Service Specification

Integrated Learning Disability Service

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Version **1.1**

Version Control

Suggested Change	By whom	Added date	Version no.
Merging of current Section 75 and Solent Health Spec	Mark Paine		0.1
Add in Activity Boundaries	Ian Chalcroft	26.02.15	0.2
Outcome indicators & measures amended on comments received as a result of invitations of key stakeholder to respond	Mark Paine	10.03.15	0.3
Addition of Quarterly performance monitoring template - Appendix A	Mark Paine	10.03.15	0.4
Clarification of the roles around case management and agreement of targets	Ian Chalcroft	30.07.15	0.5
Re-write of service aims and beliefs. Amendments to service delivery. Updated staffing and governance structures. Revised KPIs.	Dominic Dew/Ian Chalcroft	02.02.18	1.0
Agreed amendments to vers. 1.0	Dominic Dew/Ian Chalcroft	15.02.18	1.1

Section 1: Purpose

1.1 General Overview

Approximately 1.5 million people in the UK have a learning disability. It is estimated that in England in 2011, 1,191,000 people have a learning disability. This includes 905,000 adults aged 18+ (530,000 men and 375,000 women) (Source: People with Learning Disabilities in England 2011).

The above figures therefore equate to about 22 people in every thousand having a learning disability. Applying this estimate to the local population, the national Learning Disabilities Observatory estimates that 4,594 people (across all age ranges) in Portsmouth have a learning disability. It needs to be recognised that this figure will include people across the full range of learning difficulty and learning disability and that not everyone with a learning disability will need to access statutory services.

1.2 Vision

People with learning disabilities who are members of the Learning Disability Partnership Board have set out their vision that should be remembered when determining how to deliver services, and what differences they would like to see in their lives.

Their vision is that:

"We should be treated equally and our views respected, and we should be helped to live the lives we choose. You need to make sure we are safe in services if we need support or care"

1.3 Principles

They said that when people think about what they need to do to make this vision a reality they need to remember these principles:

- We are treated equally and have the same rights and responsibilities as everyone else
- Our views are respected, and we are supported to make informed choices about our lives
- We are always at the centre of decisions about us, remember the motto "nothing about us without us"
- We should be safe in services, especially if we have to live outside of Portsmouth
- You should make sure you use the money in the best way and remember that sometimes "small things can make a bigger difference"
- Family carers who support people with learning disabilities are listened to, and given the information and support they need
- Organisations should make sure they work in a person centred way, and only share information about us when they need to

1.4 Outcomes

They also said that these are the differences they want to see in their lives:

- Improved health and wellbeing – “we are helped to keep well, happy and safe”
- Making a positive contribution – “we are supported to speak up and say what we think”
- Improved quality of life – “we get the support we need to make our own decisions and are helped to do the things we want to do”

1.5 Service Aims

The Integrated Learning Disability Service (ILDS) have a number of overarching aims:

- To support people to have valued, meaningful and satisfying lives
- To ensure support provided achieves clear outcomes for the individual that promotes their independence, health, relationships and community participation
- That people should be active members of their communities, including the use of local services and facilities
- To provide support that is effective, efficient and personalised.

1.6 Service Core Beliefs

Underpinning these aims are Four guiding beliefs that influence our approach:

- **Co-production.** The service should actively demonstrate how services can develop with the input from its users.
- **Challenge.** The service should challenge its expectations of its users, its partner providers and itself.
- **Competence.** The service should seek to improve the competence of its users, its partner providers and itself.
- **Valued roles.** The service will ensure that the work it undertakes, the services it commissions, and, the way it behaves promotes valued roles for its users.

These beliefs will be expressed in a number of ways including:

- Care and support are outcome focussed and reflect the lives people want to live.
- Trusted relationships are central to effective service delivery.
- Focus should be on a person's assets and not their deficits.
- Risk is part of life and people have the right to take risks.
- People can change and grow.
- We need to help people “dare to dream”.
- People respond to the way we perceive them.
- Addressing people's needs holistically is essential.
- Integration of services gives us that opportunity.

Section 2: Scope

2.1 Model of Service

The Integrated Learning Disability Service will operate under a Section 75 Lead Provider arrangement with Portsmouth City Council (PCC) as the lead provider. The funding and contractual flow of the service is detailed below:

- Learning Disability Health and Social Care service provision to act as a single integrated service.
- PCC to act as the lead commissioner.

