SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	05/MHLD/0006
Service	**Community Learning Disability Teams (Health Component)**
Commissioner Lead	**Dorset Clinical Commissioning Group – MH & LD CCP**
Provider Lead	Specialist Service Manager, Children and Adult's Learning Disability Services
Period	1st April 2014 to 31st March 2016
Date of Review	To be Agreed

1. Population Needs

1.1 National/local context and evidence base

The service will be provided in line with current and any emerging guidance and/or policy regarding the management of people with a learning disability. Documents referred to in the development of this specification include:

i. Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD), Dept. of Health, 2013
ii. Improving the Health and Wellbeing of people with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs), October 2012
iii. Winterbourne View – report of the investigation which identified serious concerns in relation to the care, welfare and safeguarding of people who use services from abuse and the quality of service provision. Care Quality Commission - July 2011
iv. Strengthening the Commitment, the report of the UK Modernising Learning Disabilities Nursing Review, 2012
v. Developing better commissioning for individuals with behaviour that challenges services- a scoping exercise. Tizard Centre and Challenging Behaviour Foundation. 2010
vi. Raising our Sights: services for adults with profound intellectual and multiple disabilities. Tizard Centre, 2010
vii. Personalisation through Person Centred Planning. Department of Health. 2010
viii. Improving the health and wellbeing of people with learning disabilities – world class commissioning. Department of Health, 2009
ix. Working Together for Change: using person centred information for commissioning. Department of Health, 2009
x. Valuing People Now: a new three year strategy for people with learning disabilities. Department of Health, 2009
xi. Autism Act, 2009
xii. Person centred commissioning – now: a pathway approach to commissioning learning disability support. IDeA. 2008
xiii. Healthcare for All, 2008
xiv. Carers Act, 2008

xv. A Life Like Any Other Human Rights of Adults with Learning Disabilities, 2008
xvi. Services for people with learning disabilities and challenging behaviour or mental health needs (Revised edition) Department of Health, 2007
xvii. Commissioning Specialist Adult Learning Disability Health Services: Good Practice Guidance. Department of Health, 2007
xviii. Good Practice in Learning Disability Nursing, Dept of Health, 2007
xix. 'Our Health, Our Care, Our Say', 2006
xx. Relevant NICE Guidance

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

2.2.1 People with a learning disability are supported to have greater independence and social functioning.
2.2.2 Annual Health Checks are offered routinely and the take up of these checks monitored.
2.2.3 People with a learning disability are supported to have optimal psychological and emotional wellbeing.
2.2.2 Improved access to mainstream health services for individuals with learning disability.
2.2.3 Families and carers of individuals with a learning disability are able to access support to meet their needs
2.2.4 Care providers who are commissioned to provide care and support have access to training and support to enable them to meet the specific needs of individuals.
2.2.5 All adults with Learning Disability will be offered and supported to have a Yellow Health Book
2.2.6 Eligible service users are offered and supported to access relevant screening programmes
2.2.7 All eligible service users have an annual CHC review.
2.2.8 All carers are offered a carer assessment to support the identification of needs and development of relevant action plans.
2.2.9 Support should be proactive to meet the healthcare needs of the individual, to reduce the risk of crisis and subsequent unscheduled hospital admissions.

3 Scope

3.1 Aims and objectives of service

3.1.1 The aim of the CLDT is to promote health and wellbeing, independence and a better quality of life for adults with a learning disability by:

i. Delivering the principles set out in key government policy and papers, and in legislation, with particular reference to the Department of Health's document 'Valuing People Now' (2009)
ii. Adhering to the principles of, and implementing, Person Centred Planning (PCP), that focuses on inclusion, choice, equity, community participation, partnership, rights and promotes recovery and independence
iii. In conjunction with social care colleagues, providing a high quality, health and social care service, and evidence-based treatment and care for service users
iv. Providing support that enables each service user to achieve their individual goals and aspirations
v. Placing good communication with service users, carers and professional colleagues at the core of its operations, and in particular using appropriate, accessible methods and formats to communicate with service users
vi. Informing service users and carers about options for support and treatment and hence, enable service provision and treatments to be guided by service user choice
vii. Completing carers assessments and providing information, support and advice to carers
viii. Ensuring all adults with a Learning Disability are offered and supported to have a Yellow Health Book and are able to access services that meet health needs as identified in their Health Action Plans.
ix. Assisting service users to access a range of mainstream services, (this list is not exhaustive) e.g.
    - Primary health care
    - Acute and specialist health care services
    - Continuing Health Care/Personal Health Budget services
    - Advocacy/IMCA
    - Housing
    - Employment or meaningful occupation
    - Post 18 years education
    - Appropriate leisure opportunities
x. Ensuring all eligible service users are offered relevant screening programmes including dementia
xi. Ensuring all eligible service users have an annual CHC review.
xii. Supporting transition work from children's to adult services
xiii. Promoting physical and mental health and wellbeing (Health Promotion)
xiv. Ensuring that care and support provided by the team is offered in accessible locations and in a timely manner
xv. Reviewing care and support provided by other providers, including third sector organisations, to ensure good quality and that the agreed care is being delivered
xvi. The promotion of an environment and culture that safeguards vulnerable service users in all organisations
xvii. Support the identified needs of carers and families
xviii. Joint working with the Adult Learning Disability Intensive Support Team to identify and respond to more severe, complex and risky behaviours which might threaten the viability of the person continuing to live at home

