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NHS England

Transforming Care

Model Service Specifications:
Supporting implementation of the service model

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Model Service Specifications:

A resource for commissioners to develop service specifications to support implementation of the national service model for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

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Equality and Health Inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values and the Transforming Care programme of work. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Further guidance for NHS Commissioners on Equality and Health Inequalities legal duties is available.

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Introduction

Supporting commissioners to develop service specifications to support implementation of the national service model for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

About this document

The Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.

The programme 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 hospital admissions and length of stay

These model service specifications are aimed at supporting health and social care commissioners to develop their own, locally-specific service specifications which support implementation of the national service model. They build on the service model by providing additional detail for commissioners about the purpose, functions and intended outcomes of three aspects of the service model[1].

"Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life."

Vision statement, national service model 2015.

These are:

1 **Enhanced/Intensive Support** (principle 7 of the service model)

2 **Community-based Forensic** Support (principle 8 of the service model)

3 **Acute Learning Disability Inpatient Services** (principle 9 of the service model)

These three aspects of the service model describe specialist health and social care provision aimed specifically at supporting people with a learning disability and/or autism who display behaviour that challenges. However, mainstream health and social care services can and should meet a large proportion of people's everyday needs. The following key principles (as described in the national service model) therefore apply to all three aspects of provision described in this document:

1 The starting point should always be for mainstream services to support people with a learning disability and/or autism, making reasonable adjustments where necessary and with access to specialist multi-disciplinary support as appropriate;

2 A core element of any such specialist provision should therefore be on enabling mainstream services, and other partners, to support people directly. Where meeting health and care needs are particularly complex, more intensive specialist multi-disciplinary support may be needed in order to ensure equity of outcome for people;

3 The onus is on service providers to put forward a compelling rationale for any proposal to deviate from the principle of supporting access to mainstream provision, whether community or hospital based services.

[1] Three advisory groups were established to support development of the three model service specifications. See Annex C.

As set out in the service model, the underpinning approach to transformation must be based on a whole system approach to delivering high quality support and services for people. For this to be a reality, services need to demonstrate a strong commitment to a shared value base which place individuals and their quality of life at the centre everything they do.

This value base should reflect the 'golden threads' of the service model and be evident on the basis of capable environments[2] within which care and support is delivered. Capable environments are characterised by:

- Positive social interactions,
- Support for meaningful activity,
- Opportunities for choice,
- Encouragement of greater independence,
- Support to establish and maintain relationships and
- Mindful and skilled family/carers and paid support/care staff

Delivery

What is described in these model service specifications are three "functions" of support that are needed locally to ensure improved outcomes for people.

How these functions of support are delivered will vary from area to area. The answer may not necessarily be about having one service delivering each 'function' (one dedicated Enhanced/Intensive Support service, one dedicated Community-based Forensic Support service, one specialist inpatient service). For example, it may be that one service can deliver two or more of the functions described.[3]

The solution will be dependent on local populations and geographies, and the capability and capacity of existing local services to deliver the functions of support outlined, as well as to meet the needs of differing groups with the wider population of people with a learning disability and/or autism who display behaviour that challenges (e.g. children or people with autism who don't have a learning disability).

It is likely that in some areas, pathways of care and support will need to be provided in partnership with already established teams, developing skills within those teams to provide for this population, rather than as discrete teams.

Whilst the focus and 'shape' of Transforming Care Partnership (TCP) transformation plans will vary, commissioners might find the following questions helpful in considering how the core functions of support described in these documents will be delivered locally:

- How are the core functions described currently being delivered?
- Where are the gaps?
- How are we reducing health inequalities in access and outcomes?
- How can the core functions be delivered in the future as part of local transformation?
- What data does the TCP have on this population (e.g. people known to services; young people approaching transition to adulthood; those in contact with the criminal justice system)

[2] See: http://www.kcl.ac.uk/sspp/policy-institute/scwru/news/2014/newsfolder/McGill-et-al-Capable-environments.pdf

[3] Case studies setting out how some of these functions of support are being delivered locally are included in the Annex of this document for the enhanced/intensive support and for the community forensic support specifications.

Teams delivering these functions of specialist support should agree clearly defined pathways for people, ensuring that individuals experience continuity of care and support and that there is clarity in the roles and responsibilities of different teams. These should be developed using a "no wrong door" principle and be based on need.

The Government is expected to publish its response to the National Data Guardian review of consent/opt-outs and cyber security. It may be necessary to review steps on the collection and use of data for these models, in the light of recommendations and requirements made in the response: https://www.gov.uk/government/organisations/national-data-guardian

Outcomes Frameworks

In commissioning the following services, commissioners should be mindful of the following outcome domains adapted from the NHS England Outcomes Framework, the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework:

Outcome	Measurement Domain	What this would mean for the individual
Preventing people from dying prematurely Improving the wider determinants of health	NHS Outcomes Domain 1 Public Health Outcomes Framework Domains 1 and 4	"My health needs are met by services making the reasonable adjustments I need." "I am supported to access mainstream health care provision, ensuring parity of esteem, in relation to my health needs." "I'm supported in a way that works for me and I get support to communicate what I need and how I am feeling." "I have access to a range of support that helps me to remain well and healthy." "I have a choice about where I live and who I live with." "I have a good and meaningful life."
Enhancing quality of life for people with long-term care and support needs	NHS Outcomes Framework Domain 2 Adult Social Care Outcomes Framework Domain 1	"I am treated with dignity and respect and I feel that I am valued." "I am in control of planning my care and support." "I am supported to maintain my independence and to have family relationships and friendships." "The people who are supporting me have the specialist skills and expertise I need." "I am supported by people who help me to make links in my local community."

Outcome	Measurement Domain	What this would mean for the individual
Helping people recover from episodes of ill health or injury Delaying or reducing the need for care and support	NHS Outcomes Framework Domain 3 Adult Social Care Outcomes Framework Domain 2 Public Health Outcomes Framework Domain 2	"I understand how the care, support and treatment I am getting is responsive to my needs." "I can get specialist help and support at an early stage to avoid a crisis." "I am supported to understand and manage my own behaviour, and to understand the consequences of my actions."
Ensuring that people have a positive experience of care and support	NHS Outcomes Framework Domain 4 Adult Social Care Outcomes Framework Domain 3	"I have information about my care and support that is accessible and up to date." "My family and paid staff are supported and know how to support me." "I am able to maintain relationships with family and friends." "I have help to make informed choices." "I am treated with dignity and respect and I feel that I am listened to."
Safeguarding vulnerable adults and children, and supporting people in a safe environment	NHS Outcomes Framework Domain 5 Adult Social Care Outcomes Framework Domain 4	"I am supported to manage any risks." "I am supported to be safe and a part of my community." "I feel that my community is a safe place to live and local people look out for me."
Reduced reoffending Reduced first time entrants to youth justice	Public Health Outcomes Domain 1	"I have my needs recognised in mainstream services and get the support I need." "I am offered early support to maximise my life chances."

2

Supporting commissioners to develop service specifications for Enhanced/Intensive Support

Specification: **Enhanced/Intensive Support**

This model service specification describes the core functions of Enhanced/Intensive Support that need to be delivered in the community in order to provide effective interventions for children, young people and adults with a learning disability and/or autism who present with behaviours that challenge which place themselves or others at risk of serious harm; or for whom the nature or degree of risk might otherwise lead to exclusion, placement breakdown, and admission to inpatient services.

It is a model service specification which will need adaptation by local commissioners.

(The use of [ADAPT TEXT] indicates where local changes are required.)

Population Needs[4]

National context and evidence base

The Enhanced/Intensive Support functions set out here need to be considered within the national context of 'Transforming Care' and the vision set out in Building the right support and the national Service model for commissioners of health and care services. Responsive, timely and appropriate local enhanced services are key to achieving the vision for moving away from the overreliance on inpatient care or other restrictive approaches, towards responsive, timely and appropriate interventions that support individuals to live satisfying lives in community settings. Such services also relate to good practice guidelines as set out in the Mansell Report (2007), which emphasised the need to provide highly specialist services in the community, close to people's homes, which emphasise early detection of any escalation of need and preventing crises from occurring.

Behaviours that challenge occur as a result of complex interactions between a person and their environment but are typically associated with a person having either acute or chronic unmet needs and/or an impoverished quality of life. Behaviours can include aggression, self-injury, stereotypic behaviour, withdrawal, and disruptive or destructive behaviour. Although such behaviours can challenge services, family members or carers, they may serve important functions for the person which goes some way to meeting otherwise unmet needs (e.g. producing sensory stimulation, attracting social attention, avoiding demands or communicating with other people).

While behaviour that challenges is the product of a complex interaction between biological, developmental and environmental factors, there is strong evidence that some of the key factors causing and/or maintaining behaviour that challenges are amenable to change, and that change in these factors is associated with marked reductions in risk of harm and exposure to restrictive and aversive responses and social exclusion; as well as improved quality of life for people and their families.

The primary approach to the prevention of behaviour that challenges involves the provision of high quality, person centred care and support, meaningful activities and relationships, which reduce the likelihood of people developing such behaviours in the first place and thereafter, prevent them from becoming entrenched.

Understanding the factors that increase the risk of people developing or displaying behaviours that challenge, and having a clear understanding of which individuals are most at risk, can enable services to work together to proactively put in place appropriate anticipatory support.

Primary preventative measures involve a wide range of mainstream services such as primary care, children's, mental health, housing, social care and education providing support to people who use services, their families and carers. In some instances, primary prevention may also include the provision of support by members of specialist multi-disciplinary teams such as community teams for people with a learning disability and/or for people with autism, able to support such services to consider how best to make reasonable adjustments and with the necessary skills to undertake assessments of need and to support delivery of interventions which lead to reductions in behaviours that otherwise might give rise to concern.

[4] This model service specification has been structured based on the NHS Standard Contract and needs to align to the relevant local authority standardised documentation.

Whilst early intervention is imperative across the lifespan, perhaps the most significant long term gains arise from early intervention in response to behaviours that challenge that begin to emerge in infancy or childhood. Such behaviours in small children can sometimes be easily managed but without appropriate intervention and support such as parent training, these behaviours can become ingrained and present a more significant risk and be more resistant to amelioration as the person ages.

For some people, where these primary preventative approaches prove insufficient, and behaviour that challenges may persist or become more serious to the point where a person and/or others are at risk of serious harm and where people are at risk of exclusion from ordinary community settings (including admission to hospital), there may be a need for more intensive support from specialist multi-disciplinary teams and/or, where the degree of concern about the impact of behaviours is greatest, access to an Enhanced/Intensive Support service.

Enhanced/Intensive support provides the specialist skills and capacity needed to work intensively across smaller caseloads and involves undertaking a range of activities which aim to reduce the likelihood of behaviour that challenges leading to long term restrictions of liberties, or future relapses. This includes therapies, rehabilitation techniques or interventions designed to help the person return to their desired lifestyle, as well as support to people returning to community settings from inpatient settings or other out of area placements, such as residential schools.

Prevalence

National context and evidence base

There are an estimated 1.2 million people in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2-3% of the general population). The majority live their lives without support from specialist learning disability services – for instance, of the roughly 1 million adults with a learning disability, it is estimated that 189,000 (21%) (Emerson et al. 2012) are known to learning disability services.

There are an estimated 700,000 people with autism in England (Brugha et al. 2012) of which 125,000 are children and young people under the age of 18 (Baird et al. 2006). This means that roughly 11 people in every thousand have autism (1.1% of the general population). It is estimated that 44%-52% of people with autism also have a learning disability (Emerson et al. 2010).

Those who display behaviour that challenges

Challenging behaviours are generally understood to be exhibited by 10-15% of adults with learning disabilities known to services (approx. 22-34,000 people), whilst often peaking between the ages of 20-49 (Emerson et al. 2001). A further 40,000 of children under the age of 18 are believed to display challenging behaviour (Emerson et al 2014).

As set out in Challenging Behaviour: A Unified Approach (Royal College of Psychiatrists, et al, 2007, p.14) challenging behaviour is behaviour "of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

Prevalence per 1 million population

Taking all of the above into consideration, all things being equal we would expect that for every 1 million general population, there would be:

- 400 – 650 adults with a learning disability and/or autism whose behaviour challenges
- 750 children with a learning disability and/or autism whose behaviour challenges

Not all of these individuals will require enhanced/intensive support. The caseload for each area will vary, dependent on local factors such as: (i) levels of support that local teams (such as community learning disability or autism teams) can offer before support from an enhanced service is needed, (ii) how many people are out of area and in need of support to return to the area, and (iii) complexity of individuals on caseload, as well as average episode of care and support period.

