SCHEDULE 2 – THE SERVICES

A. 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.

Service Specification No.	
Service	LSC – History of Trauma Service
Commissioner Lead	
Provider Lead	Sally Nightingale, Programme Lead – Learning Disabilities & Autism
Period	
Date of Review	

1. Service Overview

Our vision is for people to be able to live as independently as possible in their own communities, in the place where they want to be, with their families and networks around them. We want to ensure people live in the right type of home for their needs, in the right place and with the right support. Although this may not be possible for everyone, we believe that people with even the most intensive and complex health and social care needs still should have a range of choices open to them and be supported into service models which continue to maximise their independence and support their continued involvement in existing social networks.

The Service will provide flexible person-centred support for people with Learning Disability and / or Autism (aged 18 and over) with emotional instability.

“Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide.” NICE (2013)

The people to be supported may have spent some time in hospital settings, or as “revolving door” patients. Some may have already been living in the community in various settings but require more specialist services to support them to live in the community with consideration of relevant legal frameworks and restrictions.

Principles of care and support:

- That the people have real control over their care and support, actively engaging the individual, carers, local communities and partners in the co-design and development of support packages.
- The difference that they are making to the peoples’s lives through an asset-based approach celebrating and facilitating gifts, talents, and aspirations.

- That they seek solutions that actively plan to avoid or overcome crisis and focus on supporting the people within their natural communities, rather than being constrained by service and organisational boundaries.

- That they enable the people to develop networks of support in their local communities and increase community connections ensuring reasonable adjustments.

- That they take time to listen to a person's own voice, particularly those whose views are not easily heard.

- That they fully consider the needs of the family and carers when planning support and care.

- That they ensure that support is culturally sensitive and relevant to diverse communities.

- That they operate from a trauma informed model of care.

- That they take into account a person's whole life, including their physical, mental, emotional, and spiritual wellbeing.

- Demonstrate an in depth understanding of the aims and objectives set out in the Transforming Care work programme (including the legal frameworks that surround discharges from secure settings: Mental health Act, Care Act etc.)

- Evidence their commitment to adopting an inclusive and supportive approach to recruitment and staff support.

The provider will cooperate with the landlord(s) and any other appropriate agencies, especially around safeguarding issues.

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

The people will:-

- Feel more in control of their lives.
- Feel safe, secure and contained.
- Have increased emotional wellbeing, and self-efficacy.
- Become more independent and socially confident.

- Learn and make progress towards increased levels of socialisation/occupation where possible.
- Have increased levels of independence/confidence to help them with their transition into more independent accommodation.
- Build social networks.
- Be supported to determine their own required outcomes.
- Have received support, which is relevant, timely and accessible.
- Be supported by staff who have knowledge of and understand their individual needs to respond appropriately.
- Be involved in planning their own support and be consulted about the effectiveness.
- Have flexible and responsive support plans that acknowledge and build on their history and skills and work towards outcomes that are important to them.
- Be supported in the safest and least restrictive manner.

3. Scope

3.1 Aims and objectives of service

The service will achieve the following key aims:

- To support people transitioning into the service from hospitals, homes or other providers.
- To support the people to create meaningful lives that reduce the likelihood of re-admission to hospital and minimise as far as possible the occurrence of reaching crisis point.
- To support the people to feel safe and stable in their own home to that they can gain confidence to live fulfilled and healthy lives.
- To deliver an active support service which helps the person to have timely and person-centred support which is responsive at times of relapse or crisis and minimises the need for more restrictive health, community safety or social care services.
- To provide core support within an accommodation-based setting, into which additional hours of individual support may be provided under direct payment or Personal Health Budget arrangements, or additional hours of 1:1 support commissioned to enhance the support offer in line with need, directly commissioned or provided via an integrated personal budget.
- Support the people to establish and maintain independent living arrangements, prevent admission to hospital, integrate in the community, and to achieve a life that is healthy fulfilling and meaningful in line with the principles set out in: www.local.gov.uk/so-what-what-next-project
- To support the people to access other services including health, social care, education, training, access to work and leisure services and be confident in supporting socially inclusive activities that further the person's own goals.
- To support the people to increase independence and move on to more independent accommodation if their assessed need determines this.

3.2 Service description/care pathway

Overview

The provider will provide flexible person-centre support for people with learning disabilities and/or autism who have a diagnosis or presentation of EUPD or similar to live safely in communities and remain out of hospital settings; have good meaningful lives with choice, control, aspirations and friendships/relationships.

Providers of this service will need to ensure staff have the appropriate knowledge and are adequately trained in therapeutic and care approaches that meet the complex needs of people with these diagnoses.

