SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	**05/MHLD/0007**
Service	**Intensive Support Team (IST) – Learning Disability Services**
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 policy regarding the management of people with a learning disability. Documents referred to in the development of this specification include:

i. Services for people with learning disabilities and challenging behaviour or mental health needs (Revised edition) Department of Health, 2007
ii. Commissioning Specialist Adult Learning Disability Health Services: Good Practice Guidance. Department of Health, 2007
iii. Guidance for commissioners of mental health services for people with Learning Disabilities –Joint commissioning panel for mental health May 2013
iv. Person centred commissioning – now: a pathway approach to commissioning learning disability support. IDeA. 2008
v. Improving the health and wellbeing of people with learning disabilities – world class commissioning. Department of Health, 2009
vi. Working Together for Change: using person centred information for commissioning. Department of Health, 2009
vii. Valuing People Now: a new three year strategy for people with learning disabilities. Department of Health, 2009
viii. Developing better commissioning for individuals with behaviour that challenges services- a scoping exercise. Tizard Centre and Challenging Behaviour Foundation. 2010
ix. Raising our Sights: services for adults with profound intellectual and multiple disabilities. Tizard Centre, 2010
x. Personalisation through Person Centred Planning. Department of Health. 2010
xi. 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
xii. 'Our Health, Our Care, Our Say', 2006
xiii. Healthcare for All, 2008
xiv. A Life Like Any Other- Human Rights of Adults with Learning Disabilities, 2008

xv. NICE Guidance
xvi. Carers Act, 2008.
xvii. Autism Act, 2009
xviii. Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD), Dept. of Health, 2013
xix. Strengthening the Commitment, the report of the UK Modernising Learning Disabilities Nursing Review, 2012
xx. Good Practice in Learning Disability Nursing, Dept of Health, 2007
xxi. Improving the Health and Wellbeing of people with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs), October 2012

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 complex learning disabilities are managed and maintained in safe and appropriate placements according to their presenting needs.
2.2.2 Individuals are offered local placements and support packages thereby reducing the need for out of area placements
2.2.3 Individuals in out of area placements are supported to work towards returning to locally based support packages.
2.2.4 A proactive and intensive person centred approach to individuals with a Learning Disability prevents a crisis episode/placement breakdown and enables individuals to be supported in or near home.
2.2.5 The needs of carers are identified and relevant action plans developed.
2.2.6 Care providers are trained and competent to meet the specific needs of individuals placed in their care.
2.2.7 Unscheduled hospital admissions are prevented.

3 Scope

3.1 Aims and objectives of service

3.1.1 The aim of the IST is to provide a highly specialised service locally that can support good mainstream practice as well as working directly with a small number of people with the most challenging needs.
This includes:

i. Providing intensive support for those with more complex needs including those who have additional mental health needs or a history and/or risk of offending.
ii. Offering (through consultancy and preventative and proactive working) rapid and intensive support to ensure, as far as is reasonably practicable, that a service user remains in their own home
iii. Joint working with the Adult Community Learning Disabilities Teams (CLDTs) to identify and respond to more severe, complex and risky behaviours which might threaten the viability of the person continuing to live at home.
iv. To work closely with the Mental Health Crisis and Home Treatment Response Team in the management of people with Learning disabilities who have mental health needs.
v. Facilitating transition to other services, including the CLDTs as and when appropriate, with joint working when needed
vi. Completing risk assessment and risk management plans to support individuals safely in community settings
vii. Using a Person Centred Planning approach in the completion of comprehensive, evidence based assessments, and reviews that enable people in out of area placements to return to their home area as soon as possible. This will include designing and supporting alternative local services, if needed, in conjunction with commissioners.
viii. Participating in and supporting adherence to the care programme approach (CPA)
ix. Support the identified needs of carers and families

3.2 Service description/care pathway

3.2.1 The service will predominantly provide support to the CLDT to manage an individual's complex needs or arising individual crises. 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.

3.2.2 The service will:

i. Work with those people whose behaviour presents the most serious challenges to services
ii. Work in partnership with the CLDT when required to support young people in transition, aged over 14 years, when the young person meets the other referral criteria
iii. Ensure equitable and timely access to services