Examples of existing services providing the functions of support described in this model service specification for enhanced/intensive support indicate:

- An active caseload for a team (1 million general population) of approximately 10% of the group described above
- Episodes of support for those on the active caseload for periods averaging 3-6 months
- With 75% of time spent on direct work with individuals and 25% of time spent delivering other functions such as supporting mainstream and specialist services to better meet the needs of this client group.

Local prevalence

(Insert data on prevalence for the geographical footprint you want this function to serve. It is expected that to reach critical mass, this function will need to be delivered at a population of c. 1 million, i.e. at TCP/STP level. To arrive at local prevalence data, make use of the national figures above and local data e.g. from:

- *JSNA*
- *Dynamic registers*
- *Out of area placements*
- *Children in 52-week school placements*
- *Number of individuals previously excluded from local services*
- *Numbers experiencing responses such as seclusion, restraint, locked doors, abuse, punitive/aversive behaivoural interventions).*

Scope, Functions and Outcomes

Aims and objectives

The aim of this Enhanced/Intensive Support function is to reduce/manage behaviours that challenge, working with the person in their own residence, reducing/preventing the need for the use of restrictive practices, inpatient services and out-of-area/residential placements. There should be integration at a local level across all relevant services, including schools and care/support providers.

This should be achieved through 4 core functions of support:

- Assessment, treatment and support for individuals who display behaviour that challenges
- Provision of support, and person specific training for other agencies supporting those individuals
- Coordination of transitions from inpatient and other settings
- Crisis response

Each of these functions are described in more detail in the table on the following page, and include some suggested outputs and outcomes.

Each local area should have a dynamic register (as described in the national service model) which at a population level will inform the commissioning of support services and at an individual level will identify those who may go on to or are starting to display behaviour that challenges. The aim is to improve service design and enable early identification and intervention.

The provider will work closely with the commissioner at an operational and at a strategic level to develop and maintain this dynamic register. Actions will be in accordance relevant Information Governance policies. This may include the sharing of salient information from active caseload to identify at earliest stage those individuals who are at risk of admission to inpatient services, leading to agreed action to be taken to avoid unnecessary admission or to ensure in-reach and earliest return to community. On the basis of the dynamic register, the provider will accept referrals from the commissioner as required.

Core aims of Enhanced/ Intensive Support:	An increase in and sustainment of "capable environments"[5] within the local community A reduction in the reliance on restrictive practices A reduction in the use of inpatient services A reduction in the use of out-of-area and/or residential placements			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Support and training	Advice to commissioners and strategic planners on the design of services and supports with the aim of enhancing resilience and creating capable environments which do not rely on restrictive practices to manage behaviour that challenges. Expert support and advice to those who support the person on a day-to-day basis (including but not restricted to: families, personal assistants, voluntary, community, social care and other healthcare providers). Basic training and support to other services/support networks on evidence based approaches to supporting people who display behaviour that challenges (such as Positive Behavioural Support (PBS) and Active support) in order to enhance knowledge and skills across localities.	Increased resilience of providers, staff teams and family carers, enabling them to better support people. Increased involvement of families in the delivery and receipt of person specific training regardless of frequency of contact. Personalised, co-produced support plans that meet the needs of the individual and which effectively support people to manage their own needs. Enhanced working across agencies/providers. Increased information to commissioners on the quality of support provided to individuals.	Families, other carers and staff have increased confidence and understanding in supporting individuals. Improvements in quality of life for individuals and those who support them. Reduced hospital admissions. Reduced requests for crisis intervention. Risk of harm is reduced. Reduced use of restrictive practices and interventions. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Confidence measure of staff pre- and post- intervention Health equalities framework (HEF) Reduction in numbers of people in hospital settings Reduction in use of psychotropic medication Reduction in number of safety incidents reported	"My family and paid staff are supported and know how to effectively support me." "I am getting expert support from people with the right skills and expertise." "My needs are understood and met in ordinary community settings." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes." "I am respected and listened to." "I have access to services that are reasonably adjusted."

[5] See: http://www.kcl.ac.uk/sspp/policy-institute/scwru/news/2014/newsfolder/McGill-et-al-Capable-environments.pdf

Core aims of Enhanced/ Intensive Support:	An increase in and sustainment of "capable environments"[5] within the local community A reduction in the reliance on restrictive practices A reduction in the use of inpatient services A reduction in the use of out-of-area and/or residential placements			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Assessment, treatment and support	Detailed assessments of bio-pyscho-social needs and behaviour, using a functional assessment approach, and in collaboration with others who know the person well. People who use services and their families are expert partners within the assessment process. Devising and supporting the implementation of behaviour support plans that may include recommendations for environmental modifications, lifestyle changes, skills development, carer support and advice regarding safe and constructive response to occurrences of behaviours, and which take account of peoples' hopes and aspirations as recorded in their person centred plans. Support in the development of person-centred plans if the person doesn't have one. This may include provision of communication and/or hospital passports or Health Action Plans. Behaviour support plans should take account of the knowledge and skills of those who will implement it and of their support needs. Provision of bespoke, person-focused training to ensure that PBS plans are understood and implemented correctly, and support to monitor the effectiveness of intervention plans. Specialist risk assessments.	Assessments take full account of a person's mental/physical health needs as well as their cognitive and communication needs. Complex needs and environmental interactions which predict the occurrence of behaviours that challenge are described and understood within a broader context of overall wellbeing. Effective, evidence based, solution focused interventions are delivered within community settings. People develop new strategies by which to better meet their own needs. Families and other sources of support have increased confidence and skills in supporting the individual and remain fully involved. Risk assessments and management strategies that ensure the wellbeing and safety of all. Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity.	Risk of placement breakdown is reduced. Risk of harm (to self and others) is reduced. Reduced requests for crisis intervention. Reduced hospital admissions. People are supported to manage their own needs. People are supported to be involved in decision making processes. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Health Equalities Framework (HEF) Reduction in numbers of people in hospital settings Increased numbers of people who feel supported to manage their own needs Health of the Nation Outcome Scales for Learning Disability (HoNOS-LD) Evidence of increased community inclusion and participation Patient Report Experience Measures (PREM) Patient Report Outcome Measure (PROM) Reduction in number of safety incidents reported Reduction in use of medication; less complex drug regimes	"My family and paid staff are supported and know how to effectively support me." "I am getting expert support from people with the right skills and expertise." "My needs are understood and met in ordinary community settings." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes." "I am respected and listened to." "I have access to services that are reasonably adjusted."

Core aims of Enhanced/ Intensive Support:	An increase in and sustainment of "capable environments"[5] within the local community A reduction in the reliance on restrictive practices A reduction in the use of inpatient services A reduction in the use of out-of-area and/or residential placements			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Coordination of transitions from inpatient and other settings	Local leadership and coordination across multiple agencies (both providers and commissioners) at and around times of significant transitions, including from inpatient settings or other out of area placements such as 52 week placements. This may be through direct case management with individuals or though advising and guiding other teams.	Multiple agencies contribute to meeting peoples' needs in a well-coordinated manner. Responsibilities for delivering effective care and support are transparent. Community specialist team care co-ordinator receives enhanced support and guidance as required In reach to and discharge from hospitals and return to community living are more successful. Including the collation of support plans and support to families and support staff to implement these.	Timely return to the community. Support and facilitation to least restrictive settings. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Reduced length of stay in hospital settings Personal Outcomes Evaluation Tool (POET) Patient Report Outcome Measure (PROM)	"I understand what is happening to me and how my care and support is responsive to my needs." "I am supported to be safe and a part of my community." "I am supported to regain my independence."

Core aims of Enhanced/ Intensive Support:	An increase in and sustainment of "capable environments"[5] within the local community A reduction in the reliance on restrictive practices A reduction in the use of inpatient services A reduction in the use of out-of-area and/or residential placements			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Crisis response	Direct and urgent support in response to a crisis that might otherwise lead to family/service breakdown; admission to an inpatient setting; or an out of area placement. Rapid risk assessment and liaison with care commissioners and/or providers with a view to making immediate modifications to the person's care and support with the aim of reducing the risk of harm / placement breakdown. Support delivered across a range of community settings e.g. people's own homes, family homes, short break services, residential placements, short-term accommodation etc. Services are able to put in place time-limited direct and intensive support, including supporting paid carers/family carers with hands on support. Operates flexibly across 24/7 to meet needs.	The person is effectively safeguarded from potential harm. Improved confidence amongst families and those who provide day-to-day care and support. Risk assessments and management strategies that ensure the wellbeing and safety of all. People are able to stay within their community, close to family and friends ensuring maintenance of important friendships, relationships and activities.	Reduced reliance on excessively restrictive reactive management approaches. Reduction in numbers of people in hospital settings. More people are living in the community. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Health equalities framework (HEF) Reduction in numbers of people in hospital settings Reduction in numbers of people in out of area placements.	"I am supported in my own home and community." "I maintain supportive relationships with the people who are important to me." "I am safe." "Those who support me are safe."

Delivery structure

The functions of Enhanced/Intensive Support described in this service specification should add to existing specialist community provision which will lead on early identification and intervention, and support the majority of people who display behaviours that challenge. The Enhanced/Intensive support function is expected to be delivered by:

(Delete as appropriate)

a) A discrete team/service, delivering only these functions,
OR
b) An existing team/service(s) (such as community learning disability teams), delivering these functions as part of a broader service or across more than one service or team

The provider should ensure it has capacity to undertake assessment and treatment activities across all times of day, including at weekends – this may mean supplementing existing support networks, for short periods, through the introduction of hands-on specialist support in peoples' own homes.

The provider will routinely have time limited, solution focused contact with individuals with on-going responsibility being maintained by the relevant community team, care agency or other service.

Workforce competencies

Existing specialist community teams (such as those for people with learning disabilities) should have the knowledge, skills and capacity to undertake a prevention role, early identification and interventions, preliminary assessments of behaviours and needs, and implement multi-disciplinary interventions amongst this group.

The Enhanced/Intensive support function should however be able to undertake more sophisticated and specialist assessments and have oversight of resulting packages of interventions. Regardless of configuration, services should be able to provide this two tiered approach to assessment in accordance with relevant NICE guidance as well as demonstrating that practitioners have the necessary pre-requisite competencies, consistent with the recommendations of Health Education England.

The Enhanced/Intensive support function should be fulfilled by multi-disciplinary staff teams, who have expertise in working with people with a learning disability and/or autism and whose composition spans health, social care, education, further education and employment.

Delivery of the functions described will require:

- Learning disability nursing
- Occupational Therapy (OT)
- Speech and Language Therapy (SALT)
- Clinical psychology
- Social work
- Behaviour analysis
- Psychiatry
- Pharmacist
- Support workers
- Educationalists
- Therapeutic specialists in other areas
- Care and support providers

Health Education England have produced a range of generic role templates for the delivery of learning disability services in the community. These templates will be of particular interest to those developing Enhanced/Intensive Support services. There is an accompanying guide for service commissioners and providers: Using generic role templates for the delivery of learning disability services in a Community Setting.

The provider should also employ people with a learning disability and/or autism and their families as experts by experiences for specific roles such as peer support lead(s) or quality checkers, as trainers and in the recruitment of staff.

Staff members will have knowledge, skills and experience, at practitioner and at expert level, of effective working with people with a learning disability and/or autism and the ability to operate within a Positive Behavioural Support Framework, as well as the skills and expertise that enable them to work in community settings and peoples' own homes. **These include an awareness, understanding and demonstrable competency in the following areas:**

- Mental health issues
- Application of the Mental Capacity Act
- Deprivation of Liberty (DoLs) and knowledge of how to implement local procedures
- Evidence based interventions
- Risk appraisal
- Emotional intelligence
- De-escalation techniques
- Family sensitive working
- Cultural competence
- Ability to work, at times, autonomously
- Confident decision making under pressure
- Effective communication and teaching skills
- CPA, care-coordination and care management processes
- Ability to engage with a range of different professionals and agencies/caseload management

It is important to note that the delivery of this function should be recognised as a challenging and occasionally traumatic area of work for staff whose effectiveness will rely on good access to support, training and ongoing supervision.

Population covered

The population covered by this document will be

(Insert geographical footprint - to reach critical mass required to deliver this function correctly, it is expected that it will need to be delivered at TCP/STP level with a population of c. 1 million).

Any acceptance and exclusion criteria and thresholds

Enhanced/Intensive support needs to be available to children, young people and adults who have:

- A learning disability; and/or
- Autism; or
- In the absence of a confirmed diagnosis of either a learning disability or autism, evidence that on the balance of probability such a condition may be present

And:

- Who present behaviour of a nature or complexity and/or with a degree of associated concern, that requires more than primary preventative strategies; and
- Where the risk of harm, exclusion or exposure to aversive contingencies is such that it requires an intensity of case working (including assessment and treatment) that exceeds the capacity of other community teams/services (either alone or in isolation, specialist or generic/mainstream); or
- Where the individual requires advance clinical/case management skills that are similarly not available within other community teams/services.

