# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.*

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| **Service Specification No.** | SS1 (Dec 2019) |
| **Service** | Enhanced Admission Avoidance Support for Rapid Assessment and Re-enablement for People with Learning Disabilities and Autism |
| **Commissioner Lead** |  |
| **Provider Lead** |  |
| **Period** | Dec 2019 – Dec 2020 |
| **Date of Review** | June 2020 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   **National Context**  The Transforming Care Programme is a nationally mandated programme as outlined in the national plan, Building the Right Support (BRS), that aims to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition.  The Programme has been running since 2016 and has three key aims:   * To improve quality of care for people with a learning disability and/or autism * To improve quality of life for people with a learning disability and/or autism * To enhance community capacity, thereby reducing inappropriate admissions.   An overarching principle of the Programme is the provision of care in community settings, closer to home including crisis support and specialist services. The aim of an enhanced community model is to improve quality of life and the health and wellbeing outcomes of people with learning disabilities and their families to subsequently reduce reliance on inpatient care.  **Local Context**  The Lancashire and South Cumbria (LSC) Transforming Care Partnership (TCP) is one of 48 TCPs across England tasked with re-shaping local services in line with the national plan, Building the Right Support.  Our aim is to achieve the Transforming Care Programme as well as deliver wider oversight, service development and improvements for people in Lancashire and South Cumbria with a Learning Disability and / or Autism.  LSC TCP has a population of approximately 1.6m people.  **LSC Learning Disability Prevalence – All age**  There are around 7313 people within Lancashire and South Cumbria with a learning disability. This data is as of 30/04/19 based on the registered population. (Source: MLCSU dataset).  **LSC Autism Prevalence - Adults**  There is an estimated 11,640 people aged 16+ within Lancashire and South Cumbria with Autism. (Source: The Adult Psychiatric Morbidity Survey, APMS).  **LSC Autism Prevalence - Children**  It is estimated that 3,366 of children aged 0-16 within Lancashire and South Cumbria have autism however the actual prevalence of autism in children is not known. NICE guidance suggests that at least 1% of children have autism which is based on three recently published studies, each of which used slightly different population cohorts:    1. Baird, G et al. (2006). Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). The Lancet. 368, 210-215. Study suggests a prevalence of 116 per 10,000 population. Based on a cohort of children aged 9 and 10    2. Baron-Cohen S, Scott FJ, Allison C et al. Autism spectrum prevalence: a school-based U.K. population study. British Journal of Psychiatry 2009; 194:500-9. Study suggests a prevalence of 157 per 10,000. Based on a cohort of children aged 5 to 9  3: Prevalence of Autism Spectrum Disorders --- Autism and Developmental Disabilities Monitoring Network, United States, 2006. MMWR: Morbidity & Mortality Weekly Report 2009; 58:(S S10)1-20. Study suggests a prevalence of approximately 1%. Based on a cohort of children aged 8    There is generally a higher prevalence of mental health problems with people who have a learning disability than the general population and where a person with a learning disability has a mental health problem which should be treated in hospital, (for example psychosis) they should be treated in a mainstream mental health service making reasonable adjustments. Statistical evidence would suggest that at any given time in LSC, 10 to 12 people with a diagnosis of a learning disability and/or autism would be expected to be in mainstream mental health services because of a mental health issue.  Across LSC, people with learning disabilities or learning disabilities and comorbid autism have told us that providing care close to their communities is a priority.  While there are pockets of support available in the TCP, this provision is inconsistent. This is particularly true considering the limited strategic provision of crisis and re-enablement support options in the community that could support the population of LSC.  This means that when someone experiences a crisis, or their behaviour spikes and becomes challenging for families and carers to manage, they currently have very few options beyond trying to manage the crisis themselves, or watching as the individual is admitted to hospital.  In this context, the TCP recognises there is a need for a service that offers rapid assessments, short-term accommodation during moments of crisis, and re-enablement offers of support for individuals at risk of hospital admission as identified through LAEP or CTR.. This service would:   * Reduce inappropriate hospital admission for individuals with a learning disability (and autism) * Offer alternatives to inpatient hospital care for individuals in crisis * Enable individuals to remain in the community within LSC, avoiding new environments that may aggravate their behaviour |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   | **Domain 1** | **Preventing people from dying prematurely** | **X** | | --- | --- | --- | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **X** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **X** | | **Domain 4** | **Ensuring people have a positive experience of care** | **X** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **X** |   **2.2 Local defined outcomes**   * There is a reduction of admissions for individuals with a learning disability and /or Autism into out of area ATU beds * There is a reduction in unnecessary admissions for individuals with a learning disability and / or Autism into Mental Health beds * There is an increase in LSC commissioned crisis service accommodation * More people retain their current accommodation and support as a result of timely crisis interventions.   **2.3 Transforming Care Outcomes**   |  |  |  | | --- | --- | --- | | 1 | People should be supported to have a **good and meaningful everyday life** - through access to activities and services such as early year’s services, education, employment, social and sports/leisure; and support to develop and maintain good relationships. |  | | 2 | Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan. | **X** | | 3 | People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy. |  | | 4 | People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges. | x | | 5 | People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation. |  | | 6 | People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit). |  | | 7 | People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary. | **X** | | 8 | When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or ‘offending’ behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community. | x | | 9 | When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before. |  | |
| **3. Scope** |
| **3.1 Aims and objectives of service**  This community service provision is one component offered from within the pathway for people with learning disabilities and learning disabilities with autism. It has two primary aims:   1. To prevent unnecessary escalation and subsequent admissions to hospital 2. To increase community assessment treatment and reablement options   With a key focus on recovery and overall wellbeing, this service will support people at an appropriate time through effective assessment and short-term interventions (i.e. fewer than 8-12 weeks) that will enable them avoid hospital admission to remain in the community and live well. There may be exceptions to the length of stay given individual circumstances. Where this is considered appropriate, it will form part of a multi-agency discussion, and be agreed and documented by all parties beforehand.  This means that people who use the service can expect to leave having received the following care and support options:   * a ‘moving on’ support plan * a Positive Behavioural Support (PBS) plan * a risk management plan and/or care plan * any other relevant, situation-specific plans   There may be exceptions to the length of stay, however where this is the case, this will form part of a multi-agency discussion, and be agreed by all parties.  **3.2 Service description/care pathway**  This accommodation service will be available 24 hours a day with an underlying objective to support people and enable them to return home as quickly as possible with ongoing support where needed. An example of what the service’s referral mechanism could look like using digital channels, including relevant fields for information to capture is included at Appendix A.  The service will offer a therapeutic and robust environment in which person-centred assessments and care plans can be developed that address the root cause of the presenting issue. This will inform solutions and rapid interventions that support the individual and their family/carers to both manage the current crisis effectively, and to stay well in the future.  The service will be provided from single-occupancy, self-contained accommodation  There should l also be access to shared communal space for group activities, social interaction and therapeutic activities.  Accommodation will be suitably robust and safe and comply with all statutory requirements. For example, this could include window glazing with toughened or laminated glass; heating either under floor or secure metal radiators; anti-tamper ceiling lights; walls lined with soundproofing insulation. There will also be facilities for reasonable adjustments to be made for physical health conditions. Ideally the environment will be ligature free and make use of assistive technology where appropriate to support independence and appropriate staffing levels  There is an expectation that the service will work with the individual MDT and follow the directions of the NHS professionals involved to plan for discharge on admission.  The environment will ensure that individuals have time to self-regulate. There should be outside space.  **Service operating model**  The service will be provided using an electronic referral mechanism (see Appendix A for draft referral form). Referrals will be accepted seven days a week.  Referrals can also be recommended via Community C(E)TR’s and or LAEPs and can be submitted by Health Commissioners, Community Mental Health Teams, Community Learning Disabilities Teams. The catchment area for referral and admission is limited to those who are the commissioning responsibility of the LSC ICS footprint.  Once the service provider receives a referral, they will contact the referrer, or the nominated MDT representative within one hour to begin their assessment and attempt to gather the relevant information.  