- PCC to contract with Solent NHS Trust for agreed staffing establishment and associated costs with clear outcomes.
- Solent NHS Trust and PCC to enter a S75 Partnership Agreement (with Solent staff seconded to PCC) with no requirement for a pooled fund
- PCC accountable as lead provider for delivery of the integrated service specification and health and social care outcomes measures, facilitated by the S75 Partnership Agreement
- S75 partnership agreement to be overseen and monitored by the Integrated Commissioning Service (ICS).

The service will operate from a shared base, under single line management led by Adult Social Care.

The service will be supported by unified procedures and protocols within a Standard Operating Procedure (SOP) which will deliver the vision, principles and outcomes previously determined by people with learning disabilities.

The service will have a clear focus on the support and delivery of the:

- Health and wellbeing of people with learning disabilities*
- Care and ongoing support for people with learning disabilities*
- Development of life skills and rehabilitation for adults with learning disabilities, with or without autistic spectrum disorders (ASD), within a clear eligibility framework.

The service will support flexible working practices recognising people's skills, knowledge and expertise to provide case management by trusted assessors. The service will ensure equality of access and outcomes to health and social care services.

2.2 Service Population

The service will be open to adults diagnosed with a learning disability who live within the geographic area covered by Portsmouth City Council and Portsmouth Clinical Commissioning Group (CCG), and certain cases to those living outside of the City but currently or formally with a Portsmouth GP.

2.3 Components of service

The components of the service are described below:

- Integrated community team (including health and social care staff, therapy staff and LD Consultant sessions).
- Intensive Outreach Service.
- LD Liaison Nurse Service based at Queen Alexandra Hospital.

2.4 Functions

The functions of the integrated service will be to:

- Promote independence, choice, rights and inclusion
- Improve health and well being
- Address locally and nationally identified health inequalities

- Improve the service user experience
- Promote and develop mainstream inclusion in all services across the health and local authority agenda
- Support carers
- Implement key national and local directives/plans/guidance, including meeting the local Transforming Care Partnership (TCP) strategic objectives
- Provide services along a care pathway basis
- Ensure the safety of service users in services either directly provided or commissioned
- Deliver the safeguarding, quality and clinical governance agendas
- Complaints, legal and risk management
- Make best use of resources and budgets
- Involve users, carers, families and other stakeholders in the development, delivery and monitoring of services
- Manage the service under a Section 75 Lead Provider agreement

2.5 Delivery Model

The ILDS delivers its support by using the following systems/models:

- The provision of a 'named worker' to everyone eligible for support.
- Have an agreed eligibility criteria and process that includes trusted assessments
- The provision of an assessment of need and support plan
- Ensuring that every service user has an individual communication support plan where required
- The provision of health facilitation
- The screening of risks associated with asphyxia and/or choking
- The use of CPA for the co-ordination of complex support packages
- Positive risk taking strategies
- Skills teaching strategies
- The provision of link professional to our commissioned provider partners
- The Chairing and hosting of the Portsmouth LD Transforming Care Steering Group
- The maintenance of a “At Risk of Admission Register”
- Supporting the use of innovative support solutions, Personal Budgets and Personal Health Budgets where appropriate.

Section 3: Operational Delivery

3.1 Service Structure

The service comprises of Four teams that each work in partnership to deliver the identified outcomes for individuals that maximises both health benefits and resource efficiencies. Clinical and care pathways integrate all the service elements to deliver seamless care with the Service User at the centre of their support.

- **Community Multi-disciplinary Learning Disability Team**
- **Learning Disability Hospital Liaison Team**
- **Complex Healthcare Team (Intensive Outreach Service)**
- **Intensive Support Team (Intensive Outreach Service)**

3.2 Community Multi-Disciplinary Learning Disability Team

The Community Multi-Disciplinary Learning Disability Team (CMLDT) is based at St James' Hospital and includes community nurses, social workers, associate practitioners, independence support assistants, a Consultant Psychiatrist, Clinical Psychologist, Speech and Language Therapist and Occupational Therapist's. The team directly supports adults with a learning disability and provides information, advice, education and support to carers and other health and social care professionals. Much of its work concerns commissioning and monitoring packages of support, promoting communication, advocacy, health promotion, mental health, psychological wellbeing and challenging behaviour, where these require specialist healthcare support. The team also provides support on other issues including anger management, continence, issues related to ageing, nutrition, relationships, sensory loss or impairment, sexuality and sexual health.