Interdependence with other services/providers

The operation of Enhanced/Intensive Support is inherently linked to mainstream mental health services, child services, community learning disability services, autism services and housing services. The provider will need to work collaboratively with other forms of mainstream, community or inpatient provision providing support to individuals.

Without a coordinated and joined up approach, progress is likely to be undermined, people will be at risk of falling between gaps in service provision and unintended consequences may ensue. Therefore the provider will need to agree with other services a range of support pathways and ensure the range of knowledge and skills required are reflected in local workforce strategies.

The provider of enhanced/intensive support needs to build, develop and maintain effective operational relationships with a range of organisations, including, but not exhaustively:

- Community services for people with a learning disability and/or autism
- Children's services
- Family services
- Education services
- Social services
- Safeguarding services
- Providers of social care and support
- Adult community mental health services
- CAMHS services
- Community nursing and matron services
- Primary Health Care Services
- Independent, Private and Third Sector Service Providers
- The Home Office
- Criminal Justice System partners, including Courts
- Forensic Support Services

- Generic and learning disability and/or autism specific advocacy services
- Local Mental Capacity Act and Deprivation of Liberty leads
- Department for Work and Pensions (DWP)
- Job centre plus

Applicable Service Standards

(The following are suggestions)

Applicable national standards (e.g. NICE)

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guidelines, May 2015
- Autism in adults: diagnosis and management, NICE guidelines, June 2012
- NHS England Care and Treatment Review guidance
- Positive Behavioural Support Competency Framework
- Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, NHS England, ADASS, LGA, October 2015
- Confidential Enquiry into premature deaths of people with learning disabilities
- Guidance for NHS commissioners on Equality and Health Inequalities legal duties

(To be filled in locally)

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Mansell report: Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (revised), Department of Health, October 2007
- Ensuring quality standards, Local Government Association, NHS England, 2014
- Challenging behaviour: a unified approach - update, Royal College of Psychiatrists, March 2016
- Paving the way: how to develop effective local services for children with learning disabilities whose behaviours challenge, Challenging Behaviour Foundation and the Council for Disabled Children, 2016

(To be filled in locally)

Applicable local standards

(To be filled in locally)

Applicable quality requirements and CQUIN goals

Applicable Quality Requirements (See Schedule 4A-C)

Whilst quality standards will be agreed at a local level it is recommended that quality checkers are used as a regular form of quality assurance, it is expected that the service quality checkers will include experts by experience and parents and carers. It is expected that services will ensure training and support is provided to ensure involvement is meaningful and leads to a process of continuous improvement.

(To be filled in locally)

Applicable CQUIN goals (See Schedule 4D)

(To be filled in locally)

See Annex A for case studies of existing services which are delivering aspects of the Enhanced/Intensive Support functions described in this model service specification.

3

Supporting commissioners to develop service specifications for Community-based Forensic Support

Specification: **Community-based Forensic Support**

This model service specification describes a number of core functions that need to be delivered locally in order to provide effective specialist Community-based Forensic Support to meet the needs of adults (aged 18 and over) -

- With a learning disability and/or autism
- Who display behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves)
- Where this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e. relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours).

Note: Whilst this specification applies to adults only, the core functions for delivery are relevant to children and young people. NHS England will shortly be commissioning forensic CAMHS outreach services, aimed at children and young people under the age of 18, and which is inclusive of children and young people with a learning disability and/or autism. These two specifications are interrelated, recognising that behaviours leading to contact with the criminal justice system as adults will often present in childhood.

It is a model service specification which will need adaptation by local commissioners.

(The use of [ADAPT TEXT] indicates where local changes are required.)

Population Needs[6]

National context and evidence base

The community forensic functions described below are focussed on the provision of community-based support to people with a learning disability and/or autism who display behaviour that can lead to contact with the criminal justice system (such as fire-setting, physically aggressive/violent or sexually inappropriate behaviour).

The Reed and Bradley reports (1992, 2009) outlined clear principles of support for people with a learning disability who offend, including through the provision of support and treatment in the community rather than in hospital settings, early identification of people in the criminal justice system and appropriate community-based treatment and support packages for those at risk, as well as other community disposal options (such as community orders) as an alternative to secure settings or prison.

The Transforming Care programme, and the relevant underpinning policy (in Building the right support and the national service model for people with a learning disability and/or autism who display behaviour that challenges) builds on this previous policy and approach with the aim of developing community capacity that meet the needs of people with a learning disability and/or autism who display behaviour that challenges, including behaviour that can lead to contact with the criminal justice system. The aim is for a reduction (from October 2015) in the number of people in secure inpatient settings by 2019 of between 25% and 40%.

The service model describes how people with a learning disability and/or autism who come into contact with the criminal justice system, or those at risk of such contact, often 'fall through the gaps' of existing provision; often excluded from mainstream mental health or forensic services because of their learning disability and/or autism, and excluded from learning disability services because they are considered too able or too high risk, or because they have autism but do not have a learning disability.

The functions of the community-based provision required described in this model service specification provide preventative, reactive and evidence based interventions through a combination of specialist risk assessment and management, face to face therapeutic interventions and support, as well as support, training and consultancy to other services to meet the needs of this group. A core element of this provision is about the facilitation of smooth and effective discharge from secure inpatient settings and release from custody.

This function of community support is reliant on interdependencies across the local geography to ensure that needs of the population as a whole are met, either by providing the intervention directly or by supporting colleagues to provide interventions as needed. These interdependencies include links with mainstream services, which can support the various needs that the person has – for example, mainstream mental and physical health services, drug and alcohol provision and care and support to address childhood trauma.

Whilst supporting people in the community through effective risk management, there is a need to balance supporting people to take risks within a supportive, evidence based risk management structure whilst ensuring that they are protected from potential harm and that the community is kept safe. Services delivering the functions of support described here will also need to take into account the legislation around supporting the rights of the victims of crime.

[6] This model service specification has been structured based on the NHS Standard Contract and needs to align to the relevant local authority standardised documentation.

Prevalence

National prevalence

There are an estimated 1.2 million people in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2-3% of the general population). Of the adult population, it is estimated that 189,000 (21%) (Emerson et al. 2012) are known to learning disability services. Studies to screen for learning disability in police custody suites, probation services and prisons all suggest prevalence of 5-10% (higher in youth justice). Based on the current prison population, this could mean there are about 6,000 people with a learning disability in prison (Landman, 2016).

There are an estimated 700,000 people with autism in England (Brugha et al. 2012) of which 125,000 are children and young people under the age of 18 (Baird et al. 2006). This means that roughly 11 people in every thousand have autism (1.1% of the general population). It is estimated that 44%-52% of people with autism also have a learning disability.

Those in contact with the criminal justice system

It is difficult to accurately estimate how many people with a learning disability and/or autism are involved in the various elements of the criminal justice system. This is due to a number of factors, including those people with a learning disability and/or autism who are not identified or recognised within the criminal justice system and an inconsistency in data collections and terminology (e.g. 'learning disability' and 'learning difficulty').

In addition, prevalence and incidence studies often focus on those known to services and do not always take account of those people who may be known to police but not prosecuted or where incidents have not been reported. Many of those people who are admitted to secure inpatient settings may not have previously been known to adult services prior to their contact with the criminal justice system, and may not have received a formal diagnosis of learning disability and/or autism until admission to hospital.

National data should therefore be applied with caution and attempts to establish a more robust understanding of local populations should be undertaken in partnership with relevant criminal justice agencies. However, to give some context, it has been estimated that between 5 and 10% of those people known to learning disability services have had contact with parts of the criminal justice system (Murphy, 2015). Nationally, if those known to learning disability services number 189,000, those in contact with the criminal justice system will number approximately 8,500 to 19,000 people, equating to approximately 200-400 per million population.

This will represent a wide range of people, behaviour and levels of contact with the criminal justice system, and the majority will not require specialist and/or forensic support and would not be described as high risk or at risk of serious offending behaviours. Many will be able to access non-specialist community services, albeit with support; others may be more appropriately supported by community learning disability teams or enhanced/intensive support services. This will be dependent on a number of factors including the capacity and skill-set of other teams, but also on individual need and circumstance - e.g. the ability and capacity of the person to benefit from offender/treatment programmes.

Within the secure inpatient population

The Assuring Transformation data (as at 30/09/2016) tells us that, nationally, there are around 1,300 people with a learning disability and/or autism currently in secure forensic inpatient settings. 975 inpatients are in services under Part Three of the Mental Health

Act ("patients concerned in criminal proceedings or under sentence"). Of these 975, 605 are restricted patients, with Ministry of Justice involvement. This can mean, as part of conditional discharge arrangements, there are additional restrictions required to be in place in the community.

Some people under a civil section may be detained in secure settings where they pose an equivalent level of risk to others. For example, those who have been diverted away from the criminal justice system as a result of criminal justice agencies not taking the case through the courts, or discontinuing proceedings once it is seen that the person is already in hospital.

Current policy (see Building the right support) anticipates a reduction of 25-40% in secure hospital settings by March 2019, with local areas using no more than 20-25 beds per million population. This equates to 215 -440 fewer people in secure settings, and there is a need for increased forensic capacity within the community to support this ambition – both supporting transitions out of secure inpatient settings, as well as in preventing future admissions.

Prevalence per 1 million population

Taking all of the above into consideration, all things being equal and what we know of existing 'distinct' community forensic teams for people with a learning disability, we would expect that for every 1 million general population, a community forensic support function would likely need to be able to support:

- An active caseload of between 40-60 people (plus a monitoring caseload and support to wider services), plus
- Those people being discharged from secure care. (Capacity requirements will vary dependent on number of people currently in inpatient care and in line with the current policy ambitions to reduce overall inpatient numbers).

Local prevalence

(Insert data on prevalence for the geographical footprint you want this function to serve. It is expected that to reach critical mass, this function will need to be delivered at a population of c. 1 million, i.e. at TCP/STP level. To arrive at local prevalence data, make use of the national figures above and local data e.g. from:

- *JSNA*
- *Dynamic registers*
- *Local criminal justice agencies - e.g. youth offending teams*
- *People in secure accommodation - e.g. inpatient settings and prisons).*

Scope, Functions and Outcomes

Aims and objectives

The aim of this Community-based Forensic Support function is to reduce or safely manage behaviour amongst people with a learning disability and/or autism which may put members of the public at risk, and would thereby otherwise lead to contact with the criminal justice system or admission to a secure hospital. Throughout delivery of all elements of the functions of support detailed below there should be a focus on prevention and early intervention through collaboration with other services.

This should be achieved through six core functions of support:

- Forensic risk assessment and management of risk in the community to ensure public safety and safety of the individual
- Delivery of offence-specific therapeutic interventions (e.g. to prevent sexual/violent offences)
- Case management of the most complex cases
- Support and training to other agencies providing day to day support to this group
- Consultancy and advice to system partners
- In-reach support to ensure safe and timely discharge

Each of these functions are described in more detail in the table on the following page, and include some suggested outputs and outcomes.

Each local area should have a dynamic register (as described in the national service model) which at a population level will inform the commissioning of support services and at an individual level will identify those who display behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves) and where this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e. relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours). The aim is to improve service design and enable early identification and intervention.

The provider will work closely with the commissioner at an operational and at a strategic level to develop and maintain this dynamic register. Actions will be in accordance relevant Information Governance policies. This may include the sharing of salient information from active caseload to identify at earliest stage those individuals who are at risk of admission to inpatient services, leading to agreed action to be taken to avoid unnecessary admission or to ensure in-reach and earliest return to community. On the basis of the dynamic register, the provider will accept referrals from the commissioner as required.

