagnosis of Intellectual Disability are set out in classifications such as ICD-10 and DSM-IV. Both systems set very similar criteria:

Significantly sub-average intellectual functioning. This is often operationalized as a score of two standard deviations or more below the mean on a standardised intelligence test; this means an IQ of below 70

Significant limitations in adaptive behaviour/social competence/adaptive or social functioning. This means impairment in areas such as self-care, domestic and community skills, functional academic skills, work skills, etc. Levels of social competence can be measured using a variety of assessment tools

Onset of impairments in intellectual and social functioning occurs before the age of 18 years. Establishing whether this criterion is met would require a re-view of the person's developmental, psychiatric and medical history. Information would usually be gathered from a review of records and from inter-views with the person, their parents or other family members.

All three criteria must be met for a diagnosis of Intellectual Disability to be made.

Levels of adaptive functioning in particular can vary at different times in the life of an individual. Although onset of impairment needs to have occurred before the age of 18 years, diagnosis also requires impairments to be evident in current levels of functioning.

If a clear diagnosis of Intellectual Disability cannot be made a screening appointment will be offered to gather further information on which to base a decision. IQ assessments should only be undertaken by appropriately trained Psychologists. Assessments of social functioning and reviews of developmental, psychiatric and medical history may be compiled by any appropriately trained professional, working within locally agreed guidelines.

When there is insufficient information from existing records, the individual may re-quire further assessments to be undertaken, or the assessors may request further information from the referrer.

Individuals in crisis cannot be accurately assessed, and often will only be assessed when the person /situation is stable. Until this point the individual will not be formally accepted into Intellectual Disability services, although advice will be offered if appropriate. The individual should not be left without a service and discussions with any currently involved professionals will take place so that advice can be given. The individual will remain with mainstream services until eligibility can be firmly established, although there may be some joint working whilst eligibility is being ascertained.

It is acknowledged that conducting a standardized cognitive assessment to determine eligibility to the service is not always helpful and these will not be carried out routinely for this purpose; however, it will be required when there is insufficient evidence on which to base a decision. The main purpose of any assessment of eligibility is to gather enough information from the referrer and other sources in relation to the three elements of the definition to form a judgment as to whether there is enough evidence to satisfy each criterion.

When differing views are irreconcilable, the decision will rest with the Consultant Psychiatrist / Team manager. Disputed decisions may be referred to the Head of Intellectual Disability Services for adjudication.

With regard to existing clients, there may be a small number of individuals who have been in receipt of specialist Intellectual Disability services for some years, but for whom current assessment indicates lack

of eligibility. In such cases, history, needs and individual preferences should be taken into account in determining which services are the most appropriate.

Anyone can make a referral to the CIDT, and where possible the client's consent for the referral will be established and recorded. There are two separate referral meetings, one for North Powys and the other for South Powys. The North referral meeting is at Newtown and the South Referral meeting is at Bronllys and both the meetings are on a fortnightly basis. No health worker should be undertaking activities without an appropriate referral which has been through the referral process.

Urgent referrals can be allocated outside of the referral meeting. Any referrals dealt with outside the referral meeting are to be fed back at the next scheduled meeting and referral documentation recorded and filed in the normal way.

Non urgent referrals will be discussed by the MDT at the two weekly referral / team meeting and allocated within five working days. Where there is evidence of in-creased risk this may be deemed as an urgent referral, and will be allocated for a tri-age assessment as soon as is practicable.

Engagement with Primary care, Secondary and Mental Health Services

People with Intellectual Disabilities have the same right of access to generic health services as other people. The CIDT can facilitate access to these services with appropriate support and by joint working with other professionals.

Mental Capacity

The CIDT adhere to the principles of the Mental Capacity Act 2005. We assume service users have the capacity to make their own decisions unless there is evidence to the contrary. A service user with capacity who chooses not to receive a service from the CIDT will be given contact information so that they can engage with services should they choose it.

Information Sharing

Service users may have contact with more than one organisation and this may re-quire the sharing of minimum, relevant and appropriate personal identifiable information between organizations and their practitioners. Powys CIDT follows the relevant guidelines and legislation relating to information sharing.

All service users must be informed of the circumstances in which their consent will be required before their personal identifiable information may be shared. Service users have the right to object to information they provide in confidence being disclosed to a third party, and should be supported to do so by a carer or independent advocate if necessary. This applies even if the third party is someone providing essential care.