3.3 Learning Disability Hospital Liaison Team

The Learning Disability Hospital Liaison Team (LDHLT) is made up of Learning Disability Nurses from Solent NHS Trust working in partnership with Portsmouth Hospitals NHS Trust. The hospital liaison nurses work in Queen Alexandra hospital and support patients with learning disabilities throughout their planned hospital admission journey, during outpatient's appointments, and, with pre-admission planning as well as during emergency admissions. The liaison nurse's role is to ensure patients with learning disabilities understand their diagnosis, treatment options and support investigations and treatment. The team can also offer support to carers of people with learning disabilities.

Other areas that the team can help with include; compliance with the Mental Capacity Act, Safeguarding Adults, desensitisation work, helping departments make "reasonable adjustments", and discharge planning.

3.4 Intensive Outreach Service

The Intensive Outreach Service (IOS) is a specialist healthcare service that has two clinical elements – the Complex health team and the Intensive Support Team, with the aim to provide a proactive approach at a time when people's specialist health needs challenge the capacity of the existing team.

The complex health element operates as an intensive outreach service to meet the high level of complex health and nursing needs that exists within some settled accommodation and to provide healthcare to these services.

The intensive support team operates an intensive outreach service, where the combined intensity of intervention and the complexity of the presentation, creates significant difficulties, within the persons settled accommodation.

Section 4: Additional Healthcare Roles

4.1 Co-ordination, assessment and case management of continuing health care and other NHS funded placements

Solent's Learning Disability Services are tasked with monitoring placements, usually on behalf of NHS Portsmouth, where the package of care is funding wholly, or partly, by NHS Portsmouth via the Integrated Commissioning Service (ICS). This equates to Continuing Health Care (CHC) Placements, Extra-Contractual Referral (ECR) Placements - either in Specialist Hospitals, or as patients with Portsmouth funded 117 aftercare packages in Specialist Residential Care and increasingly in Specialist Supported Living.

Processes for monitoring each of the placement types differ according to the Commissioner's requirements but there are similarities across the groups. These are:-

- A registered learning disability nurse will provide the monitoring.
- The placement will be reviewed every 6 months as a minimum.
- The patient will be seen at every review, and where appropriate this will be within their accommodation area.
- Access to independent advocacy services will be offered and supported if required.
- Placement reviews will be recorded on TPP SystemOne.
- Commissioners will be alerted to significant events/changes in care needs, including the need for a Community Care and Treatment Review (CTR) to help prevent admission to a secure setting.
- The clinician will review the package of care being delivered, including risk management strategies, either via the CPA process or by reviewing care plans.
- The clinician will seek evidence of the in-patient units external accreditation process, such as those run by the Royal College of Psychiatrists or an equivalent. This may be completed at the point of commissioning the service.
- The clinician will seek to ensure that the views of family members are sought and heard.
- The clinician will monitor the placements CQC status.
- The clinician will seek to be assured that care practices within the commissioned environment reflect best practice guidance (e.g. in the use of physical interventions, etc).
- The clinician will actively support any safeguarding issues including where necessary raising alerts and attending Safeguarding Conferences for individuals.
- The clinician will support and represent at CTRs for those held in secure settings.
- The clinician will endeavour to seek the best value placement for individuals needing to be placed in specialist accommodation via the ECR process.
- The clinician will adhere to the ICS ECR guidance and methodology in applying for ECR funding.

A template for recording placement monitoring has been developed and will be used for all placement types. There are also some differences in how the placement types are monitored.

4.2 Continuing Care

a. Receiving and acting upon referral for Continuing Care Assessments and ensuring appropriate consent is given.
b. Seeking involvement of appropriate Multi Disciplinary Team (MDT) to complete Decision Support Tool (DST).
c. Support MDT through the assessment/DST process.

d. Support individual or their representative to play a full role in the process, ensuring access to advocacy if required.
e. To take reasonable steps to complete the DST within 28 days of a checklist being completed and indicating that a full assessment is required. Where the 28 day target is not reached clear reasons for this for this will be provided.
f. Ensure assessment / DST completed in accordance with the CHC Framework.
g. Ensure MDT recommendation on eligibility is sent for approval to the ICS in a timely manner.
h. Co-ordinator / MDT to present their cases to Integrated Learning Disability Team Funding Panel when required.
i. Ensuring a suitable care plan is drawn up. All care plans and subsequent reviews should as a minimum contain:

- Name of assigned case manager
- Copy of last CPA review (where appropriate)
- Detailed, accurate information in respect of background, current placement, goals, outcomes, progress
- Details of revised/new goals and outcomes
- Details of any personal budget/personal health budget (if applicable)
- Changes to care plan
- Changes to care package
- Appropriateness of current placement and/or details of suitable local services
- Expected discharge date (where appropriate)
- Discharge plan (where appropriate)

j. Ensuring that the care / support package meets individuals assessed needs and agreed outcomes.
k. Identifying potentially appropriate community packages and/or residential placements.
l. Ensuring the completion of draft Deprivation of Liberties (DoLs) applications, using Case Manager knowledge and providing any and all relevant information to aid appointed solicitors to lodge the applications with the Court of Protection, including the preparation of statements and appearances as witnesses as appropriate.
m. Where the care plan includes access to non NHS services e.g. leisure, monitor that arrangements for these are in place and working effectively.
n. Monitoring quality of care and support arrangements, responding to any difficulties / concerns about these in a timely manner.
o. Acting as a link person to co-ordinate services for the individual ensuring that any changes in a person's needs are highlighted.
p. Undertake reviews to consider whether the individual is still eligible for NHS continuing healthcare or other NHS funding and also the effectiveness and appropriateness of the care/support arrangements.

The role does not include:

- *Formally notifying patients or their advocates of the outcomes of continuing care processes. Though the ILDS will verbally inform service users/their families of the decisions of the LD funding panel.*
- *The ILDS will not make financial decisions on care interventions, but will identify the clinical needs and identify appropriate care packages and provision.*

- *The ILDS will not make independent decisions about changing providers, these will be made by the iLDS applying to the Integrated Learning Disability Funding Panel. The ILDS will provide routine liaison with providers to manage difficulties in care delivery. The lead commissioner within the ICS will be made aware of any significant concerns about providers.*
- *Acting as legal decision maker when making significant decisions about care packages on behalf of someone who lacks capacity when this results in legal applications needing to be made (e.g. to the Court of Protection). The ILDS will actively support the decision making process including preparing information for and being witness to formal applications within the DoLS framework. At all other times the ILDS will act as Decision Makers as it is understood within the MCA.*
- *Manage the resolution of formal disputes about eligibility decisions, care needs, and/or, resource allocation.*

All continuing care support packages will be evaluated, and if appropriate, agreed by the Integrated Learning Disability Service Funding Panel whose membership extends to the lead commissioner within the ICS.

4.3 ECR Hospital Placements

For low and medium secure accommodation the ILDS service will work alongside the allocated Forensic Care Manager (NHS England) in monitoring the placements and care delivery that are being commissioned for patients originating from Portsmouth. This will involve at least 6 monthly reviews (usually under CPA). The frequency of such meetings will increase at certain points in care (e.g. in planning discharge) or if the patient need requires more frequent review. Any change in needs or concerns around the placement or safeguarding will be highlighted to the Forensic Care Manager.

For non-secure placements (e.g. locked wards) we will provide the monitoring on behalf of Portsmouth CCG. Arrangements will be as above but reporting will be via the ICS who will be alerted to key changes in need or concerns around the placement or safeguarding. ICS will in turn be required to report to NHSE and the SHIP Transforming Care Partnership on inpatient numbers, discharge planning and CTR's and the ILDS will be required to help collate information from time to time.

4.4 S117 Care packages

Where Portsmouth CCG funds all or part packages of care the ILDS service will monitor the package of care on their behalf.

Reviews will normally be under the CPA process and occur every 6 months. Significant events/safeguarding alerts will be reported back to the ICS.

4.5 Health Promotion Activity

The ILDS is committed to the improvement of the health status of people with a learning disability. To support this it will:

- Offer a Health Action Plan and health facilitation to all its service users.

- Actively support the wider Leaning Disability Service economy to engage in Health Action Planning and Health Facilitation through the provision of training and mentorship.
- Liaise with primary and secondary care services around individual service users.
- Provide a link nurse to all GP practices within its geographical boundaries.
- Facilitate a range of health promotion activities including delivering a health promotion group, health promotion road shows, health promotion courses and providing a healthy eating service.
- Improve the early identification of illness among people with learning disabilities by, for example, increasing uptake of annual health checks, and for women, cervical and breast screening.
- Enhance the health literacy of people with learning disabilities and of family carers and paid carers/supporters who play a critical role in promoting healthy lifestyles among many people with learning disabilities;
- Make 'reasonable adjustments' in all areas of health promotion and healthcare in light of the specific needs of people with learning disabilities and acting within the legal framework of the Mental Capacity Act 2005 (e.g., through providing more accessible information and longer appointment times);
- monitor progress towards the elimination of health inequalities faced by people with learning disabilities.

Section 5: Performance and Quality Monitoring

These outcomes were developed jointly with people with learning disabilities in Portsmouth. The outcomes indicators and performance measures to demonstrate progress against these outcomes have been agreed jointly between the ICS and ILDS health and social care managers.