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Forensic risk assessment and management of risk in the community	Specialist forensic risk assessment, and/or training in the assessment of risk and expertise in the management of risks in the community. Detailed assessments are developed in partnership with individuals and families and facilitate the formulation of robust multi-disciplinary risk management strategies. These inform the therapeutic process whilst promoting public safety and emphasising a strong recovery based ethos to support. Delivery of adapted community-based offender/health programmes that meet the needs of people with a learning disability and/or autism (e.g. for substance misuse, social skills or sex offender treatment) that support choice and control alongside positive risk management. Direct and urgent support in a crisis which might otherwise lead to admission to an inpatient setting. Operates flexibly across 24/7 to meet needs.	Risk assessments and management strategies that ensure the wellbeing and safety of all. Innovative solutions to positive risk management. Early identification of those at risk of offending. Co-design and development of individualised and person-centred treatment and support plans that mitigate risk. Meaningful, less restrictive alternatives to hospital admission are in place in the community. Reasonably adjusted mainstream programmes for offenders that meet the needs of people with a learning disability and/or autism. Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity.	Risk of harm (to self and others) is reduced. Reduced hospital admissions. Prevention and reduction in offending/forensic behaviours. Reduced use of restrictive interventions. Increased confidence and skills of families and other sources of support in supporting the individual. **Potential measure(s):** Reduction in risk scores relating to: • HCR-20 (Historical Clinical Risk Management -violence risk assessment scheme • SVR-20 (Sexual Violence Risk) HoNOS-LD scores – (Health of the Nation Outcome Scale – Learning Disability) Reduction in numbers of people in hospital settings Increased numbers of people with a learning disability and/or autism accessing programmes for offenders in the community Health Equalities Framework (HEF)	"I am getting expert support from people with the right skills and expertise." "I am supported to be safe and a part of my community." "I am recognised and respected as the person I am." "I understand how the care and support I am getting is responsive to my needs." "I understand what I must do and what I must not do to stay out of trouble" "I know what to do if I am in a situation I know is risky."

Core aims of community-based forensic support:	A reduction in the number of people with a learning disability and/or autism who require inpatient facilities. A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system. Improved support to people through the criminal justice system			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Delivery of offence-specific therapeutic interventions	Delivery of individual and/or group offence-specific interventions, such as work to prevent sexual or violent offences. This could include offering adapted community orders (with adapted treatment programmes or mental health treatment requirement (MHTR) options) to the courts in partnership with the police, probation and other partners and work with Liaison & Diversion service to inform court and pre-sentence reports.	Development and delivery of community-based interventions that are adapted to meet the needs of this group. Support and expertise to criminal justice system partners. Effective, outcome and evidence based interventions delivered within community settings. Management strategies that ensure the wellbeing and safety of all.	Reduction in behaviour leading to contact with the criminal justice system. Increased treatment options in the community. Reduction in numbers of people in hospital settings Risk of harm (self and others) is reduced. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Number of MHTRs/adapted programmes available for people with a learning disability and/or autism. Numbers of people accessing MHTRs/adapted programmes. Health Equalities Framework (HEF) Patient Report Experience Measures (PREM) Patient Report Outcome Measure (PROM) Recovery Focused Outcome measures	"I am supported to understand and manage my own actions, and to understand the consequences of them." "I understand how the care and support I am getting is responsive to my needs." "I am supported to be part of my community."

Core aims of community-based forensic support:	A reduction in the number of people with a learning disability and/or autism who require inpatient facilities. A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system. Improved support to people through the criminal justice system			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Case management and interventions	Case management and direct support of individuals with the most complex needs, through delivery of specific therapeutic interventions. Support delivered across a range of settings, such as the person's own home as well as in inpatient facilities.	Co-design, development and delivery of individualised and person-centred treatment and support plans that mitigate risk factors. People are enabled to develop strategies that manage their behaviours. Management strategies that ensure the wellbeing and safety of all.	Reduction in numbers needing to access treatment in a hospital setting. Reduction in behaviour leading to contact with the criminal justice system. Reduction in breakdowns in support. Increased treatment options in the community. Risk of harm (self and others) is reduced. **Potential measure(s):** Quality of life outcome measures LD HoNOS. Health Equalities Framework Recovery Focused Outcome measures.	"I am getting expert support from people with the right skills and expertise." "I am supported to be safe and a part of my community." "I am supported to understand and manage my own actions, and to understand the consequences of them." "I understand how the care and support I am getting is responsive to my needs."

Core aims of community-based forensic support:	A reduction in the number of people with a learning disability and/or autism who require inpatient facilities. A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system. Improved support to people through the criminal justice system			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Support and training to those providing day to day support	Expert support and training to providers of day to day support in the community (including but not restricted to families, personal assistants, voluntary, community and social care providers), helping with the design of services and supports and facilitating least restrictive settings. Support in the development of contingency plans for crises and relapses.	Increased capacity and capability of community providers, families and others including understanding of the criminal and youth justice systems Support and training resulting in person-centred support and care Staff and family carers are able to identify early signs of risk, and have the skills to address this. Enhanced working across agencies/providers.	Reduction in behaviour leading to contact with the criminal justice system. Reduction in numbers needing to access treatment in a hospital setting. **Potential measure(s):** Number of staff receiving training Staff feedback Quality of life outcome measures Health Equalities Framework Confidence measure of staff/ families pre and post intervention	"My family and paid staff are supported and know how to effectively support me." "I am supported to be safe and a part of my community." "My needs are understood and met in ordinary community settings." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes." "I have access to service that are reasonably adjusted."

Core aims of community-based forensic support:	A reduction in the number of people with a learning disability and/or autism who require inpatient facilities. A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system. Improved support to people through the criminal justice system			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Consultancy and advice	Consultancy, support and collaborative working with other services/agencies (such as social care and mental health services, the police, MAPPA, Liaison and Diversion, the courts, probation, youth offending teams, housing and employment) to support pathways away from the criminal justice system where appropriate, or to ensure that an individual's passage through the system is informed and adapted to meet their needs. Including training to frontline staff (e.g. police in custody suites). Collaborative working with the criminal justice system is paramount in the contribution to the assessment, treatment and management of people whilst promoting recovery and being mindful of public safety.	Support and reasonable adjustments ensuring appropriate support for people through the criminal justice system. Criminal justice system partners are better skilled to work with and support people with a learning disability and/or autism. Clear pathways for (appropriate) diversion from the criminal justice system to health and social care services. People are better supported to exercise their rights. Recommendations for community disposal options from people with the right expertise to make recommendations for treatment. Risk assessments and management strategies that ensure the wellbeing and safety of all.	Early intervention and prevention leading to a reduction in numbers offending Fair access to the criminal justice system **Potential measure(s):** Health Equalities Framework (HEF) Quality of Life outcome measures Confidence measures of staff in Criminal Justice System and other services pre and post intervention	"I am supported to understand my legal rights and to access the criminal justice system/ youth justice system." "I have access to service that are reasonably adjusted." "I am respected and listened to." "I am treated fairly in the justice system."

Core aims of community-based forensic support:	A reduction in the number of people with a learning disability and/or autism who require inpatient facilities. A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system. Improved support to people through the criminal justice system			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
In-reach support	Liaison role for individuals, to enable a safe, well-managed and timely return to the community for those being discharged from secure hospital settings and other secure settings. This may be through direct work with individuals or through advising other teams. This should be both about facilitating discharge and following up on patients following discharge, preventing readmissions.	People experience co-ordinated discharge planning There is a clear care pathway for each patient from hospital though to discharge Multiple agencies contribute to meeting peoples' needs in a well-coordinated manner. Responsibilities for delivering effective care and support are transparent Early identification of discharge pathway/placement Discharge from hospitals and return to community living are more successful	Timely return to the community Support and facilitation to least restrictive settings **Potential measure(s):** Reduced length of stay in hospital settings Reductions in readmissions/re-offending Patient Reported Outcome Measures (PROM) Patient Reported Experience Measures (PREM) Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Personal Outcomes Evaluation Tool (POET)	"I am supported to regain my independence." "I am supported to be safe and a part of my community." "I understand what is happening to me and how my care and support is responsive to my needs."

Delivery structure

The functions of community-based forensic support are expected to be delivered by (or a combination of)

(Delete as appropriate)

a) existing mental health forensic teams in the community, with staff who have specialist knowledge and expertise in working with people with learning disability and/or autism

b) specialist community learning disability/autism team(s), with staff who have specialist knowledge and expertise in working with people who present a forensic risk

c) a specialist forensic learning disability and/or autism service, focused on a sub-set of the population (i.e. those with forensic needs which cannot be met by existing local mental health, forensic or learning disability/autism services; including those who may pose the most significant risk to others or who demonstrate the most serious offending behaviours). This should function as a tertiary level service, operating over a large geography and working closely with more local mental health and learning disability/autism services.

The provider will need to agree local pathways with providers of other related services to ensure seamless provision of support to this population.

Services should identify how they will manage the transition from children's to adult services to ensure continuous and effective support. Providers will need to co-operate / collaborate in relation to service provision over the transition period.

Workforce competencies

The functions of community forensic support should be delivered by both health and social care professionals, providing a collaborative multi-disciplinary approach to support that is focused on supporting people through a combination of the right specialisms and expertise, within the broader context of the individual's whole life, including, their family and the community in which they live and work. Regardless of configuration, services should be able to demonstrate that practitioners have the necessary pre-requisite competencies, consistent with any recommendations by Health Education England.

Delivery of the functions described will require:

- Forensic psychiatry
- Clinical psychology
- Learning disability nursing
- Social work
- Occupational therapy (OT)
- Speech and language therapy (SALT)

Health Education England have produced a range of generic role templates for the delivery of learning disability services in the community. These templates may be of use to those developing community-based forensic support services. There is an accompanying guide for service commissioners and providers: Using generic role templates for the delivery of learning disability services in a Community Setting.

The provider should also employ people with a learning disability and/or autism and their families as experts by experiences for specific roles such as peer support lead, as quality checkers, as trainers and in the recruitment of staff.

Staff members will have:

- Knowledge, skills and experience of effective working with people with learning disabilities and/or autism
- Knowledge, skills and capability to work with the forensic population of people with a learning disability and/or autism
- Knowledge and skills to conduct assessment of risk (including risk to others and to self) and in the management of risk
- The ability to recognise and manage emerging risks and to provide interventions to reduce risks to self and others
- In-depth knowledge of the relevant legal frameworks relevant to working with people with a learning disability/autism, including the Mental Health Act and Mental Capacity Act
- Knowledge and understanding of the criminal justice system and related agencies, including the police, liaison and diversion, court, prison, MAPPA and the probation service
- Knowledge of the management of common psychiatric comorbidities associated with this group such as personality disorder, substance misuse and significant mental health issues
- Knowledge of the management of past/childhood trauma and ability to provide specific therapeutic interventions to address this

It is important to note that this sort of support and intervention be recognised as a challenging and occasionally traumatic area of work for staff whose effectiveness will be reliant on good access to support, training and ongoing supervision.

Population covered

The population covered by this document will be

(Insert geographical footprint - to reach critical mass required to deliver this function correctly, it is expected that it will need to be delivered at TCP/STP level with a population of c. 1 million).

Any acceptance and exclusion criteria and thresholds

Since the functions described above do not necessarily apply to a single service, these referral criteria are deliberately broad. **The core functions of this support is for adults with:**

- a confirmed diagnosis of learning disability; and/or
- a confirmed diagnosis of autism; or
- in the absence of a confirmed diagnosis of either a learning disability or autism, evidence that on the balance of probability such a condition may be present

AND who either:

- have a conviction for an offence
- have had an allegation of offending made against them
- are considered to be at significant risk of offending
- present a risk of serious harm to the public

Nb. "At risk of offending" means that an individual has exhibited behaviours which could be construed as an offence (such as assault) or have carried out activities which may be viewed as pre-cursors to more serious offending behaviours.

The provider should take referrals from a wide range of sources including housing, criminal justice system agencies and health and social care services. It should also establish mechanisms for self-referral and from families and carers. The service should accept referrals on the basis of need rather than being restricted purely to diagnosis.

Interdependence with other services/providers

The operation of specialist community forensic provision is inherently linked to the delivery of support within mainstream mental health/forensic services, children and young people's services, community and inpatient learning disability services, autism services and enhanced/intensive support services. The provider needs to work collaboratively with other forms of mainstream community or inpatient provision providing support to individuals.

Whichever way the functions of support described in this specification are delivered (dependent on local circumstances), there is a need for working across age groups ensuring a smooth transition from children to adult services. Local all-age pathways will need to be agreed between service providers to ensure a comprehensive and seamless provision of support.

Without a coordinated and joined up approach, progress is likely to be undermined, people will be at risk of falling between gaps in service provision and unintended consequences may ensue. Therefore, the creation of locally agreed support pathways and amendments to existing service specifications will be required.

The provider of community-based forensic support needs to build, develop and maintain effective operational relationships with a range of organisations, including, but not exhaustively:

- Secure inpatient services
- MAPPA
- Community Safety Teams
- Prison healthcare
- Youth Justice services
- Prisons
- Public health
- Liaison and diversion
- Community teams for people with a learning disability and/or autism
- Social services and other Local Authority departments e.g. housing, education
- Adult mental health and forensic health services
- CAMHS/forensic CAMHS services
- Courts
- Providers of day to day support
- Police
- Probation
- Safeguarding leads
- Crown Prosecution service

Applicable Service Standards

(The following are suggestions)

Applicable national standards (e.g. NICE)

- Harmful sexual behaviour among children and young people, NICE guidelines, September 2016
- Autism in adults: diagnosis and management, NICE guidelines, June 2012
- NHS England Care and Treatment Review guidance
- Guidance for NHS commissioners on Equality and Health Inequalities legal duties
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guidelines, May 2015
- Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, NHS England, ADASS, LGA, October 2015
- Mental Health problems in people with learning disabilities : prevention, assessment and management, NICE, September 2016
- Antisocial personality disorder: prevention and management, NICE, January 2009, updated March 2013
- Drug Use disorders in adults – Quality Standards, NICE, November 2012

(To be filled in locally)

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- The Bradley report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009
- Mansell report: Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (revised), Department of Health, October 2007
- Ensuring quality standards, Local Government Association, NHS England, 2014
- Royal College of Psychiatrists joint faculty report "Forensic care pathways for adults with intellectual disability involved with the criminal justice system", Faculty Report FR/ID/04, February 2014

(To be filled in locally)

Applicable local standards

(To be filled in locally)

Applicable quality requirements and CQUIN goals

Applicable Quality Requirements (See Schedule 4A-C)

Whilst quality standards will be agreed at a local level it is recommended that quality checkers are used as a regular form of quality assurance, it is expected that the service quality checkers will include experts by experience and parents and carers. It is expected that services will ensure training and support is provided to ensure involvement is meaningful and leads to a process of continuous improvement.

(To be filled in locally)

Applicable CQUIN goals (See Schedule 4D)

(To be filled in locally)

See Annex B ffor case studies of existing services which are delivering aspects of the Community-based Forensic Support functions described in this model service specification.

4

Supporting commissioners to develop service specifications for Acute Learning Disability Inpatient Services

Specification: **Acute Learning Disability Inpatient Services**

This model service specification describes the core functions of inpatient provision for adults with a learning disability and/or autism who present an immediate risk to those around them and/or to themselves, and whose behaviour and/or mental state is such that assessment and/or treatment cannot be provided safely and effectively in the community.

It is a model service specification which will need adaptation by local commissioners.

(The use of [ADAPT TEXT] indicates where local changes are required.)

Population Needs[7]

National context and evidence base

The inpatient service set out here needs to be considered within the national context of 'Transforming Care' and the vision set out in Building the right support and the national Service model for commissioners of health and care services.

The service model sets out the vision for moving away from an overreliance on inpatient care (and other restrictive approaches), towards responsive, timely and appropriate interventions that support individuals to live satisfying lives in community settings. However, it also emphasises that people with a learning disability and/or autism should be able to access inpatient services as and when they need to. These services should be high quality, integrated with community services, and focused on proactively encouraging independence, recovery and swift discharge back to the community.

Services should seek to minimise a person's length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measureable outcomes. Admissions should be to services that are as local as possible.

Prevalence

National prevalence

There are an estimated 1.2 million people in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2-3% of the general population). The majority live their lives without support from specialist learning disability services – for instance, of the roughly 1 million adults with a learning disability it is estimated that 189,000 (21%) (Emerson et al. 2012) are known to learning disability services.

There are an estimated 700,000 people with autism in England (Brugha et al. 2012) of which 125,000 are children and young people under the age of 18 (Baird et al. 2006). This means that roughly 11 people in every thousand have autism (1.1% of the general population). It is estimated that 44%-52% of people with autism also have a learning disability.

Mental ill-health and behaviours that challenge

People with learning disabilities present with a considerably higher prevalence of mental health problems than the general population (estimates vary between 30% - 50%).

Challenging behaviours are generally understood to be exhibited by 10-15% of adults with learning disabilities known to services (approx. 22-34,000 people), whilst often peaking between the ages of 20-49 (Emerson et al. 2001).

As set out in Challenging Behaviour: A Unified Approach (Royal College of Psychiatrists, et al, 2007, p.14) challenging behaviour is behaviour "of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

Challenging behaviour can be the consequence of mental ill-health (in which case inpatient mental health care may be appropriate if treatment cannot be provided in the community), but it can also be the consequence of physical ill-health/pain (e.g. dental

[7] This model service specification has been structured based on the NHS Standard Contract and needs to align to the relevant local authority standardised documentation.

problems) or the consequence of the environment (physical and social) that the individual is living in, in which case an inpatient mental health service is highly unlikely to be the best environment for the individual concerned.

The expected level of specific mental ill health and behaviour issues experienced by people with a learning disability, for an average TCP covering a population of 1 million will be approximately:

Condition numbers:

- **Dementia**: higher prevalence 22% cf 6% general population age 65+; people with Down Syndrome at higher risk of developing dementia 30-40 years younger than general population [Kannabiran & Deb, 2010]
- **Schizophrenia**: prevalence is 3-4% in people with a learning disability, compared with 1% general population; difficult to diagnose in those with more severe learning disabilities.
- **Mood disorders**: common, 4 times greater risk [Richards et al 2001]; 9% in children [Tonge 2007]. 20% in adolescents [Masi et al 1999]. Point prevalence in adults with learning disabilities 3.8% for depression; 0.6% mania, 1% bipolar illness [Cooper 2007]
- **Anxiety Disorders**: prevalence rates in boys 8%; girls 20% [Tonge 2007]; most of those referred for anxiety disorders had experienced a major life event/trauma in the preceding 6/12; 35% of adults referred who had suffered sexual abuse met diagnostic criteria for Post-Traumatic Stress Disorder.
- **Obsessive/Compulsive Disorders**: reported in 40% of adults with severe/profound learning disability; 0.2% in community samples.
- **Eating Disorders**: Abnormal eating behaviours in specific syndrome e.g. hyperphagia in Prader-Willi syndrome;. Pica 9-25% in institutional settings; 2% in community-based studies.
- **Severe Challenging Behaviours**: 10-15% adults with a learning disability known to services.

Using mainstream services

The majority of people with a learning disability and/or autism live their lives without support from specialist learning disability services; of the roughly 1 million adults with a learning disability (in England) it is estimated that 224,000 (22%) are known to learning disability services.

Many people with a learning disability and/or autism should be able to access 'mainstream' inpatient mental health services, with reasonable adjustments being made as necessary. In accordance with the provisions of the Equality Act 2010, people with a learning disability and/or autism who need to be admitted to hospital should be assessed and treated in mainstream inpatient services wherever this is reasonably practicable. This is most likely to be the case for people with a mild-moderate learning disability and/or autism who have a mental health problem.

This specification is for services catering to those for whom reasonably adjusted mainstream inpatient services would be an inappropriate environment, and who therefore require inpatient care specifically designed for people with a learning disability and/or autism.

Inpatient provision per 1 million population

Over the past several decades, reliance on inpatient care to meet the needs of people with a learning disability and/or autism has markedly reduced, and as a consequence of the Transforming Care Programme local areas are now investing in community alternatives to inpatient care.

It is therefore expected that the vast majority of the needs of the group of people described above will be met by services in the community.

With the services set out in the national service model it is expected that no local area will need non-secure inpatient provision (of which acute learning disability beds would be one type) for more than 10-15 in-patients with a learning disability and/or autism, per million population, at any one time. (NHS England, LGA, ADASS, Building the Right Support, 2015).

Local prevalence

(Insert data on prevalence for the geographical footprint you want this function to serve. It is expected that to reach critical mass, this function will need to be delivered at a population of c. 1 million, i.e. at TCP/STP level. To arrive at local prevalence data, make use of the national figures above and local data e.g. from:

- *JSNA*
- *Dynamic registers*

Scope, Functions and Outcomes

Aims and objectives

The aim of acute learning disability inpatient services is to provide the following three core functions of support:

- Assessment (including for potential mental illness) of the causes of challenging behaviour, where it cannot be safely carried out in the community
- Treatment of mental illness where this is the cause of challenging behaviour (complemented by other interventions as appropriate), where it cannot be safely carried out in the community
- Reintegration of the individual back into the community after hospital treatment including provision of support/guidance to families and support providers

Each of these functions are described in more detail in the table on the following page, and include some suggested outputs and outcomes.

Core aims of Acute learning disability inpatient services	High quality assessment and treatment focused on proactively encouraging independence and recovery Collaborative working with community services as part of a broader, integrated care and support pathway Admissions supported by a clear rationale of planned assessment and treatment with measurable outcomes			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Assessment	Services actively undertake and review bio-psycho-social assessments in conjunction with the person and their family. Individuals are only admitted for assessment if that cannot be provided safely in the community. Assessments identify and address factors that predispose, precipitate and perpetuate the difficulties that led to admission and take account of atypical manifestations of mental illness which may arise as a result of factors such as additional health problems, behavioural phenotypes, communicative and cognitive impairments. The person will access all necessary physical health checks and screening, and will have an up to date Health Action Plan and Hospital Passport. Services are actively undertaking Care and Treatment Reviews in line with the national policy There is proactive engagement and communication with the individual and their families/carers (where appropriate) including through the provision of information in accessible formats	People receive individualised, holistic person-centred assessments, which draw heavily on the historical observations and experiences of those who support the person in the community and lead to a clear formulation. The individual and their families and carers (where appropriate) understand the rationale for admission and are supported to remain involved in planning, delivering and evaluating care. Care and Treatment Reviews ensure that inpatient admission is the right option for people. Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity. Inpatient units are working with commissioners, social care and community services from day 1 to begin planning discharge.	The causes of challenging behaviour are understood, and a plan developed to address them Risk of harm (to self and others) is reduced People are supported to be involved in decision making processes People are only in hospital for assessment if they need to be there **Potential measure(s):** Quality of life outcome measures Health Equalities Framework (HEF) Increased numbers of people who feel supported to manage their own needs Evidence of increased community inclusion and participation Patient Report Experience Measures (PREM) Patient Report Outcome Measure (PROM) Clinician Report Outcome Measure (CROM) Reduction in number of safety incidents reported Proportion of people with a discharge plan within 28 days of admission	"I am getting expert support from people with the right skills and expertise." "I am respected and listened to." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes." "My needs are understood." "I understand how the care and support I am getting is responsive to my needs." "I maintain supportive relationships with the people who are important to me."

Core aims of Acute learning disability inpatient services	High quality assessment and treatment focused on proactively encouraging independence and recovery Collaborative working with community services as part of a broader, integrated care and support pathway Admissions supported by a clear rationale of planned assessment and treatment with measurable outcomes			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Treatment of mental illness	Delivery of positive and proactive care within a positive behavioural support framework, with effective arrangements for care coordination and governance frameworks that minimise the inappropriate use of restrictive interventions of all forms and which focus on recovery, social inclusion, independence and harm reduction. Development and delivery of multi-element treatment plans which reduce risks and address the person's identified needs. These may include: treatment of comorbid physical health conditions; establishing plans to reduce the risk of the person experiencing serious health inequalities in future; psychosocial interventions that aid recovery, including the development of alternative coping strategies; and the judicious use of psychotropic medication. Safeguarding people from the inappropriate prescribing of psychotropic medication in the absence of a recognisable mental health problem, for the primary purpose of behavioural control. Regular and comprehensive review of medication and the provision of accessible information on the benefits and disadvantages of taking medication to the individual and their family as appropriate. Proactive engagement and communication with the individual and their families/carers (where appropriate) including through the provision of information in accessible formats that provides a clear understanding as to why the person presented with the problems that led to admission and how a person's needs should be met in order to avoid deterioration Services are actively undertaking Care and Treatment Reviews in line with the national policy	Psychological treatments are modified to take account of peoples' cognitive and communication needs. People receive individualised, evidence-based treatment that ensures a swift return to a community setting by highlighting key issues and ongoing support needs. When in hospital, people have access to appropriate facilities, as well as meaningful activities, access to fresh air, exercise, and healthy food. Clear position on existence of mental illness including diagnosis with its rationale has been communicated to all Medication plans reflect a clear evidence base and clear rationale Relapse prevention and crisis contingency plans in place Plans include information on any additional physical health investigations needed as a result of treatments and this is reflected in the health action plan There is a clear care pathway for each individual from hospital through to discharge A full suite of assessments and support plans that can transfer into the community are available The individual and their families and carers (where appropriate) are involved in planning, delivering and evaluating care. Care and treatment promotes recovery, social inclusion, independence and harm reduction. Care and Treatment Reviews ensure that inpatient admission is the right option for people	Length of stays for individuals are minimised Risk of harm (to self and others) is reduced Reduced numbers in hospital People's preferences, aspirations and desired outcomes are informing care and treatment approaches People are supported to manage their own needs People are involved in decision making processes and empowered their care and treatment **Potential measures** Health of the nation outcome scales for people with learning disabilities (HoNOS LD) Health Equalities Framework (HEF) Clinician Report Outcome Measure (CROM) Number and outcome of medication reviews Patient satisfaction surveys Carer Satisfaction surveys Number of people being discharged within 3 months Number of people being discharged within 6 months	"I am supported to regain my independence." "I am supported to be safe and a part of my community." "I am supported to understand my behaviour." "I am safe." "I understand what is happening to me and how care and support is responsive to my needs." "My family and paid staff are supported to know how to effectively support me." "During my stay I have been able to do things I enjoy." "I maintain supportive relationships with the people who are important to me."