To ensure rapid risk assessments, the service provider will attempt to meet the service user in person within four hours of receiving the referral in order to complete the assessment. This assessment will include an appraisal of the individual’s:   * an understanding of their usual “baseline” and needs * current level of independence * risk to harming themselves and/or others * mental and physical health needs (including cognitive and communication needs) * staff ratios and the level of clinical input required to support them effectively.   Support can begin at home where possible, or the individual can be accompanied to the service setting (if required) within eight hours.  The service will provide a ‘core support team’ during the day. Waking night staff will also be provided (the number will be based on individual risk) with access to an on-call, clinically-trained member of staff. Transport to and from the service will be also provided. Exact staffing ratios will be determined upon individual assessment, and may vary during the individual’s stay depending on their presentation.  All staff will be trained in working with people with learning disabilities, challenging behaviour, PBS, Autism Spectrum Condition, and Management of Actual and Potential Anger (MAPA) for de- escalations. This will also include physical intervention training, although the expectation is that this is used solely as a last resort in exceptional circumstances.  The activities and therapeutic interventions offered by this service in conjunction with NHS professionals will include, but are not limited to:   * Standard referrals, triage, and assessments * Rapid risk assessments * Community signposting and communication with existing local providers * Functional and sensory assessments * Therapeutic interventions * PBS planning * Care and support planning * Behavioural support strategies * ‘Discharge and ongoing plans * Practical support and advice for families or carers * Skills development and direct family work   **3.3 Population covered**  This service is available for people who are the commissioning responsibility of the LSC ICS CCGs and are registered with a GP within the LSC footprint.  **3.4 Any acceptance and exclusion criteria and thresholds**  This service will be available to support people who meet the following eligibility criteria:   * are 18+ years of age * have a diagnosis of learning disability and/or Autism * have a diagnosis of learning disability and comorbid autism * have a diagnosis of learning disability and/or Autism & have a mental health illness and/or behaviour that challenges * are the commissioning responsibility of the LSC CCG’s * are known and are referred by NHS professionals who have identified the health needs to be met within the placement   **Exclusions:**  This service is not to be used to resolve placement breakdown only.  Patients sectioned under MHA  Individuals will have exhausted community services and have been identified at risk of hospitalisation  **3.5 Interdependence with other services/providers**  A high degree of interagency communication between relevant NHS and Local Authority stakeholders and the individual’s current care provider will be critical to the success of this service, and introducing the service’s operating model and interfaces with other agencies is that of the selected service provider.  As part of the mobilisation exercise, all identified health and social care agencies that may interface with this new service, should be informed and consulted.  It would be expected that the providers ensure   * appropriate service information is shared with Commissioners who will support the distribution of this information with relevant teams * regular updates (in an agreed format) are shared with commissioners detailing service vacancies |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)**  The aims and outcomes of the Transforming Care Programme are outlined in the national plan, *Building the Right Support (BRS).*  <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>  **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**  This service’s scope, high-level operating model, functional activities and outcomes have been informed by national guidance and good practice, found in NHS England & Improvement’s Transforming Care Model Service Specifications.  The provider is required to provide the services taking into consideration and applying where applicable the “Building the Right Support” guidance. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**   2. **Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
| The provider shall provide the services at locations within the Lancashire and South Cumbria boundaries and as agreed by the Commissioner |
| **7. Individual Placement Agreement** |
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**Appendix A**

The form below is an example of what the service’s referral mechanism could look like using digital channels, including relevant fields for information to be captured.

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| REFERRAL FORM | |
| Name of referee |  |
| DOB |  |
| Name of Referrer and Organisation |  |
| Current Location |  |
| Usual Place of Residence |  |
| Legal status |  |
| Medical conditions (including diagnosis, symptoms etc.) |  |
| Current medication |  |
| Social worker/CLDT/CPN |  |
| GP |  |
| Consultant |  |
| Other relevant agencies |  |
| Host CCG/LA |  |
| Primary reason for referral |  |
| Brief social history (events leading up to referral/incidents/episodes) |  |
| Individual needs (Include all ADL’s) |  |
| Risks to self |  |
| Risks to others (including staff) |  |