3.2 Service description/care pathway

3.2.1 The health components of the service will be delivered via an integrated management approach with social care provision and governed by an agreed operational policy between health and social care providers. The operational policy will include the relevant governance processes for ensuring successful delivery of all requirements associated with an integrated health and social care approach.

3.2.2 The service will respect the rights of every service user, regardless of age, race, gender, sexuality, religion or disability and provide a service where service users are supported to reach their full potential, physically, emotionally, socially and psychologically and to be as independent as possible.

3.2.3 Staff will support a multidisciplinary team approach to assessment of need which will result in the development of care plans which focus on achieving the best outcome for an individual with a learning disability. This will also include meeting the needs of carers and/or families.

3.2.4 Responsibilities of health practitioners within the integrated service include/require:

i. Responsibility for assessing health needs and provision/facilitation of health related interventions that support a joint health and social care approach to the management of individuals accessing the service.
ii. Support the maintenance of an accurate database of active and dormant cases known to the CLDT. Information related to each individual should include individual characteristics (eg highly challenging behaviours, level of risk) and the details of the registered GP.
iii. Working closely and in conjunction with the Intensive Support Team in the management of people with severe and complex behaviour when in crisis, and additional intensive support is required. Also continue to provide an allocated case worker, with clear handover arrangements
iv. Carry out multidisciplinary assessments in a variety of settings, taking into account risk, and service user choice in line with the policies of DHUFT and each Local Authority as appropriate.
v. Working in partnership with service users and carers to agree an assessment of their health needs and the development of a Person Centred Support Plan, including a Health Action Plan to meet those needs.
vi. Ensuring that service users and carers have the necessary information, in an appropriate format, to allow them to make meaningful choices about the services, care and support options, and therapeutic interventions available to them
vii. Provision of therapeutic interventions, as and when appropriate, including nursing support, occupational therapy, physiotherapy, medication management, management of epilepsy, and psychological therapies.
viii. Supporting individuals known to the service who have epilepsy by working closely with the specialist epilepsy service to ensure individuals have a documented care plan that outlines their epilepsy management plan. The service will also support and oversee changes to prescribed medication recommended by the specialist epilepsy service.
ix. Ensuring that all individuals with a learning disability with complex needs have

an identified local Care Coordinator who will continue to support them irrespective of where placed.

x. Ensuring that pro-active plans are developed for individuals with long term health problems including identification of risks, ways of managing the identified risks, a crisis plan and clear guidance about when hospital admissions are appropriate.

xi. Working with the service user/carers to develop, implement, monitor and review a care and recovery plan in accordance with the Assessment and Person Centred Care Planning Policy and Care Programme Approach (CPA). The minimum review period under CPA is annually but good practice suggests 6 monthly reviews or more regularly dependent on the needs of the individual.

xii. Link with and refer to Learning Disability Speech and Language Therapy services and LD psychology services as appropriate.

xiii. Link and work in partnership with palliative care teams where appropriate to ensure the needs of people with Learning Disability are adequately understood and met.

xiv. Undertake risk assessments and risk management planning in line with agreed operational policies.

xv. Adhere to the Dorset Wide Multi Agency Safeguarding Adults Policy and Procedures and support adult safeguarding investigations as necessary

xvi. Ensure all service users have access to advocacy services or where appropriate IMCA services.

xvii. Implement Health Action Planning (HAP) in partnership with colleagues from Primary Care, acute care providers and community health services, ensuring that Yellow Health Books are maintained and reviewed regularly.

xviii. Establish a named link nurse for acute hospitals, community hospitals and mental health services ensuring servicer users' needs are communicated effectively.

xix. Establish a named Link Nurse with each GP practice and establish links with GP Locality groups to facilitate pro-active management of health needs including annual health checks and screening programmes.

xx. Assist GP Practices to maintain accurate Learning Disability registers and correct read coding.

xxi. Assist service users to access physical health screening programmes, e.g. annual health checks and cancer screening by working in partnership with GP Practices.