It is an expectation within this delivery model that there will be a dedicated person/s who will be responsible for ensuring staff have access to regular supervision, support and leadership to enable proactive and confident care delivery.

The provider will support the people to develop the necessary strategies and skills towards independence that is sensitive to their individual developmental needs and values the critical importance of effective therapeutic relationship building.

The provider will connect the people into their local communities (as appropriate), ensure they have choice and control over their own lives, and can build life skills, friendships and relationships in a meaningful way.

Key characteristics of this service

The Service will be delivered flexibly and efficiently for up to 24 hours a day, 7 days a week and 365 days a year. This may be via direct staffing (waking night or sleep in), as appropriate and agreed for each Service and Person supported, as dictated by the needs of ther Person and those residing in each address.

- Any property to be close to local community facilities with good transport links.
- Be based upon an own front door model and with access to adequate internal and external space to enable support to be safely and sensitively delivered.
- The provider will have a robust staff team with proven experience of supporting people who self harm and / or can be a risk to others, consistent staff team with the skill mix to meet the service objectives.
- The provider will have robust clinical and management supervision and debriefing processes for staff in order to ensure staff resilience.
- The provider will have a clear understanding of legal restrictions and be able to support the people under such restrictions whilst still focusing on improving quality of life.
- The provider will ensure that staff are trained to understand each individual's ongoing support to manage their risks safely and support skills developed in therapy.

Key Principles

The provider will work with other relevant stakeholders to develop the best possible service for the people creating a climate where the 9 principles of the Service Model within the National Plan – Building the Right Support[1] can be met.

The provider will have an enhanced knowledge, clinical leadership, skill and experience of providing support in line with a variety of legal frameworks. Legal frameworks include the Mental Health Act, Mental Capacity Act, and Court of Protection directions, as well as Criminal justice/probation

The provider will ensure that staff operate in line with formal Deprivation in Domestic settings (DiDS), The principles of PBS, principles of trauma informed care, least restrictive practice principles, reducing restrictions

[1] https://www.england.nhs.uk/learningdisabilities/natplan/

according to ADASS guidance, enhancing mental capacity, advocacy, best interest decision making, positive risk management, duty of care, strong relevant local leadership, and legal competence.

The service Provider will:-

Employ and provide high quality support to appropriately skilled and trained staff to provide the following support:

- Clinical leadership.
- A core dynamic staffing model reflecting changing need and providing shared access to 24-hour support.
- Value and retain its staff by offering competitive rates of pay with a clear progression pathway and incentives.
- Have an emphasis on developing strong therapeutic relationships within a boundaried approach ensuring timely support, supervision, debrief is available to staff.
- Ensure that each service user has an outcomes-focused support plan that captures progress.
- Emphasise the importance of staff training and development, through a training approach which includes values based, psychological, behavioural, and positive risk management approaches.
- Develop effective working relationships with local health/social care teams within the locality that they are based.
- Ensure that records are kept up to date and accurate in line with registration and professional requirements.
- Provide any monitoring evidence and reports as required.
- Identify and manage any risks and safeguarding concerns using the appropriate local guidance.
- Have knowledge of activities, groups, leisure and cultural services in the community, to support meaningful access.
- Have a focus on health promotion, reasonable adjustments and ensuring access to mainstream health services is not restricted.

Recruitment

The provider must ensure:

- Robust recruitment policies and procedures and ensure that there are appropriate arrangements in place to cover rota emergencies. Agency/bank staff must only be used in exceptional circumstances and where possible consistency in staff members must be maintained.
- Professional leadership at a senior management and individual service level is essential to ensure that appropriate support is offered to the staff and teams working with the people who are being supported.
- In addition to the above, some of the people supported in this scheme will require access to professionally qualified staff e.g. RNMH, RNLD.
- Quality assurance systems are in place.
- They have a Staff Code of Conduct that staff follow at all times.
- They have a lone working policy in place including risk management that is reviewed at periodic intervals.
- They recognise the importance of informal support and neighbourhood and community connections and actively encourage service users to engage and participate.
- There are robust procedures in place for ensuring that staff comply with the support identified in support plans, risk management plans etc. Assurance procedures must be in place to help reduce

the risk of standards slipping, staff misunderstanding their role or deliberately disregarding instructions.

- That the staffing levels are adequate for the well-being of the people who use the service and the people have a dedicated, consistent staff team.
- That its staff work effectively with the other agencies and organisations needed by those who use the services.
- They can demonstrate approaches which enable staff to work in creative, person-centred ways.
- Zero-hour contracts should not be used (unless the provider has their own bank staff who are suitably trained in the care plans for each individual) and providers will need to describe how their workforce plans support consistent and familiar staff support.