iv. Provide enhanced individualised community-based assessment and treatment alongside integrated CLDTs and facilitate joint working where indicated.
v. Facilitate assessment based on a framework of positive behaviour support that result in a documented individualised behaviour support plan that includes:
    - A description of the person's challenging behaviour
    - A summary of the most probable reasons underlying the persons challenging behaviour
    - Proactive strategies
    - Reactive strategies
    - Monitoring and review arrangements
    - Implementation arrangements
vi. Be responsible for facilitating the implementation, monitoring and evaluation of the individualised behaviour support plan.
vii. Be committed to achieving outcomes based on Valuing People principles and adhere to the process of Person Centred Planning and Health Action Planning
viii. Promote the use of Positive Behaviour Support and non-aversive techniques by staff.
ix. Be provided in settings appropriate to the needs of the individual. This may be in the in the person's own home, day service or other place that the person attends as part of their day to day life.
x. Work in partnership with care and support providers to share specialist knowledge and skills, and to help managers to lead their staff in the provision of effective local services based on individuals specific needs.
xi. Provide in-reach support to people with a Learning Disability with mental health needs who have required an admission to mainstream mental health services
xii. Provide in-reach support to people with a Learning Disability with acute medical needs who have required admission to mainstream acute general hospital services.
xiii. Provide in-reach support to an individual who has a learning disability and whose behaviour has brought them into contact with the Criminal Justice System, this will include liaising with the pan Dorset Custody and Court Advice, Liaison and Diversion Service as necessary.
xiv. Facilitate the return of individuals from out of area placements by carrying out a regular review at least on a six monthly basis and work jointly with the provider in the development of a care and treatment plan and service to meet their individual needs.
xv. Respond to requests from Continuing Healthcare (CHC) to monitor and review individuals with a Learning Disability who have been placed out of area due to their complex needs.
xvi. Provide clinical supervision across all areas and the availability of specialist advice across all teams.
xvii. Be available to act as an appropriate adult when the individual is known to the Intensive Support Team.
xviii. Support carers and/or families by identifying their needs through thorough assessment processes such as Person Centred Plans, Care Needs Assessments and using the Care Programme Approach (CPA); and devising the necessary action plans to meet those requirements. Roles and responsibilities associated with CPA will be clearly documented.
xix. The service will work closely with organisations that represent service users

with other presenting features ensuring that there are no avoidable barriers to accessing the service. The service will ensure that people with specific needs have access to appropriate information about the services available. Specific population groups include:

- Adults with mental health and/or substance misuse problems
- Adults with an Autistic Spectrum Condition (ASC)
- Offenders
- People with long-term physical conditions
- Carers
- People from black minority and ethnic (BME) communities and including travellers and gypsies
- Gay, lesbian bisexual and transgender people
- Older people

3.2.3 The team will operate 52 weeks of the year, 7 days a week (Monday to Sunday) 12 hours a day (8am to 8pm). On the rare occasion additional hours maybe required to manage a crisis event. Subject to the availability of funds, charges associated with additional hours in relation to crisis management may be charged separately by invoice.

3.2.4 All referrals will be acknowledged by email on the day of receipt (at the time the referral is received and recorded on the Integrated Electronic Service User Record).

3.2.5 Responses to referrals will be based on presenting needs and category of referral as outlined below and highlighted within attached pathway

- Emergency
- Urgent (anticipated that most referrals will fall within this category)
- Routine

intensive support service pathway.pdf

3.3 Any acceptance and exclusion criteria and thresholds

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

3.3.2 In individual cases, the service will support the CLDT to oversee the management of individuals aged 14 and over in transition.

3.3.3 Referrals will be accepted from CLDT's, GP's, Commissioners, and Emergency Services via Health and/or Social Care. (Individuals will normally be known to the local CLDT, however in the event that they are not known this will not preclude acceptance to the service).

3.3.4 The service will accept requests and referrals from CHC to facilitate reviews of out of area placements.

3.4 Interdependence with other services/providers

3.4.1 The Intensive Support Service will be delivered by a multidisciplinary team utilising the Care Programme Approach, providing a seamless service working jointly with the CLDTs and 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 the CLDTs
iii. Working in partnership with other services, including (this list is not exhaustive):
    - Primary Care
    - Acute Care Providers
    - Community Health Services
    - Community Mental Health Teams (CMHTs)
    - 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

5 Applicable quality requirements and CQUIN goals

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

5.1.1 Emergency referrals will be responded to within 2 hours of receipt.
5.1.2 Urgent and routine referrals will be reviewed at an multi-disciplinary team meeting within 48 hours of referral.
5.1.3 Monthly review meetings will be held with the relevant CLDT to update treatment plans, behavioural support plans and discharge plans.

5.1.4 The service will report quarterly on the frequency of monitoring arrangements for individuals under the care of the service including those in out of area placements.

5.1.5 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.

5.1.6 The service will maintain a record of all:

i. Complaints (including summary of issues raised)
ii. Serious incidents
iii. Safeguarding alerts raised

5.1.7 All staff will participate in Continuing Professional Development (CPD) to enable the implementation of evidence-based practice. Training and development needs will be identified through an annual Personal Development Review (PDR).

5.1.8 All staff will complete mandatory training as per national requirements including safeguarding children and adults training; Mental Capacity Act training; and Deprivation of Liberty Safeguards 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 service will operate out of two bases located in Dorchester and Bournemouth respectively.

7 Individual Service User Placement

7.1