Core aims of Acute learning disability inpatient services	High quality assessment and treatment focused on proactively encouraging independence and recovery Collaborative working with community services as part of a broader, integrated care and support pathway Admissions supported by a clear rationale of planned assessment and treatment with measurable outcomes			
Functions of support	**Description**	**Outputs**	**Outcomes**	**Outcomes for the person**
Reintegration into the community	Proactive discharge planning will commence at point of admission with the development and review of a clear plan, with projected timescales, which outlines the assessment and treatment outcomes and likely duration in order that an anticipated date of discharge can be determined. As soon as risk assessment predicts that risks have reduced, or would likely be reduced by moving to a community setting, consideration should be given to discharging the person to a less restrictive environment, even if this means that the process of assessment and treatment remains unfinished at the point of discharge and needs to continue thereafter. Where risks reduce and discharge occurs before completion of assessment and treatment, the person's CPA care plan outlines what residual assessment and treatment remains to be concluded. Active engagement of the individual and those closest to them in discharge planning and their discharge pathway Collaboration and joint working with a range of community services and support in the identification of sustainable ongoing support that people are likely to require post discharge, in order to lead meaningful lives. This includes consideration of the support needs of families and carers. Identification and provision of a discharge facilitator to work closely with the community based CPA care coordinator in order to ensure that there is adequate progression towards discharge. Support and advice to those supporting the person in the community, to continue to support them in relation to those areas of need that do not require hospital intervention. Active engagement with community based CPA care coordinators who keep under review the need for a continuing hospital stay and ensure that the overall CPA care plan continues to promote recovery and timely discharge.	Each person has a discharge plan from the point of admission, which they are empowered to understand People experience coordinated discharge planning Inpatient and community staff understand and deliver on their roles and responsibilities to ensure timely and effective discharge Each person's CPA care plan is continually reviewed to promote recovery, timely discharge and any ongoing care and support required in community Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity. A full suite of assessments and support plans that can transfer into the community are available that are clear and understood by those supporting the person in the community Any short term medications has a clear plan for the GP and others to follow in terms of criteria for continuation and outline for discontinuation	Families, other carers and staff increased confidence and understanding in support individuals People who use services remain connected to their communities and those who are important to them. People are discharged as soon as possible and are empowered to understand their discharge pathway and care pathway for continued support in the community. People are informed and involved in all decisions about their care and support in accordance with the MCA and best interest practices Deprivation of Liberty practices are understood and action taken at earliest stage of discharge planning. **Potential measure(s)** Number of readmissions Reduced length of stay in hospital settings Quality of life outcome measures Personal Outcomes Evaluation Tool (POET) Health Equalities Framework Length of stay Duration of assessment and treatment Duration of delayed discharge Readmission rate	"I am involved in my discharge planning." "I am respected and listened to." "I understand what is happening to me and how my care and support is responsive to my needs." "I am supported to be safe and a part of my community." "My family and paid staff are supported and know how to support me." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes."

Note: The Learning Disability Professional Senate are due to be publishing a paper on Key Performance Indicators and Standards for Assessment and Treatment Units for adults with a learning disability.

Delivery structure

The functions of inpatient support described in this service specification are expected to be delivered by:

(Delete as appropriate)

• A discrete, dedicated inpatient ward/unit, co-located within other (mainstream) mental health services [IT IS EXPECTED THAT TO REACH CRITICAL MASS, SUCH A UNIT WOULD NEED TO SERVE A POPULATION OF C. 1 MILLION, I.E. OPERATING AT TCP/STP LEVEL]
OR
• An existing mainstream inpatient service, with staff skilled in supporting people with a learning disability and/or autism and a vulnerable inpatient area as an annex to the generic ward, which can be cordoned off from the rest of the ward if necessary, to provide an adapted environment for vulnerable patients [IT IS EXPECTED THAT THIS MODEL COULD BE VIABLE AT CCG LEVEL]

People with a learning disability and/or autism should be assessed and treated in mainstream inpatient services where this is the most appropriate option. This is likely to be the case for people with a mild learning disability and/or autism who have a mental health problem of a type and severity that warrants inpatient care. Providers should make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning disability and/or autism specialists). This might require providers to designate particular wards as suitable for this purpose. People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care should be admitted to a specialist unit if they require inpatient care. These specialist beds should be increasingly co-located within mainstream hospital settings as part of integrated specialist inpatient services, rather than in isolated stand-alone units. With the right support at the right time in the community, use of inpatient services should be rare and only for clearly defined purposes.

Inpatient providers must work closely with Community Learning Disability Teams and services delivering Enhanced/Intensive Support to carry out outreach work to prevent admission, hasten discharge and prevent readmissions.

Workforce competencies

The service should have a broad range of disciplines engaged in service delivery, including as a minimum:

- Learning disability nursing
- Pharmacy
- Occupational Therapy (OT)
- Speech and Language Therapy (SALT)
- Clinical psychology
- Psychiatry
- Social work (With AMHP capabilities)

Staff members will have knowledge, skills and experience, at Practitioner and at Expert level, of effective working with people with learning disabilities and/or autism in accordance with relevant NICE guidance as well as demonstrating that practitioners have the necessary pre-requisite competencies, consistent with the recommendations of Health Education England. Competencies include:

- Identification and management of mental health issues
- Evidence based interventions,
- Behavioural analysis
- Care & support planning
- Risk appraisal,
- De-escalation techniques
- Family sensitive working,
- Have an understanding of & demonstrate competence in the application of the Mental Capacity Act
- Have an understanding of Deprivation of Liberty (DoLs) & how to implement local procedures
- Cultural competence,
- Effective communication and teaching skills,
- A clear understanding CPA, care-coordination and care management processes,
- The ability to engage with a range of different professionals and agencies/caseload management

The provider should also employ people with a learning disability and or autism and their families as experts by experiences for specific roles such as peer support or quality checking, and for training/recruiting staff.

The provider must facilitate patient access to independent statutory and non-statutory advocacy throughout the duration of an inpatient's stay, but should not employ those advocates itself.

The patient will have a community based Care Programme Approach (CPA) co-ordinator who will continue to co-ordinate the CPA plan. The provider must facilitate this community based CPA co-ordinator and ensure a discharge facilitator is identified to support.

Population covered

The population covered by this document will be

(Insert geographical footprint - to reach critical mass required to deliver this function correctly, it is expected that it will need to be delivered at TCP/STP level with a population of c. 1 million).

Any acceptance and exclusion criteria and thresholds

Admission to the service should only ever be considered when adjustments to equivalent generic adult mental health services' (i.e. environments, care pathways and policies, in order to render them as accessible and effective as they are for the general population,) are either unlikely to ensure equity of outcome, or could not reasonably (i.e. in all the relevant circumstances) be made.

Access to the service is restricted to:

- Adults (aged 18 or above)
- Displaying abnormally aggressive or harmful behaviour of such frequency, severity or duration as to place the person or others at serious risk of harm
- Whose assessment and formulation cannot be provided in the community under conditions of lesser restriction, even with the introduction of additional resources such as Enhanced/Intensive Support , and
- Who display signs consistent with a diagnosable mental illness, amenable to treatment in an inpatient mental health service (liable and effective treatment could not be safely provided in a community setting
- Who have had a community (pre-admission) Care and Treatment Review (CTR), which has determined that inpatient admission is the right option for them

In the event of an urgent admission where a community CTR has not been carried out, this should take place within 10 working days of admission.

The service is not intended for people whose needs could better be met in community settings (including people whose challenging behaviour is not related to mental ill-health); people in need of respite / short breaks; or those in need of long-term accommodation.

Whilst people displaying challenging behaviour unrelated to mental ill-health might appropriately be admitted to the service for assessment (particularly if there is a concern the individual might have a mental health problem), as soon as mental illness is deemed unlikely to be the cause of the individual's behaviour, the individual should be referred on to a more appropriate service.

The provider should deliver the service in a swift and timely manner, aiming to discharge patients back into the community and their normal lives as quickly as possible.

- The majority of patients should be assessed and, if appropriate, treated and then discharged/referred to other services within 3 months of admission.
- 90% of patients should be assessed and, if appropriate, treated and then discharged/referred to other services within 6 months of admission

Interdependence with other services/providers

The operation of specialist learning disability in-patient services is inherently linked to generic mental health services, community learning disability services and other forms of generic inpatient provision that have rehabilitation functions. Without a coordinated and joined up approach, progress is likely to be undermined, people will be at risk of falling between gaps in service provision and unintended consequences may ensue.

Inpatient services are part of a wider network of both learning disability and generic mental health services. Inpatient services need to build, develop and maintain effective operational relationships with a range of organisations, including, but not exhaustively:

- Community services for people with a learning disability and/or autism
- Children's services
- Family services
- Education services
- Social services
- Safeguarding services
- Providers of social care and support
- Adult community mental health services
- CAMHS services
- Community nursing and matron services
- Primary Health Care Services
- Independent, Private and Third Sector Service Providers
- The Home Office
- Criminal Justice System partners, including Courts
- Forensic Support Services
- Generic and learning disability and/or autism specific advocacy services
- Local Mental Capacity Act and Deprivation of Liberty leads
- DWP
- Job centre plus

Applicable Service Standards

(The following are suggestions)

Applicable national standards (e.g. NICE)

- Mental health problems in people with learning disabilities: prevention, assessment and management, NICE Guidelines, September 2016
- Autism in adults: diagnosis and management, NICE guidelines, June 2012
- NHS England Care and Treatment Review guidance
- Guidance for NHS commissioners on Equality and Health Inequalities legal duties
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guidelines, May 2015
- Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, NHS England, ADASS, LGA, October 2015
- Positive Behavioural Support Competency Framework
- Confidential Enquiry into premature deaths of people with learning disabilities
- Guidance for NHS commissioners on Equality and Health Inequalities legal duties

(To be filled in locally)

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Mansell report: Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (revised), Department of Health, October 2007
- Ensuring quality standards, Local Government Association, NHS England, 2014
- Challenging behaviour: a unified approach - update, Royal College of Psychiatrists, March 2016
- Paving the way: how to develop effective local services for children with learning disabilities whose behaviours challenge, Challenging Behaviour Foundation and the Council for Disabled Children, 2016

(To be filled in locally)

Applicable local standards

(To be filled in locally)

Applicable quality requirements and CQUIN goals

Applicable Quality Requirements (See Schedule 4A-C)

Whilst quality standards will be agreed at a local level it is recommended that quality checkers are used as a regular form of quality assurance, it is expected that the service quality checkers will include experts by experience and parents and carers. It is expected that services will ensure training and support is provided to ensure involvement is meaningful and leads to a process of continuous improvement.

(To be filled in locally)

Applicable CQUIN goals (See Schedule 4D)

(To be filled in locally)

Annex A

Case studies, delivery of Enhanced/ Intensive Support functions

Ealing Intensive Therapeutic Short Break Service

This service specification describes the Ealing Intensive Therapeutic Short Break Service (ITSBS) which supports children and young people with a learning disability, or both a learning disability and autism, who display behaviour that challenges and who are at risk of a residential school placement or admission to inpatient services.

The team is based within the local Children and Young People Mental Health Services and funded by the local authority. The team shares a base with other multi-agency child services for children and young people with additional needs, including community paediatricians, SEND leads, specialist health visitors, educational psychologists, social care, occupational therapy and speech and language services.

Population and caseload

The service covers a **general population of 345,000**. It operates within the North West London Transforming Care Partnership (TCP), spanning Ealing Clinical Commissioning Group and local authority.

The team was initially funded to take 8 new referrals a year. However, over time this has fluctuated, depending on how long cases remain open on the caseload. As of November 2016, the team's caseload has ranged from 5-8 children and young people at any one time on the active caseload, (with an average of 2-3 years on caseload with intensity of support varying by individual and circumstances at time).

Scope, Functions and Outcomes

Aims and objectives

The Ealing Intensive Therapeutic Short Break Service (ITSBS) is for young people with a learning disability who display behaviour described as challenging at imminent risk of residential placement.

The aim is to enable the young person to remain within their family home and community settings longer term. The ITSBS provides families with intensive interventions and follow-up support, combining a carefully tailored package of additional short breaks and intensive clinical psychology therapy to reduce challenging behaviours and provide a break for the parents/young person. It uses a Positive Behaviour Support (PBS) approach. Following a successful pilot, the ITSBS became a permanent service. The service is staffed by a Clinical Psychologist and an Assistant Psychologist but they work very closely with allocated social workers from the Children with Disabilities Social Care Team.

The key functions provided by the Ealing intensive therapeutic short break service are:

- Extended/additional short breaks
- Intensive clinical psychology interventions
- Ongoing family support and psychological therapy for the young person and family members, if needed
- Development of a behavioural support plan based on PBS approaches
- Training of school, home, carers, short break setting and other professionals in the young person's network. Training aims to support the development of problem solving strategies

- Liaison and consultation with short break staff, school and other professionals
- Ongoing monitoring of the intervention plan and modifications as necessary
- Tailored training and support for parents

Workforce competencies

Key skills in the team are:

- Skills and knowledge in supporting people with a learning disability
- Skills and knowledge in supporting people with autism
- Positive Behaviour Support (PBS) as the cornerstone approach
- Systemic approaches
- Working in partnership with the network around the young person. Emphasis on collaboration and coordination drawing on solution-focused approaches
- Individual therapy
- Sibling support work
- Coordination of support using CPA and CTRs
- Planning/designing a capable environment and supporting transitions

Team configuration

- Band 8a clinical psychologist 1wte
- Band 5 Psychology assistant 1wte

(The clinical psychologist post is a job share post with each coming from the CAMHs Learning Disability team.)

The team is managed by the Ealing local authority, Social Care manager for children with disabilities.

Any acceptance and exclusion criteria and thresholds

Children and young people with a learning disability who are in receipt of short break services (including after school support, respite, carers going into the family home) who are at risk of admission to hospital or to residential school.

Interdependence with other services/providers

Interdependencies with:

- The team is co-located in the Ealing Service for Children with Additional Needs (ESCAN) which consists of multi-agency services (see above)
- Special schools
- Short breaks providers
- All those involved in the young person's network

For more information on this service please email england.ld-bestpractice@nhs.net

Southwark Enhanced Intervention Service

This service specification describes the Southwark Enhanced Intervention Service (EIS) which supports adults with a learning disability, or both a learning disability and autism, who display significant behaviour that challenges.

Community learning disability services in Southwark are provided by three services: the Adults with Learning Disability Team (Southwark Social Care); Community Team for Adults with Learning Disabilities (Guys and St Thomas' Foundation NHS Trust) and Mental Health and Mental Health Learning Disabilities Team (South London and Maudsley NHS Trust, SLaM). All three services contribute to the membership of the Enhanced Intervention Service (EIS), whose team members are also members of their respective services.

The EIS is led by SLaM. It has discrete functions and team members' EIS time is ring-fenced, but its clients are also the clients of the three contributing services and its staff are full members of the staff of their respective services and maintain close links with their colleagues in these services; this ensures smooth transfer of care to these services when EIS input is no longer required.

Population and caseload

The service covers a **general population of 300,000**. It operates within the South East London Transforming Care Partnership (TCP), spanning Southwark clinical commissioning group and local authority.

Caseload

During 2016 the team's caseload has ranged from 10 - 15 adults at any one time, as follows:

- 6-10 people on active caseload, depending on intensity of work
- 2-4 people on monitoring caseload (e.g. period of monitoring prior to discharge)
- Collaborative support averages 1-2 people at any point in time (e.g. direct support to other services to work with an individual)

In addition, the team also provides 'population' level work, including:

- Training and consultation to Child & Adolescent Mental Health Service - Learning Disability (CAMHs-LD) and local providers
- Supporting local service developments for people presenting with more significant and complex behaviours that challenge through training and consultation
- Strategic developments around enhanced provision and Transforming Care within the local borough and TCP.

Scope, Functions and Outcomes

Aims and objectives

The Enhanced Intervention Service is in addition to services provided by the specialist community learning disabilities teams but with a focus on the Transforming Care group, with an explicit aim of avoiding more restrictive, out of area environments and with capacity to respond intensively and rapidly.

The key functions of support provided by the Enhanced Intervention Service are:

- Working preventatively with local services to increase their capacity to create capable environments through training and consultation
- Rapid, flexible, intensive MDT multi-element assessments and interventions at point of crisis or potential service/family breakdown to help avoid hospital admission/ placement breakdown/out of area placement
- Service design, planning and strengthening services for people returning to Southwark; additional clinical expertise to support step-down back from more restrictive environments

The service works with adult mental health, child and forensic services around interface issues, as and when it is needed.

Workforce competencies

Key skills in the team are:

- Strong value-base and a shared vision
- Timely, intensive, coordinated multi-element assessment, formulation and interventions
- Positive Behaviour Support (PBS) as the cornerstone approach alongside regular systemic consultation meetings
- Speech and Language therapy interventions
- Nursing/health interventions
- Mobilising the network of concern around a person. Working closely with families and carers with an emphasis on collaboration and drawing on solution-focused approaches
- Intensive work with the provider/family/education e.g. modelling/ training
- Flexible and creative approaches and a commitment to "make it work"
- Coordination of support using CPA and CTRs
- Planning/designing a capable environment and supporting transitions

Team configuration

(New staffing from April 17):

- 1 wte 8b clinical psychologist and lead for EIS
- 1 wte band 6 behaviour support practitioner
- 0.6 wte senior practitioner – Southwark social care
- 0.5 wte band 7 community nurse
- 0.5 wte band 7 Speech and Language Therapy

Access to psychiatry, CPNs and OT within CLDTs as required.

Acceptance criteria and thresholds

Adults with a learning disability presenting with significant behaviour that challenges, and:

- At risk of admission or placement breakdown/restrictive practices, exclusion from

services, admission to Assessment & Treatment (A&T) unit and / or specialist Out of Area (OOA) placement

- Requiring joint clinical and social care input at crisis point
- With presentations of co-morbidity, a predominant presentation of challenging behaviour to the crisis is identified.
- Sign up from the network of concern and care manager and clarity about respective expectations.
- The person is stepping-down from an A & T unit or specialist OOA placement and requires a short period of high intensity support to enable a successful transition back to the local community.

The Enhanced Intervention Service will consider referrals around service design/planning for people identified as displaying complex needs and risk of significant challenging behaviour, where clinical input at this stage is identified. This is for individuals living out of area, where there is a clear plan to move back to Southwark, and for individuals living in Southwark where there is a risk of placement breakdown/out of area placement. Acceptance and priority/speed of response for these referrals will be based on an assessment of the referral context, including timescales, capacity of the service, and close liaison with the social work and commissioning team.

Exclusion criteria

People not eligible for specialist learning disability services (e.g., with high functioning autism (i.e. IQ greater than 70); acquired brain injury; onset of cognitive impairment after age 18);

No active clinical input for people under 17.5 years old.

Interdependence with other services/providers

Interdependencies with:

- Southwark Transforming Care Steering Group
- Adult Social Care and Transition teams
- Adult Learning Disabilities Team (GSTT)
- Southwark MHLD
- Southwark Joint High Risk Meeting
- CAMHS-LD
- Some interface with forensic, police, psychiatric liaison and AMH services as and when.

For more information on this service please email england.ld-bestpractice@nhs.net

Gloucestershire Additional Support Services

This service specification describes two services within Gloucestershire:

1 The Learning Disability Intensive Support Service (LDISS), and;

2 The Positive Behavioural Support (PBS) Service

Both services support individuals with a learning disability, or both a learning disability and autism, who display behaviour that challenges. The Positive Behavioural Support Service works with adults (18+), whilst the LDISS works across children, young people and adults.

Community learning disability services in Gloucestershire are not currently integrated but provided by separate social care and health providers. These child and adult teams have been working closely together as part of the local Challenging Behaviour Strategy to ensure comprehensive support is available to children, young people and adults with a learning disability.

The Learning Disability Intensive Support Service, which provides support to children, young people and adults in crisis to prevent the need for a hospital admission or an out of county placement with the aim of providing support in the community and keep people in their own homes. The LDISS is a joint service delivered with both health and social care practitioners.

The **Positive Behavioural Support (PBS) Service** works with young people and adults with learning disabilities who display behaviour that challenges but are not yet reaching crisis. In line with Gloucestershire's response to the Children and Families Act 2014, and the subsequent Code of Practice published jointly by the Department of Health and Department of Education this service also delivers training in PBS to the 0-25 age group.

Population and caseload

The service covers a **general population of 650,000**. It operates within the Gloucestershire Transforming Care Partnership (TCP), spanning Gloucestershire's clinical commissioning group and local authority.

Caseload

As of November 2016, the caseloads of each service were, as follows:

Learning Disability Intensive Support Service:

- 44 people on active caseload, 31 adults and 13 children & young people.
- 7 people on monitoring caseload (e.g. period of monitoring prior to discharge)

The average length of time a service user is on the case load is;

86 days for April 2015-2016 with the longest being 399 days and the shortest being 4 days.

Positive Behavioural Support Service:

- 40 individuals on active caseload, working across 4 service providers
- An additional 12 one-to-one active cases
- 15 individuals on monitoring caseload

In addition, both services provide 'population' level work, including:

- Supporting local service developments for people presenting with more significant and

complex behaviours that challenge through training and consultation;

- Delivery of training across all ages, within the Challenging Behaviour Strategy
- Strategic developments around enhanced provision and transforming care within the local area and TCP.

Scope, Functions and Outcomes

Aims and objectives

The Learning Disability Intensive Support and Positive Behavioural Support service are in addition to services provided by the specialist community learning disabilities community and inpatient services, but with a focus on supporting people with learning disability who display behaviours that challenge. They aim to provide a preventative and early intervention function as well as avoiding more restrictive, out of area environments and have the capacity to respond intensively and rapidly.

The key functions provided by the services are:

- Working preventatively with local services to increase their capacity to create capable environments through training and consultation
- Rapid, flexible, intensive MDT multi-element assessments and interventions at point of crisis or potential service/family breakdown to help avoid hospital admission/ placement breakdown/ out of area placement.
- Service design, planning and strengthening services for people returning to Gloucestershire; additional clinical expertise to support step-down back from more restrictive environments
- Supporting transitions of individuals from out of area educational placements to return to the local area;
- Working proactively to support timely discharges of individuals within Assessment and Treatment units;
- Provision of a range of training- including but not limited to- Positive Behavioural Support, Positive Behaviour Management, Communication;
- Work alongside families to provide support, advice, guidance and signposting;
- Provider support, training guidance and 'hands on' support to minimise the likelihood of placement breakdowns;
- Support the development and implementation of relevant plans.

Workforce competencies

Key skills in the teams are:

- Strong value-base and a shared vision
- Timely, intensive, coordinated multi-element assessment, formulation and interventions
- Positive Behaviour Support (PBS) as the cornerstone approach alongside regular systemic consultation meetings,
- Positive Behavioural Management skills
- Mental Health
- Health & exercise

- Speech and Language therapy interventions
- Nursing/ health interventions
- Mobilising the network of concern around a person. Working closely with families and carers with an emphasis on collaboration and drawing on solution-focused approaches
- Intensive work with the provider/family/education e.g. modelling/ training
- Flexible and creative approaches and a commitment to "make it work"
- Coordination of support using CPA and CTRs
- Planning/ designing a capable environment and supporting transitions

Team configuration

The Learning Disability Intensive Support service consists of:

- 1 wte Nurse manager
- 1 wte Clinical nurse specialist
- 4 wte qualified practitioners – (currently 3 nurses & 1 health & exercise practitioner)
- 6 wte Community support workers
- 2 wte Positive behavioural support practitioners
- 0.2 wte Psychology, 0.3 wte Occupational therapy, 0.3 wte Speech & Language therapy, 0.2 Positive behavioural management trainer

The Positive Behaviour Support Service consists of:

- 2 wte Positive Behavioural Support Specialists

Acceptance criteria and thresholds

Learning Disability Intensive Support Service:

Children, young people and adults with a learning disability displaying behaviour that challenges and open to the community learning disability team or Children & Young People learning disability service. Referrals will also be accepted from commissioners for people returning back to the county from out of area placements.

LDISS is provided countywide for all Gloucestershire residents who are Gloucestershire GP registered or funded by NHS Gloucestershire / Gloucestershire County Council

Positive Behavioural Support Service:

Adults (18+) with a diagnosed learning disability in receipt of social care services. Referrals are made via Gloucestershire County Council and the service is countywide.