Staffing, Management, Training & Supervision

The provider must demonstrate that staff have received adequate training and/or have the competence to carry out the tasks, which they are required to perform.

The provider should identify ongoing training needs and ensure that workers receive appropriate on-going training (including refresher training) to develop the skills that are necessary to perform tasks to the required standards.

Skills required

Personalised training, supervision and opportunity for reflective practice should be provided for all staff as appropriate to their role.

The provider will ensure that all staff strive to demonstrate the principles of compassion, curiosity and empathy when working with people with personality disorder and endeavour to challenge stigma at all times.

The provider will ensure that the staffing team and management in place for this service should also have experience in:

- Supporting people with Learning Disabilities and / or Autism (flexibility will be needed when employing support staff to allow for training).
- Person-centred thinking skills.
- Managing Acute Mental Distress including self-harm, suicidal thoughts, threats, and attempts.
- Understanding of behaviour that challenges and use of Positive behavioral support approaches (including reactive as well as proactive management strategies)
- Understanding of relevant law, ethics and safeguarding vulnerable adults
- Supporting people who have experienced abuse / trauma in their lives.
- Basic understanding of effective evidence-based psychological approaches such as DBT and mindfulness based techniques.
- Medication management.
- Facilitating meaningful occupation.
- Communication skills.
- The ability to engage with a range of different professionals and agencies.

This is not an exhaustive list and staff may require additional specific training around the needs of the people they support.

On call arrangements should be a robust and effective part of the structure and will need to be agreed with commissioners at point of contract award.

Finances and Property

- The provider will support the people regarding managing their money and accessing appropriate benefits.
- The provider will support the people to have control over their own money and resources.
- The provider will facilitate and explain decision-making regarding household financial management where resource and/or responsibilities are shared if any of the people share housing.
- The provider will assist the people to maximise their income. The provider will have robust financial policies and procedures.
- The provider will support tenants in all aspects of their relationship with their landlord.
- The provider must maintain a housing management/service level agreement with the landlord or their agent where the individual is not able to do so.

Health and Care

The provider will ensure the people are registered with the local GP of their choice and access local community health services. This will include support to access annual health checks, medication reviews (including those related to the STOMP agenda) and other health/medical appointments, including, but not limited to doctors, dentists, opticians, podiatrists and auditory specialists.

- The provider will manage challenging behaviour and adopt the least restrictive approach.
- The provider will take an enabling approach to ensuring that a person's personal care needs are met.
- The provider will ensure that all assistance and support with personal care is given in a discrete and dignified manner.
- The provider will support the people to monitor (and record, if appropriate) their own health and well-being, through regular health checks, making referrals and seeking advice and support as necessary.
- The provider will support the people to manage their own physical health as much as possible; learning what is good and bad for health and enabling healthier choices.
- The provider will support and encourage the people to promote healthy lifestyle choices, including diet, sleep patterns, activities and exercise.
- The provider will promote positive mental health using the national guidance of the five ways to wellbeing.
- The provider will promote and support access to all health services.
- The provider will ensure staff will follow a detailed, documented Provider Support Plan with clear information that will guide them to understand each person's conditions.
- The provider will ensure Induction and ongoing staff training will support the knowledge and expertise required.
- The provider will work closely with any health professionals involved to support delivery of medicines, treatments and therapeutic programmes.
- The provider will continue to develop, maintain and implement Health Action Plans; or Education, Health and Care Plans with support as required from the adult social care team.

The provider will work collaboratively with community health and care teams during any needs led review process and provide information and data in an agreed format that informs any holistic person centred or contract review.

Social Inclusion

The provider will support the people to maintain and develop (or rekindle) their social networks with natural relationships beyond professional and paid support, by promoting and facilitating where necessary positive contact with family and friends.

The provider will ensure that staff role-model interaction that enhances the person's confidence and self-esteem, through positive relationships both inside and outside their home.

The provider will facilitate contact with neighbours, local shops, leisure services and community groups, so that the people can participate in the local community in a way that suits their needs and preferences.

The provider will ensure that staff support appropriate online behaviours and online safety for those wishing to access social media and other technology to maintain and enhance relationships.

The provider will enable the people to have freedom and the ability to enjoy a wide range of experiences; whilst learning about risk and how to look after their own safety as much as possible including support with interpersonal relationships and capacity to engage.

The provider will ensure that the people are fully involved in their support plans that indicate how best to support them to manage behaviour that challenges. This should include guidance about how to discuss distress and behaviour with the individual before during and after any incident.

