# 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 – Forensic Risk of Offending Service Specification |
| **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 to people with a Learning Disability and / or Autism (aged 18 and over), who may have been through the criminal justice system and may also be subject to Ministry of Justice (MOJ) / Imprisonment for Public Protection (IPP) involvement/restrictions.

The People to be supported:

- may have been through the criminal justice system as a result of any of a range of criminal offences including those resulting in being identified in any of the Multi Agency Public Protection Arrangements (MAPPA) categories included offences under Schedule 15 of the Criminal Justice Act 2003
- may remain at moderate to high risk of reoffending, due to responsiveness to treatments and level of insight; or risk of harm to themselves
- will be considered to no longer need hospital treatment but still require a robust and secure environment, with consideration to legal frameworks, restrictions, and possible exclusion zones; and
- are likely to have a range of complex needs, which may include other/multiple diagnoses, communication difficulties, complex behaviours that challenge, and additional complex physical health needs in addition to a Learning Disability and / or Autism. These could include for example: personality disorder, depression, anxiety, communication difficulties, substance misuse history, epilepsy, and other complex health issues.

This list is not exhaustive.

**Principles of care and support:**

Providers will be able to 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 and related frameworks and guidance)
- evidence their commitment to adopting an inclusive and supportive approach to recruitment and staff support
- evidence their ability to provide good quality evidence based care. They will have experience of achieving safe discharges from inpatient settings with the aim of keeping people living safely in communities and out of hospital / prison settings
- that people have real control over their care and support, actively engaging individuals in the co-design and development of support packages
- the difference that they are making to people's lives through an asset based approach celebrating and facilitating people's gifts, talents, and aspirations
- that they seek solutions that actively plan to avoid or overcome crisis and focus on people within their natural communities, rather than service and organisational boundaries
- that they enable people to develop networks of support in their local communities and increase appropriate community connections
- 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; and
- considering a person's whole life, including their physical, mental, emotional, and spiritual wellbeing.

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 in the group 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 and / or 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 meet the care and support needs of the identified cohort group
- to support sustainable discharges from hospital that reduce the risk of readmission and in so doing contribute to the Transforming Care Programme and positive individual stories for the identified cohort group
- to deliver a pro-active Service which helps the person to minimise risk of crisis occurring
- to deliver support flexibly across Lancashire and South Cumbria, in any form required, such as individual bespoke community models of care or an accommodation-based 24 hour 7 days a week scheme including a core staffing model alongside any additional support required. There will be well suited staff groups and the recruitment and purchase of support staff which, apart from any core hours, could be provided under direct payment or Personal Health Budget arrangements
- for each package of care to be tailored to support each person
- to support people to live safely in communities and remain out of hospital / prison settings having good, meaningful lives with choice, control, aspirations and friendships/relationships and the achievement of identified outcomes
- to support people to access other services including health, social care, education, training, access to work and leisure services and be confident in a range of methods linking people into their community and supporting socially inclusive activities that further their own goals
- to support people to engage with the professionals involved in their care and to be active participants in their lives
- to support people to move on to more independent accommodation if their assessed need determines this.

### 3.2 Eligibility

This Service is designed to be accessed for people with a Learning Disability and / or Autism, who may have been through the criminal justice system and may also be subject to MOJ / IPP involvement/restrictions; or other needs which entitle them to health/social care support and are compatible through assessment or natural relationships with other users of this Service.

Access is specifically for people being discharged from an inpatient-settings, either long or short term and to prevent a hospital admission where someone may be currently living within the community.

This is the intention in the initial stages of this development however this may change over time depending on circumstances and by mutual agreement between commissioners, the Provider and the people supported.

### 3.3 Service description/care pathway

The provider will work with other relevant stakeholders to develop the best possible service for people creating a climate where the 9 principles of the Service Model within the National Plan – Building the Right Support 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 have experience of working with people with complex needs, either organisationally or via direct staff experience, and experience of providing specific training required for staff supporting this cohort group.

The Provider will have a track record related to forensic risk/knowledge and understanding of strengths-based models of support appropriate for this cohort is essential.