xxii. Work with primary care to ensure individual carers of people with learning disability are registered as carers on the GP practice register.

xxiii. In recognition of the higher associated risk of developing dementia, specifically for people with Downs Syndrome, develop close working relationships with memory services to facilitate assessment and diagnosis of dementia. The registered GP will be notified of all new diagnosis of dementia. 8Baseline screening of individuals with Downs Syndrome will be carried out from the age of 30 years.

xxiv. Work with and support children's services to provide assessment and support to individuals who are moving towards transition.

xxv. Collect relevant data as required by Commissioners to meet local and national performance indicators to include the completion of audits and surveys to improve practice and steer service delivery.

xxvi. Adhere to best practice principles in patient administration and information governance in line with organisational policies.

xxvii. Health Practitioners to act as Case Manager for Continuing Health Care (CHC)

eligible service users undertaking reviews as per agreed CHC protocols

xxviii. Support individuals with a LD who have come in to contact with the Criminal Justice System (CJS)

xxix. Ensure that staff are available as appropriate adults for service users when required

xxx. Participate in mental health assessments for their service users where required.

xxxi. Where it applies, ensure statutory requirements associated with Section 117 cases. The S117 after-care plan should be regularly reviewed and the ongoing S117 requirement clearly documented. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed that it is no longer necessary. Where a service user is subject to S117, consideration should be given to discharging the Service User from S117, at the same time they are discharged from CPA/standard care.

xxxii. Liaise with the Clinical Commissioning Group Health Facilitator to overcome any barriers associated with meeting the health needs of the population with a learning disability.

3.2.5 The services will be provided in settings appropriate to the needs of the individual. These will include:

i. The service user's own home/normal place of residence (including residential home)
ii. Day care or out-patient settings
iii. The CLDT base, where appropriate facilities exist
iv. Hospital settings
v. Primary Health Care settings

3.2.6 Health staff will operate a service during normal working hours of Monday – Friday 9.00am – 5.00pm

3.2.7 Referral to the CLDT will be made via one point of access as appropriate to each of the three Local Authority areas. Referral information should include:

i. Date of referral
ii. Referral Source details
iii. The Service users name, date of birth and, where possible, the Integrated Electronic Service User Record (IESUR) reference number.
iv. The reason for the referral
v. The urgency of the referral – emergency, urgent or routine
vi. Diagnosis if known
vii. Details of any behaviour that is causing concern
viii. Interventions that have already been used and the outcome
ix. Carers contact details
x. Identified risks
xi. Other agencies involved including GP

All other referrals received by any of the health professionals will also be channelled through the common access point for each CLDT.
Identified members of the team will be allocated the referral to undertake the initial screening and assessment.

3.2.8 Process for Case Closure
The decision to close a case file should be jointly made by the relevant multi-

disciplinary team members, service user and, where appropriate, the carer. Such decisions should be made in advance of the case closure. All decisions should be recorded in the health progress notes in line with organisational policy and on the relevant Social Services IT system.

Prior to closure all Service Users should have a Person Centred Care and Support plan completed which includes:

i. Diagnosis
ii. Current and planned future treatment
iii. Current risk assessment
iv. Documenting information and advice given to the service user and carer
v. Information on how to re-access the service
vi. Recording of Care and Support Plan on electronic record system
vii. Personal Budget for social care services

A copy of the care plan will be provided to the Service User's GP.

3.3 Any acceptance and exclusion criteria and thresholds

3.3.1 The service will operate an open referral system accepting self-referrals, referrals from carers, GPs, and other agencies representing an individual.

3.3.2 The service will use the following definition from Valuing People (DH, 2001) that describes having a learning disability as including the presence of:

- *A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;*
- *A reduced ability to cope independently (impaired social functioning);*
- *and which started before adulthood, with a lasting effect on development.*

This encompasses a broad range of disabilities. Having an IQ of 70 or below, is not sufficient a reason for deciding whether a person should be provided with health and social care support. Further assessment of social functioning and communication skills should also be taken into account when determining need.

3.3.3 The service will be available to anyone who is over the age of 18 years and who is registered with a Dorset CCG GP or is a resident in the Bournemouth, Dorset or Poole area

3.3.4 The service will work with children's services to manage individuals aged 14 and over in transition where the young person meets the other referral criteria.