A Programme Management Group (PMG) consisting of a senior ICS and ILDS managers will meet quarterly to review progress against the agreed measures.

5.1 Integrated Performance Targets

% of service users who have a named worker (target 90%)

% of reviews completed within 12 months (target 80% - s117 100%)

% of support plans completed within 12 months (target 80%)

% of people whose communication needs have been screened (target 80%)

% of support plans that are available in an appropriate format as suggested by their communication screen (target 90%)

% of people whose risk of choking has been screened (target 80%)

% of people who have a current Health Action Plan (target 80%)

% of referrals to the service that begin active support within 18 weeks (target 90%)

% of positive feedback from service users (target 80%)

% of people in supported living services compared to residential care (above 60%)

% of Service users are offered a personal budget as part of their review (90%).

For those KPIs where, as indicated in Appendix A, are to be provided as part of the Annual Report, this will be completed **during Apr/May** of each calendar year.

5.2 The Hospital Liaison Service has separate performance targets:

i) % of hospital admission forms (e.g. passports) used for all patients who are known to have a learning disability (target 90%)

ii) % of patients with a learning disability and with whom the liaison nurse/s have contact have consent forms completed accurately which are supported by assessment of capacity and best interest forms in relation to their hospital treatment (target 90%)

iii) % of cases where the need for a discharge planning meeting is considered and when needed occurs in good time to facilitate effective discharge of all patients with a learning disability (target 90%)

5.3 The community health services have separate performance targets around activity levels:

This is measured by the level of Face to Face activity across the service.

The combined annual target is for 8,400 face to face contacts per year (700 per month). This equates to:

CLDHT = 3,600 PA (300 per month)

CHT = 3,600 PA (300 per month)

IST = 1,200 PA (100 per month)

Performance to be reported in Annual Report.

5.4 Health Focused Quality Indicators

- Quality Schedule compliance submissions where required
- Delivery of care within an 18 week referral to treatment schedule
- User and carer satisfaction data will be continually gathered and analysed. This will be summarised within an annual report.
- The ILDS will undertake patient facing activity reviews to monitor effectiveness.
- The ILDS will introduce PROMs across all teams

5.5 Activity Boundaries

- Monitor 35 CC funded placements and 10 ECR‟s within current resources.
- Provide 30 hrs per week input to QAH within current resources.
- Night cover from the CHT is not provided.
- Training to external agencies is not provided, e.g. within the CC role, at no cost.

5.6 National Outcomes Frameworks

The local outcomes detailed above will support delivery of the following national outcomes which are shared or complimentary outcomes from NHSE, Public Health and Adult Social Care Outcomes Frameworks:

- Improving the wider determinants of health
- Health improvement
- Preventing people from dying prematurely
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- Enhancing the quality of life for people with care and support needs
- Ensuring that people have a positive experience of care and support
- Safeguarding adults who are vulnerable and protecting them from avoidable harm
- Avoiding inpatient admissions and length of stay

Appendix A: Quarterly Reporting Format to PMG (Performance Management Group)

KPI reporting format to be completed prior to each quarterly PMG meeting								
Performance Measure	**Target**	**Baseline**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**	**Commentary**	**RAG**
1. Services users are allocated a named worker	90%							
2. i) Service user statutory reviews completed within a twelve month period ii) Of i), s117 reviews completed	80%* 100%*						*% by end 4th Quarter	
3. Service users have clear support plans, completed within 12 months, with outcomes identified across the 5 key domains of: health, work, independence, communication and relationships	80%						*Annual Report required*	
4. i) Service users have had their communication needs screened ii) Support plans are in an appropriate format in adherence with their communication screen	80% 90%						*Annual Report required*	
5. Service users offered a risk of choking screen by ILDS.	100%						*Annual Report required*	
6. Service users with an up to date Health Action Plan in place	80%							
7. Service users referred to the ILDS will have active input within 18 weeks.	90%							
8. People using the service have a positive experience	80%						*Annual Report required (case study examples of where feedback has improved services to be provided)*	

9. Current proportion of Supported Living based support vs Residential Care	Maintain above 60%	60%						
10. Service users are offered a personal budget as part of their review.	90%							
Hospital Liaison service specific indicators								
11. Hospital admission forms used for patients (known to have an LD)	90%							
12. Patients with an LD and with liaison nurse contact, have consent forms completed accurately which are supported by assessment of capacity and best interest forms in relation to their hospital treatment	90%							
13. Cases where there is a need for discharge, are considered and when needed occurs in good time to facilitate effective discharge of the patient	90%							