Families are a key partner and should be valued. If people want to involve their families in their decisions, small or large, they should be supported to do so.

The Provider will use every effort to ensure the person supported has a full understanding and involvement in the 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) or using technology and on call, as appropriate and agreed for each Service and person supported, as dictated by the needs of the person and those residing in each address. The use of Assistive Technology should complement the staffing model to ensure the least restrictive environment and it should not be used in isolation.

The workforce will need to operate in line formal Deprivation in Domestic settings (DiDS), least restrictive practice principles, reducing restrictions according to ADASS guidance, enhancing mental capacity, advocacy, best interest decision making, positive risk management, duty of care, strong local leadership, and legal competence.

Informal/natural support should be encouraged where safe and appropriate and staffing should be optimised to ensure the delivery of each Person's daily and weekly programmes effectively and efficiently.

The Provider will ensure that staff have the ability to build good relationships to make sure that they understand the People they support, what is important to them, their personal strengths, and ambitions. Staff should support People to identify opportunities and take positive risks to enable them to try new things and build a better life.

The staff team will give advice and assistance to people supported that enable them to establish and maintain independent living arrangements and to maintain good mental health and wellbeing.

The Provider will have staff that are highly trained, experienced and resilient who will have access to supervision and further training in order to provide appropriate support for this group of people.

Resilient and robust management structures must be in place to ensure that appropriate decision making and support to staff and to the people supported is available at all times.

The Provider will use collaborative ways of working that support people to actively engage in the design, delivery, and evaluation of their services.

The Provider will also demonstrate approaches which enable staff to work in creative, person-centred ways, underpinned by the organisational systems and effective management structures to support and sustain this.

The Provider will support people to move on to more independent accommodation if their assessed need determines this.

The Provider will ensure that there are appropriate and robust policies and procedures in place to ensure that all staff understand their responsibilities and adhere to the General Data Protection Regulations (GDPR).

The Provider will employ and provide high quality support to appropriately skilled and trained staff to provide the following support:-

- a core staffing model reflecting changing need and dynamics and providing shared access to 24 hour support; either via physical proximity or an active and responsive on-call system
- value and retain its staff by offering competitive rates of pay with a clear progression pathway and incentives
- ensure that each person supported has a co-produced outcomes-focused support plan that captures progress through an outcome framework
- develop and maintain effective working relationships with the Community Learning Disability Teams and Autism Teams within Lancashire and South Cumbria footprint
- make use of high quality direct and indirect training and supervision from professionals including psychological and behavioural approaches to a range of behaviours and issues
- ensure that records are kept up to date and accurate and any administration task is managed on time and to a high quality
- provide any monitoring evidence and reports as required
- manage and monitor medication concordance as per own governance arrangements and in line with care plans
- identify and manage any risks and safeguarding concerns using the appropriate local guidance
- have knowledge of activities, groups, leisure, and cultural services, so that people can be supported to access mainstream services. Support People to make best use of community assets and create connectivity that will help to replace statutory and professional with other services from the voluntary sector and promote organic and naturalistic support
- 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 our 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 and 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 the staffing team and management is 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-centered 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
- Medication management.
- Facilitating meaningful occupation.
- Communication skills.
- Understanding sexual harmful behaviour
- Working within legal frameworks and MAPPA
- Risky behaviour and management techniques
- 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 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.

Services must be able to operate 24/7; this will entail a combination of staffing presence, on call and technology, as appropriate and agreed for each Service and Person supported. Staffing arrangements must include effective communication management.

There must be evidence of rational security boundaries for this client group.

Management should be in place to offer a robust structure; including maintaining a regular scheme resence to retain operational oversight, as well as quality checking service and making decisions where required.