Exclusion criteria

Learning Disability Intensive Support Service:

People not eligible for specialist learning disability services (e.g., with high functioning autism (i.e. IQ greater than 70); acquired brain injury; onset of cognitive impairment after age 18);

Positive Behavioural Support Service:

- People who are not in receipt of a social care services
- People under the age of 18

Interdependence with other services/providers

Interdependencies with:

- Child and Adult Social Care and Transition teams
- Community learning disability teams (adult)
- CAMHS-LD
- Schools
- In patient services
- Social care providers
- Some interface with forensic, police, psychiatric liaison and Adult Mental Health services.

For more information on this service please email england.ld-bestpractice@nhs.net

Annex B

Case studies, delivery of Community-based Forensic Support functions

Avon Forensic Community Learning Disabilities Team

This service specification describes the Avon Forensic Community Learning Disabilities Team (provided by Avon & Wiltshire Mental Health Partnership Trust) which supports men and women aged 18 and above (involvement with transition pre 18 years old) with a learning disability, or both a learning disability and autism who have come into contact with the criminal justice system or admission to a secure hospital setting, or are at risk. The service also accepts spot purchased referrals of people with autism, who do not have a learning disability if the person is held by a clinical team.

This discrete team links closely with local community learning disability and mental health teams and is part of a mental health trust.

Population and caseload

The service covers a **general population of 1.1 million**. It operates within the Bristol, Bath and North East Somerset, South Gloucestershire, North Somerset Transforming Care Partnership (TCP), spanning 4 clinical commissioning groups and local authorities (Bristol, Bath and North East Somerset, South Gloucestershire, North Somerset). This is a mixed urban, inner city and rural areas with the majority of referrals coming from the city of Bristol.

Caseload

As at November 2016 the team had a caseload of 50 as follows:

- 40 people on active treatment (i.e. active caseload);
- 5 on monitoring caseload (e.g. CLDT maintain lead role in care and support of the service user, with support/long-term monitoring from the Community Forensic LD Team)
- 5 Collaborative support (e.g. direct support to other services to work with an individual without direct work with the individual)

In addition, the team also provides 'population' level work, including:

- Providing training for providers relating to transition of service users/relapse prevention/ risk management
- Providing consultancy/supervision/support to providers/clinicians/ liaison and diversion/ prison
- Awareness raising sessions/interventions relating to staff in criminal justice/ police/ probation and prison services
- Training to psychiatry, psychology and nurse trainees
- Involvement in Service design and development
- Community integration- community groups/ developing relationships with voluntary sector

Scope, Functions and Outcomes

Aims and objectives

The Avon Forensic CLDT provides support, assessment and intervention:

- at all stages of an individual's contact with Criminal Justice Services
- for a variety of offending behaviours
- taking account of the complex needs of the individual
- in an accessible way
- taking into consideration the status of the individual and with regard to their offending or risk behaviours

The service aim is to reduce or safely manage offending behaviour amongst people with a learning disability and/or autism which puts those individuals or the public at risk, and would thereby otherwise lead to contact with the criminal justice system or admission to secure hospital.

It aims to both prevent admission to hospital, as well as support admission where this is the most appropriate option for people. In supporting those people who are admitted to a secure hospital, the focus is on supporting the process of discharge from point of admission, reducing length of stay and ensuring full consideration of alternative options (e.g. treatment programmes) that could instead by offered in a community setting rather than in hospital.

Prevention work is both at point of admission and earlier in the pathway through proactive and partnership working with community based services.

The service provides the following functions of support:

- Forensic risk assessment and formulation, risk management and liaison
- Delivery of offence specific treatments/interventions, addressing for example physical violence, sexual violence, fire-setting – both group and individual, including treatments that address underlying emotional regulation problems; including facilitating social group/peer support networks to address issues of social isolation
- Consultation and liaison for Multi Agency Public Protection Arrangements (MAPPA panels) and other services
- Support to housing, education and other partners, including support to ensure people can access meaningful activities
- Assessment and support to carers (alongside social care colleagues).
- In-reach to secure inpatient settings, supporting transition into appropriate alternate provision be it step down, rehab, or transition to the community
- Support appropriate admissions to secure hospital and continue to be actively involved with the patient journey with a focus on rehabilitation and recovery and a return to the community
- Some case management and care-coordination under CPA but with a focus on supporting primary and secondary services to support directly
- Early identification of transitional cases from CAMHS to adult services.

The service supports the principles of co-production and works with those people who use the service to understand and shape what the service should deliver and how it should

operate. The team have an active Service User Forum who meet monthly and advise on service development.

Workforce competencies

Staff members have:

- Knowledge and skills in working with people with learning disabilities and or autism who have complex behaviours often associated with offending.
- Ability to delivery specific training to develop and enhance knowledge base across all stakeholders
- Knowledge and skills to carry out forensic risk assessment.
- Ability to work collaboratively and in a leadership role when required with other services to support intervention planning.
- Understanding of the criminal justice system and the mental health act, mental capacity act, safe guarding, public protection.
- Support to others to manage their anxieties when working with risk and complex needs
- Ability to build and sustain networks
- Skills & knowledge in specific treatment options including, cognitive behavioural therapy (CBT), Dialectal behaviour therapy (DBT), & sex offender treatment.
- Research skills
- Understanding and application of systemic theory
- Ability to provide practical solutions and ensure collaborative engagement from all stakeholders

Team configuration

- Clinical Psychologist – 1.2wte (these are clinical psychologists with forensic knowledge)
- Team leader – 0.8 wte
- Learning disability nurse practitioner – 1.0 wte
- Team secretary 0.6wte

Any acceptance and exclusion criteria and thresholds

The service is for:

- People who would be eligible for Local Learning Disability service,
- Who have a conviction or be considered at significant risk of offending.
- (Also, accept spot purchased referrals of people with autism who do not have a learning disability, if the case is held by a clinical team)

Interdependence with other services/providers

Interdependencies with:

- Community learning disability teams (CLDTs)
- Adult Mental Health and forensic mental health services:
- Children & young people mental health services,

- Autism service,
- ADHD, PD, services
- Secure inpatient services,
- Crisis Teams
- Probation
- Police
- Courts/ Prisons
- Secure inpatient services
- Public protection
- Liaison and diversion,
- Criminal justice liaison,
- Social services,
- Commissioners,
- MAPPA
- Private providers
- Voluntary sector
- Advocacy

For more information on this service please email england.ld-bestpractice@nhs.net

Secure Outreach Transitions Team (Tees, Esk and Wear Valleys NHS Foundation Trust)

This service specification describes the Secure Outreach Transitions Team (Tees, Esk and Wear Valleys NHS Foundation Trust) which supports men and women aged 18 and above with a learning disability, autism or both, who have come into contact with the criminal justice system or admission to a secure hospital setting, or are at risk.

The Tertiary team is part of the forensic service at Tees, Esk and Wear Valleys, working closely with forensic mental health in-patient and community services, and forensic learning disability in-patient services. It is co-located with local authority care staff.

Population and caseload

The service covers a **general population of 1.3 million**. It operates within the North East and Cumbria Transforming Care Partnership (TCP), spanning five clinical commissioning groups (Durham Dales, Easington and Sedgefield, North Durham, Darlington, Stockton and Hartlepool, and South Tees) and six local authorities (Redcar Cleveland, Middlesbrough, Stockton, Hartlepool, Durham and Darlington). In addition, there is a limited service in parts of North Yorkshire, covering the North Yorkshire Transforming Care Partnership.

Caseload

As at November 2016 the team has a caseload of 81 as follows:

- 39 people on active treatment (i.e. active caseload/case management);
- 27 monitoring caseload (e.g. CLDT maintain lead role in care and support of the service user, with support/long-term monitoring from the secure outreach transitions team)
- 25 Collaborative support (e.g. direct support to other services to work with an individual)

In addition, the team also provides 'population' level work, including:

- Providing training for providers relating to transition of service users/relapse prevention/ risk management
- Providing consultancy/supervision/support to providers/clinicians/ liaison and diversion
- Awareness raising sessions/interventions relating to criminal justice/ police and probation
- Awareness raising sessions and interventions with local authority, adult services including learning disability and mental health teams and inpatient wards
- Involvement in Service design meetings
- Community integration – community groups/ developing relationships with voluntary sector
- Recovery work – focused work to support carer involvement and coproduction working

Scope, Functions and Outcomes

Aims and objectives

The service aim is to reduce or safely manage offending behaviour amongst people with a learning disability and/or autism which puts those individuals or the public at risk, and would thereby otherwise lead to contact with the criminal justice system or admission to secure hospital.

It aims to both prevent admission to hospital, as well as support admission where this is the most appropriate option for people. In supporting those people who are admitted to a secure hospital, the focus is on supporting the process of discharge from point of admission, reducing length of stay and ensuring full consideration of alternative options (e.g. treatment programmes) that could instead be offered in a community setting rather than in hospital.

Prevention work is both at point of admission and earlier in the pathway through proactive and partnership working with community based services.

The service provides the following functions of support:

- In-reach to secure inpatient settings, supporting transition into appropriate alternate provision whether step down, rehab, or transition into the community
- Support appropriate admissions to secure hospital and continue to be actively involved with the patient journey with a focus on rehabilitation and recovery and a return to the community
- Forensic risk assessment and formulation, risk management and liaison
- Delivery of offence specific treatments/interventions, addressing for example physical violence, sexual violence, fire-setting – both group and individual, including treatments that address underlying emotional regulation problems; including facilitating social group/peer support networks to address issues of social isolation
- Some case management and care-coordination under CPA but with a focus on supporting primary and secondary services to support directly
- Consultation and liaison for Multi Agency Public Protection Arrangements (MAPPA panels) and other services
- Early identification of transitional cases from CAMHS to adult services;
- Support to housing, education and other partners, including support to ensure people can access meaningful activities
- Assessment and support to carers (alongside social care colleagues).

The service supports the principles of co-production and works with those people who use the service to understand and shape what the service should deliver and how it should operate.

Workforce competencies

Staff members have:

- Knowledge acquired through experiential learning of working with people with learning disabilities and or autism who have complex behaviours often associated with offending.
- Ability to deliver specific training to develop and enhance knowledge base relating to risk, conditions, behaviour including offending type behaviours and positive behaviour

support (PBS), complex presentations, mental health, offence specific interventions and or treatments, various therapies including Dialectal Behaviour Therapy (DBT).

- Knowledge and skills to carry out in-depth risk assessments and formulations.
- Ability to work collaboratively with other services to support intervention planning.
- Understanding of the criminal justice system and the mental health act, mental capacity act, safe guarding, public protection.
- Support of and focus on recovery based interventions
- Excellent communication skills to deal with complex confidential issues.

Team configuration

- Band 7 = 1 WTE
- Band 6 = 8.6 WTE
- Band 3 = 7.6 WTE
- Band 6 SaLT =1 WTE
- Band 6 OT =1 WTE
- Band 3 OT Assistant = 1 WTE
- Psychiatry = 1.3 WTE
- Psychology = 1.3 WTE
- Psychology assistant = 1.0 WTE

The team works in partnership with social workers.

Any acceptance and exclusion criteria and thresholds

The service is for men and women aged 18 and above, who have:

- A learning disability
- Autism
- Both a learning disability and autism

And

- Have a history of significant and serious offending, or
- Have had an allegation of offending or likely to engage in offending behaviour,

To be eligible to access the service, the individual will need to be able to benefit from the structured, supported and consistent interventions and specialist skills within the secure outreach service.

Individuals may on occasion, be accepted without criminal convictions, where there is clear evidence of a danger to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats.

Individuals are likely to have a co-existing mental illness, personality disorder or other neuro-developmental disorder.

Interdependence with other services/providers

Interdependencies with:

- Secure inpatient services
- Adult learning disability services
- Public protection
- Liaison and diversion,
- Criminal justice liaison,
- Social services,
- Commissioners,
- Adult mental health and forensic mental health,
- CAHMS,
- Police,
- Probation
- MAPPA
- Private providers
- Voluntary sector
- Advocacy

For more information on this service please email england.ld-bestpractice@nhs.net

Annex C

More about the Advisory groups

With thanks to the advisory group members for supporting the development of this document, and to others who have contributed, including those who attended the expert by experience day in Leicester.

The three advisory groups included commissioners, experts by experience, families, clinicians and representative organisations, and were chaired by:

Enhanced/Intensive support function:
Dr Steve Noone, Consultant Clinical Psychologist / Pathway Lead for adults with learning disabilities, Positive Behavioural Support Pathway, Northumberland, Tyne and Wear NHS Foundation Trust.

Community Forensic Function:
Dr David Fearnley, Medical Director at Mersey Care NHS Foundation Trust and Associate National Clinical Director for Secure Mental Health at NHS England.

Acute inpatient services for people with a learning disability:
Dr Roger Banks, National Senior Psychiatric Lead, NHS England, Learning Disabilities Programme, NHS England.