Service user access to records

Access to information must be restricted to authorised users only and must be protected by appropriate controls. The CILD follow current procedures and legislation relating to Data Protection, Freedom of Information and Confidentiality.

Care Co-ordination

Care Co-ordination is a term that is used as part of the legal requirement under the Mental Health Measure (WAG 2010), and the Care Coordination and Care Treatment Planning regulations (WAG 2011), to describe a relevant person who leads on a person's care plan. However under the above legislation there are specific roles and responsibilities that the identified person is required to perform.
Care co-ordination under CTP

Part 2 of the Mental Health (Wales) Measure 2010 places duties on Service Providers – Local Health Boards and Local Authorities in Wales – to act in a coordinated manner to improve the effectiveness of the Mental Health Services they provide to an individual.

Section 14 of the Measure requires that the "relevant Mental Health Service Provider" for a relevant patient must appoint an individual to be the relevant Patient's Care coordinator and to undertake the functions required of them.

Section 18 of the Mental Health (Wales) Measure 2010 and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011 require that Care and Treatment Plans be provided for service users of all ages who have been assessed as requiring care and treatment within secondary Mental Health Services.

The term Care Co-ordinator refers to the person allocated to an individual that is receiving secondary Mental Health Services, who will:-

Work collaboratively with the relevant client and Mental Health Service Providers with a view to agreeing outcomes which those Mental Health Services are designed to achieve.

Ensure that a Care and Treatment Plan is developed and written.

Ensure that the Care and Treatment Plan is reviewed and revised.

Provide advice to Service Providers on the effective co-ordination of care which is delivered.

Keep in touch with the person / family / carer where appropriate. The Mental Health (Wales) Measure 2010 places a duty on the 'relevant Mental Health Service Provider' to appoint a Care Co-ordinator as soon as is reasonably practical and in all but exceptional circumstances within 14 days from when an individual is accepted into secondary Mental Health Services.

Caseload management and clinical supervision

Caseload management and clinical supervision are an important aspect for staff in their daily work. Caseloads will be actively managed by the Team Leads in consultation with the member of staff's Professional Lead (where appropriate).

Professionals within the CLDT are responsible for their individual caseloads in line with their professional registration requirements, and should inform the team man-ager/lead of any difficulties they may have.

All staff will receive regular supervision and an annual Personal Appraisal Development Review (PADR) which will ensure,

Positive outcomes and achievements are recognised.

Individual workloads are managed effectively.

Individual stress levels can be monitored and appropriate action taken to address

Shared decisions can be taken about long-term working and the need for ending an episode of care/discharging client.

Training development needs will be identified and implemented.

Quality of work audit completed (Standards to be developed).

Revalidation support for the Nursing Staff.

Compliance to Mandatory and Statutory Training

(For further information refer to the Powys clinical supervision policy)

Discharges

Discharges may not mean that the person is fully closed to the team as discharges have four stages to reach that point;-

Clinical discharge open to review, this means that a person is discharged from a clinician's case load as the agreed work has been completed, but will remain open to the local authority as a statutory review of services is required.

Clinical discharge with review, this means a person is being discharged from a health clinician's case load but will remain open to the health team for review; such as CHC funded packages of care, or where someone's epilepsy is stable but requires an annual review.

Closed to team, which means that the client is fully discharged from the CIDT, but remains on the ID register if eligible. However if a client is under part 3 of the mental Health Measure they have the right to refer themselves back to the service.

Governance

Compliance must be made with the principles and standards of corporate governance relevant to Powys Teaching Health Board.

Staff Accountability

Staffing within each CIDT consists of multi-disciplinary professionals who, whilst retaining professional accountability through appropriate professional registrations and clinical supervision arrangements will work together to provide coordinated support plans for individuals / carers, whilst remaining accountable to the CIDT leader. Staff will receive management support from the team lead and professional support from appropriate professional/clinical leads. The professional leads are expected to take part in the annual appraisal and staff development process. The following have been identified:

Nursing – Team Leader/Intellectual Disability Lead Nurse through to the Director of Nursing
Psychology-Team Leader/Head of Therapies through to the Therapies Director
Psychiatry-Team Leader/ Medical Director
Occupational Therapy – Occupational Therapy Lead through to the Therapies Director
Speech and Language Therapy – Speech and Language Therapy Lead
Physiotherapy – Physiotherapy Lead through to the Therapies Director
Administration – Administration Lead.

All team members will be professionally responsible for individuals under their care and for recognising the limits of their own competencies and job description. This includes the responsibility to seek appropriate supervision both within the team and within their professional body.