The Provider should identify ongoing training needs and ensure that workers receive appropriate training (including refresher training) to develop the necessary skills. This should include as a minimum:

- Positive Behavioural Support – British Institute of Learning Disabilities (BILD) accredited or similar to ensure staff understand the origins and functions of behaviour that challenges and the range of ways to support People
- Autism – staff should have training to a level identified in the Skills for Health that will help them understand and respond appropriately to needs arise from Autism Spectrum Disorders
- Attachment and Trauma – staff should understand the role that attachment issues relationship history and trauma can play in the development of behaviour that challenges
- Understanding and responding to psychological distress
- BILD accredited application of behavioural intervention techniques including physical intervention as part of a hierarchical approach
- Suicide intervention training
- Knowledge of a range of psychological approaches that may be used for People experiencing distress e.g., Cognitive Behaviour Therapy (CBT) for psychosis and anxiety and the ability to support People to use CBT/Dialectical Behaviour Therapy/other therapeutic skills to manage periods of increased anxiety/distress.
- Communication strategies
- Recovery theory
- Training specific to offending behaviour and legal restrictions resulting from MOJ and IPP.

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

It is important that appropriate staff supervision arrangements are in place and followed, providing a safe and confidential place for staff at regular intervals. This must form part of ongoing staff development and appraisal processes.

Supervision should be of a high quality, formulation driven and evidence reflection and learning in the context of working with offenders.

**Finances and property**

The Provider will:-

- support People regarding managing their money and accessing appropriate benefits
- where the Person has the potential to undertake this role and there is no need for an appointee
- support People's control over their own money and resources. so that they are enabled to manage money, budgets, letters etc. as much as they are able to. Where support is needed this takes account

of the Person's preferences and wishes in how their money is spent and their financial responsibilities.

- facilitate and explain decision-making regarding household financial management where resource and/or responsibilities are shared between People in the household
- assist People to maximise their income. where necessary, offering guidance and support in respect of income (including access to benefits), expenditure and the safe keeping of money whilst minimising the risk of financial abuse. The Service will have robust financial policies and procedures
- proactively support the Person to ensure their tenancy is maintained – support People in all aspects of their relationship with their landlord. in fulfilling their own obligations as tenants and supporting them to access the right support (for example regarding advice, repairs, etc.) from landlords
- maintain a housing management/service level agreement with the landlord or their agent.

**Health and care**

Support will be provided to register with the local GP 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. This will also include, for example, health checks related prescribed medications and access to universal services and screening.

To ensure that Services and staff support Positive Behaviour Support:

- managing challenging behaviour and adopting the least restrictive approach
- take an enabling approach to ensuring that a Person's Personal care needs are met
- staff will ensure that all assistance and support with personal care is given in a discrete and dignified manner
- staff will help 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
- people should be supported to learn how to manage their own physical health as much as possible; learning what is good and bad for health and enabling People to make healthier choices
- staff will encourage and promote healthy lifestyle choices, including diet, sleep patterns, activities and exercise
- staff will encourage and promote positive mental health using the national guidance of the five ways to wellbeing
- the Service will promote and support access to all health services
- staff will follow a detailed, documented Provider Support Plan with clear information that will guide them the Service will have an understanding of People's conditions
- induction and training will support the knowledge and expertise required. Additional training requirements should be highlighted to the adult social care team
- the Service will work closely with any health professionals involved to support delivery of medicines, treatments and therapeutic programmes
- the service 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
- Providers will work collaboratively with adult social care team during the annual reviews process and provide information in an appropriate format that will help inform the review
- Providers will work collaboratively within 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 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 People'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 People can participate in the local community in a wide range of experiences and in a way that suits their needs and preferences, whilst learning about risk and how to look after their own safety as much as possible.

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 support people to become more independent and develop life skills as appropriate to their needs and circumstances.

The provider will ensure that People are aware of their own behaviour and are supported to manage this for themselves and understand the consequences.

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

**Technology Enabled Care**

It is expected that the provider will 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 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.

**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'.

**Communication**

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

**Culture and quality**

The provider will have a strong person-centred culture. Providers must have as a minimum:

- an approach to training staff which focuses on continuous improvement and quality
- be able to support People to manage their own safety and security both inside and outside of the home
- be able to communicate changes in need to the relevant professionals and adult social care
- have an awareness and knowledge of protected characteristics and how to support People 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.

### 3.4 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.

### 3.5 Any acceptance and exclusion criteria and thresholds

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

- have learning disability and/or autism
- have a forensic history and/or risk of offending

### 3.6 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, Community Forensic Autism Service, Community Forensic Learning Disability 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**