3.4 Interdependence with other services/providers

3.4.1 The CLDT services will be delivered by a multidisciplinary team, providing a seamless service working jointly with other services according to the needs of the individual. This will be achieved by:

i. Working in partnership with individuals and their families
ii. Joint working with other CLDTs across Bournemouth, Poole and Dorset
iii. Working in partnership with other services, including (this list is not exhaustive):

- Intensive Support Team
- Primary Care
- Acute Care Providers
- Community Health Services
- Community Mental Health Teams (CMHTs)
- Mental Health Crisis Teams and in-patient treatment units
- Child and Adolescent Mental Health Services (CAMHS)
- Care and Support Providers
- Education services
- Local Authorities
- Advocacy Services
- Voluntary Agencies
- Criminal Justice System (CJS)
- Police
- Housing

4 Applicable Service Standards

4.1 Applicable national standards (eg NICE)

i. Mental Capacity Act (2005) Code of Practice,
ii. Deprivation of Liberties Safeguards (DoLS) (DH, 2007)
iii. Mental Health Act, (DH, 1983, revised 2007).
iv. Safeguarding Adults: The Role of Health Service Practitioners (DH, March 2011)
v. Applicable NICE Guidance
vi. Transforming Care – a National response to Winterbourne View Hospital
vii. Self-Assessment Framework

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

i. The Nursing and Midwifery Council – The Code: Standards of conduct, performance and ethics for nurses and midwives.
ii. The Health and Care Professions Council code of conduct.
iii. Meeting the health needs of people with learning disabilities (RCN 2011)

4.3 Applicable local standards

i. Compliance with multi-agency protocol for case management of people with a learning disability whose care is health or joint health and social care funded.

5 Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.1.1 **Emergency Referrals:** Emergency Referrals are deemed to require a response on the same day. This is appropriate for those who may put themselves or others at risk are at risk of significant harm from others or where current support arrangements have broken down leaving them at risk. A person referred in an emergency will be screened, allocated and seen on the day of referral. This process may include an emergency referral to the Intensive Support Team.

5.1.2 **Urgent Referrals:** Seen within 5 working days, urgent referrals are appropriate for

people whose current situation is at risk of breaking down imminently if alternative arrangements or services are not allocated to support them.

5.1.3 **Routine referrals:** Will be seen within 28 working days

5.1.4 Review meetings will be held at least monthly or by local agreement with the Intensive Support Team to update treatment plans, behavioural support plans and discharge plans.

5.1.5 All staff will participate in Continuing Professional Development (CPD) to enable the implementation of evidence-based practice.

5.1.6 All staff will complete all mandatory training requirements including safeguarding children and adults training; Mental Capacity Act training; and Deprivation of Liberty Safeguards training.

5.1.7 The service will undertake patient/service user experience surveys with active caseload members on a 6 monthly basis in addition to ensuring that patient/service user surveys are undertaken with service users at the point of discharge.

5.1.8 The service will maintain a record of all:

i. Compliments and Complaints (including summary of issues raised)
ii. Serious incidents
iii. Safeguarding alerts raised
iv. Yellow books offered and accepted.

5.1.9 The service will develop an audit programme to include:

i. Health Action Plans
ii. Compliance with usage of yellow health books
iii. Monitoring of database completion of active/dormant cases

5.1.10 All staff will receive monthly management supervision.

5.1.11 All staff will have an annual Personal Development Review (PDR) which will identify training and development needs.

5.1.12 All staff will have access to and receive regular clinical supervision from a suitably qualified professional.

5.1.13 The service will submit a quarterly quality report split by team including:

i. An audit schedule and narrative associated with any previously completed audits.
ii. A summary of results of patient/service user experience surveys.
iii. A summary of all complaints / serious incidents / safeguarding alerts
iv. The number of yellow health books offered and accepted
v. A narrative regarding the maintenance of the database of active/dormant cases known to the service
vi. Staff compliance rates for mandatory training requirements
vii. A narrative on the assessment and support being provided to individuals who are moving towards transition
viii. Community LD Service compliance with the Care Programme Approach (CPA)

5.1.14 The service will work together with the relevant Local Authority to ensure that risks arising in the provision of the Services are identified and managed and addressed in the most appropriate way. DHUFT will take responsibility for the risk management procedure and will co-operate fully with the relevant Local Authority Health and Safety Manager in respect of their staff.

5.1.15 All information systems used by the service will be compliant with national information governance standards and staff will have completed the required

information governance training.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6 Location of Provider Premises

6.1 The Provider's Premises are located at:

6.1.1 The teams will be based as follows:

Dorset:

i. Weymouth and Portland - Weymouth
ii. West Dorset - Bridport and Sturminster Newton
iii. South and East Dorset - Purbeck, Ferndown and Christchurch

Poole

i. Delphwood – Canford Heath

Bournemouth

i. Hillcrest – Ensbury Park

6.1.2 The service described in this specification will operate as part of an integrated health and social care team governed by jointly agreed operational policies.

7 Individual Service User Placement

7.1