The provider will ensure the people are supported in the least restrictive way that is possible and safe.

Technology Enabled Care

It is expected that the provider execute a plan to develop the use of Technology Enabled Care in the delivery of this Service. Uses of Technology Enabled Care may include (but are not limited to);

- Managing the support network around the person
- Improving access to advice and support
- Supporting the people to access primary and secondary care
- Support in managing medication where appropriate
- Maintaining and/or improving a person's independence
- Maintaining and/or improving a person's social participation
- Reducing/removing support where appropriate and safe to do so

Safeguarding and Behaviour Management

The provider will adhere to local safeguarding policies and procedures for children and vulnerable adults.

Communication

The provider must be able to use a wide variety of communication methods, incorporating a Total Communication approach.

Asset Based Approach

The provider will use an asset-based approach that recognises and builds on a combination of the human, social and physical capital that exists within local communities.

The provider will also act as a facilitator in linking up with the social assets each person has, including support from family, friends, health professionals, community groups and voluntary organisations.

The provider will develop a strong working knowledge of what is available in the area and developing partnerships with other local providers to further develop the concept of an 'Asset Based Approach'.

Culture and Quality

The provider will have a strong person-centred culture. Providers must have the following as a minimum;-

- Have an approach to training staff which focuses on values, continuous improvement and quality.
- Be able to support the people to manage their own safety and security both inside and outside of the home.
- Be able to communicate changes in presentation and need in a timely fashion to the relevant professionals and adult social care.

Have an awareness and knowledge of protected characteristics and how to support people with complex presentations in a community setting.

Ethical Care

The provider will ensure that service users will be allocated the consistent support worker(s) team wherever possible.

Monitoring and Review

The service provider will be required to provide information as agreed for monitoring purposes. This will be based on but may not be limited to outcomes from individual plans and any other stipulated indicators and measurements detailed agreed with the commissioner on award of the contract. Regular monitoring meetings will take place and the provider will provide evidence to demonstrate that the service is being delivered in accordance with the service specification.

3.3 Population covered

Lancashire and South Cumbria Integrataged Care Board (ICB) is made up of GP practices covering Lancashire and South Cumbria. The service is to be provided for patients registered with a GP within the boundaries of the ICB.

3.4 Any acceptance and exclusion criteria and thresholds

This service will meet the needs of people aged 18 or over, either on discharge from hospital or to prevent a hospital admission. They may:

- Have a diagnosis of EUPD or demonstrate similar presentation.
- Have learning disability and/or autism
- Have a history of serious self-harm and / or suicidal attempts.
- Need an environment where their risks can be managed safely.
- May have more than one mental health diagnoses.

Access to the service will be via the Lancashire and South Cumbria commissioners (Health and Local Authorities) specifically for people being discharged from in-patient settings either long or short term and to prevent a hospital admission where someone may be currently living within the community.

3.5 Interdependence with other services/providers

The provider will work with the following agencies (not exhaustive): Health and Social Services commissioners, Lancashire and South Cumbria and Blackpool Foundation Trust Mental Health teams, Lancashire and South Cumbria Foundation Trust Intensive Support Team, Merseycare Specialist Support Team, Community Learning Disability Forensic service, Local Community LD Teams, Probation, leisure services, and local police/fire/ambulance, local Primary Care services: such as GPs, Pharmacies, Dentists, Opticians, voluntary sector, employment services.

4. Applicable Service Standards

4.1 Applicable standards

The Provider shall comply with all relevant legislation, national policy and national guidance including those detailed within the following non-exhaustive list as may exist or come into effect from time to time:

- National Service Model (2015)
- Building The Right Support (2015)
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015
- CQC (Care Quality Commission) New Standards (2014)
- Positive and Proactive Care, Department of Health (2014)
- The Care Act (2014)
- REACH: Support for living an ordinary life: Service review – Pavilion Publishing and Media Ltd and its licensors 2013
- Raising our Sights Mansell Report: services for adults with profound intellectual and multiple disabilities DoH (2010)
- Dignity in Care (2010)
- Equality Act (Oct 2010)
- The Autism Act 2009
- Care Quality Commission (Registration) Regulations (2009)
- The NHS Constitution – The NHS belongs to us all (2009)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 2012
- High Quality Care for All (2008)
- Our Health, Our Care, Our Say (2006)
- Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards
- Mental Health Act -1983 and 2007
- Human Rights Act 1998
- NICE (National Institute for Health and Care Excellence) Guidance, Guidelines and Standards
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015
- Annual NHS Operating Framework.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

7. Individual Service User Placement

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate