SERVICE SPECIFICATION

COMMUNITY CRISIS OUTREACH SUPPORT
FOR ADULTS WITH A LEARNING DISABILTY AND/OR AUTISM

From 4th December 2022 until 3rd December 2027

Service Specification for the Provision of Outreach Crisis Support for Adults with a Learning Disability and/or Autism - 2022- 2027

CONTENTS:

1. Introduction

1.1 This document sets out the service specification relating to the provision of Community Crisis Outreach Support for adults aged 18 years and over with a Learning Disability and/or Autism who are ordinarily resident in, or are the responsibility of, Somerset County Council (SCC).

1.2 This document also sets out the service specification, outcomes and quality standards which apply to the provision of this care and support to adults with a Learning Disability and/or Autism who are funded either solely or jointly by SCC, and/or NHS Somerset Clinical Commissioning Group, (hereafter referred to as SCCG). It describes the key features of the service being commissioned and the expectations of the partners involved.

1.3 This Specification should be read in conjunction with the contract and its appendices and schedules

1.4 This Service Specification is for the provision of person centred – outreach crisis support service to support people with a Learning Disability and/or Autism whose placement is at risk of breakdown and / or at risk of mental health hospital admission and / or who cannot be supported in their own home.

1.5 It is recognised that the people using this service will be living in a variety of accommodations, e.g. supported housing, rented accommodation, owned home, residential care, or with family and friends. For the purpose of these service specifications, these accommodations shall be defined as the person's own home.

1.6 SCC and SCCG are committed to working with independent providers in a spirit of consultation, co-operation and partnership to ensure that appropriate services are available to meet the needs of Adults with Learning Disabilities and/or Autism and their carers and families.

1.7 It is a statutory requirement that all Providers of regulated care services for adults are registered with the Care Quality Commission (CQC). Therefore, the regulations required for registration (and their associated standards), and the monitoring of the achievement of those regulations and standards, are not duplicated in this specification.

1.8 SCC is fulfilling its Obligations and Duties under The Care Act 2014 for the provision of 'welfare services' to disabled persons and to carry out an assessment of the person's needs for those services and then decide whether the person's needs call for the provision by them of a service. SCCG is fulfilling its Obligations and Duties by providing specialist health services, provided

through the Rapid Intervention Team (RIT) and other specialist LD services as part of their contract with Somerset Partnership Foundation Trust.

1.9 Where a person has been assessed to have a 'primary health need', they may be eligible for NHS continuing healthcare. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, SCCG is responsible for providing all of that individual's assessed health and social care needs – including accommodation, if that is part of the overall need and will contribute towards the costs of the services delivered under this service to meet the needs of each person they fund.

1.10 This specification reflects national policy, advice, and guidance, and sets out the philosophy and care standards to be adhered to in the provision of such care, and forms part of the Somerset Transforming Care Partnership Plan.

1.11 The SCC and SCCG, in partnership with Service Users and providers, has an outcome-based approach to the commissioning and provision of services which is reflected in this Service Specification.

1.12 The SCC and SCCG wish to work in partnership with the Provider in delivering high quality service to Service Users. The aim is to maximise the use of available resources by establishing longer-term, more integrated relationships with Providers.

1.13 By signing up to a "Partnership Approach", the SCC, SCCG and the Provider (working closely with the RIT) are making a commitment to:

i) Share key objectives.
ii) Collaborate for mutual benefit.
iii) Communicate with each other clearly and regularly.
iv) Be open and honest with each other.
v) Listen to, and understand, each other's point of view.
vi) Share relevant information, expertise and plans.
vii) Avoid duplication wherever possible.
viii) Monitor the performance of both/all parties.
ix) Seek to avoid conflicts, but where they arise, to resolve them quickly at a local level, wherever possible.
x) Seek continuous improvement by working together to get the most out of the resources available and by finding better, more efficient ways of doing things.
xi) Share the potential risks involved in service developments.
xii) Promote the partnership approach at all levels in the organisations (e.g. through joint induction or training initiatives).

xiii) Be flexible enough to reflect changing needs, priorities and lessons learnt, and which encourages Service User participation.

xiv) Contribute to ongoing collaborative reviews of the service throughout the contract, enabling learning to be captured and shared and to inform the future of the service and specifications.

1.15 The Provider shall be willing to assist the Commissioners in planning for future service demands and also be prepared to participate in programmes to build capacity, adding value to future commissioning decisions.

1.16 During the period of this contract, the Commissioners, ASC, the RIT and the provider shall work together to develop the nature and delivery of the Service to reflect the needs of people accessing the service. Any changes to the service or how they are delivered shall be negotiated between the Commissioners and the Provider, including any associated changes to the price. Reviews will be held on a quarterly basis.

2 Client Groups

2.1 In respect to adults with a Learning Disability the Valuing People (2001) definition of Learning Disability includes the presence of:

- a significant reduced ability to understand new and complex information to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

2.2 In respect to adults with Autism, the National Autistic Society definition describes Autism as a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, while all people with autism share certain areas of difficulty, their condition will affect them in different ways. Asperger's Syndrome is a form of Autism and for the purposes of this specification the term Autism will include this group.

2.3 A person with a Learning Disability and / or Autism will be supported through:

2.3.1 The Somerset Adults Social Care Community Teams and / or

2.3.2 The Somerset Partnership Foundation Trust LD Specialist Health Services Team (including the RIT)

2.3.3 For the purposes of this specification the ASC Community Teams and the RIT will be responsible for identifying those people in crisis who might benefit from an intervention from the provider Team using the agreed risk criteria and the Somerset Risk Register.

2.3.4 For the purposes of this specification, whether a referral will be accepted is to be agreed by way of a multi-agency meeting (which can be done via teleconference) comprising of the provider Team lead, the SCC Lead Commissioner, a representative of the RIT team and the ASC operational Lead. This group will be referred to in this service specification as the "Referral Team".

2.4 In addition to the above to be eligible for care and support a person must:

- Be ordinarily resident in, or are the responsibility of, SCC.
- Meet the Care Act 2014 criteria, or require short term preventative/ enabling services under the Care Act 2014
- Be eligible for care and support which is health funded or joint funded. This would include people who are funded under Section 117 arrangements, Continuing Health Care, or who have Direct Payments.

2.5 Individuals accessing these services are likely to have complex needs, which could include, but are not limited to:

- a mild to severe Learning Disability.
- over or under sensitivity to sounds, touch, tastes, smells, light or colours.
- a range of vision, hearing or minor movement impairments.
- Mental Health needs
- conditions such as epilepsy and diabetes
- difficulty communicating and typically express themselves through non-verbal means.
- social interaction difficulties including making friends, understanding social rules, understanding what other people are thinking and feeling
- social communication, including understanding what is said, making conversation, understanding gestures, taking things literally
- social imagination including problem solving, fixed interests, anxiety at change
- behaviours that challenge, including self-injurious behaviour.
- eating disorders.

2.6 Service Users with a Learning Disability and/or Autism who are also under Multi-Agency Public Protection Arrangements (MAPPA) or have a Probation Officer will not routinely be supported by this service / this service should not

be used as an alternative to the usual CJS processes. There will be an opportunity for referrals to be considered on a case by case basis by the Referral Team.

2.7 The definition of behaviour which challenges services used in relation to access to this service provision is:

"Behaviour that may cause harm to the person or to those around them and may make it difficult for them to go out and about. It may include aggression, self-injury or disruptive or destructive behaviour. It is often caused by a person's difficulty in communicating what they need"

2.8 Behaviours that challenge services may be physically aggressive, self-injurious, disruptive or destructive in nature.

2.9 An eligible Customer will typically have difficulty in expressing or communicating their needs; and have difficulty understanding the impact that their current situation may have on their health, well-being or life choices

3 Scope

3.1 To Provide a specialist outreach crisis support service comprised of; domiciliary Care, multi-provider liaison / collaboration, positive behaviour support planning / implementation, assessment and risk reduction / management.

3.2 The circumstance under which Crisis Support may be required are:

a. Breakdown of a Customer's current situation due to an increase in challenging behaviours causing harm, distress or risk.
b. Prevention of breakdown of a Customer's current situation by allowing time limited respite, or support, in situ for all parties, provided by an Outreach Team to reduce/avoid the need to long term arrangements and/or support the existing arrangements while these are put in place.
c. Providing outreach support to customers during the process of transition from the residential element of the service to the previous or new or care setting.

3.3 The primary reasons for crisis support are:

a. Assessment, design and implementation of a Positive behaviour support plan

b. Rehabilitation, including increasing community support and links for a Customer who has experienced a crisis and/or has been previously supported by an Acute Mental Health Service.

3.4 In order to be eligible for referral to a service offering Crisis Support the Customer must:

a. Have a primary need of a learning disability and / or autism as defined by Somerset County Council and Somerset CCG and
b. A level of behaviour which challenges services that requires specialist support and
c. Meet the National Minimum Eligibility Threshold under the Care Act (2014) as determined by the Council and/or an organisation authorised to act on its behalf. or
d. Be 18 years of age or older, with the exception of young adults approaching the age of 18 that fall within the scope of the service's CQC Registration and have the referral agreed by Commissioners, Learning Disability specialists within Child and Adolescent Mental Health Services (CAMHS), and where appropriate the Rapid Intervention Team.
e. Display needs and / or behaviours in relation to the Crisis pathway risk register criteria

3.5 This service is intended to support mainstream local services for people with a learning disability and / or autism. It will not:

a. Exist to isolate or exclude people from the community
b. Operate as a hospital or any form of Assessment and Treatment Unit (ATU)

3.6 Out of scope activities include:

a. Providing Short Breaks
b. Supporting customers who are not in crisis but need alternative care arrangements arranged at short notice, for example where their family carer is ill or another provider is experiencing operational difficulties unrelated to a customer's behavioural needs, unless this has been agreed by the Referral Team with explicit agreement.
c. Providing long term care and/or support:
    i. Unless an extension is agreed in writing the maximum length of stay in the Residential Care element of the service will be no longer than 8 weeks.

ii. Unless an extension is agreed in writing the maximum length of provision of Outreach Support will be no longer than 8 weeks.

d. Accepting referrals with respect to any Customer for whom continued support in the community or a placement in a residential care environment would not be appropriate, for example, Customers with a significant violent or sexual offending history where the assessed level of risk is such that a more restrictive environment is required.

e. Accepting referrals with respect to any Customer whose principle need relates to the management and treatment of their mental health. However, the service will support people with a treatment plan in place that have access to mental health services available to the whole community and who can be supported appropriately by the service.

f. Accepting referrals with respect to any Customer whose primary needs relate to a housing crisis, such as eviction, and who would be disadvantaged by a move into a residential care setting as it devolves responsibility for housing from the District Council's housing team.

g. Accepting referrals for anyone who is not Ordinarily Resident in Somerset with respect to the provision of social care services funded by Somerset County Council, unless:

i. A local authority other than Somerset County Council has provided written agreement that it will pay the full cost of any services required to meet the customer's social care needs and/or

ii. The services required will be wholly, or where paragraph i above applies, partially funded by the NHS because a person is registered with a local GP but is not Ordinarily Resident in Somerset with respect to the provision of social care services

3.7 Where notice has been served to a person preventing them to return to their current home, the relevant agencies (i.e. ASC, the RIT, The provider, current provider and commissioners) must work together to start identifying an alternative longer-term plan immediately.

4 Service Outcomes

4.1 The Outcomes that the Council requires the Crisis Support Service to achieve include all those that are applicable to the individual needs of the Customer

being supported, in consultation with their representative and/or an Independent Advocate, contained within the following Service Specifications:

a. Supported Living and Domiciliary Care for Adults with Learning Disabilities

And

a. Customers with complex behavioural needs are enabled to remain in their own homes;
b. The impact of the Customer's behaviours on their life choices is reduced as much as possible
c. The additional opportunity to use this resource for skills building, with the objective to support people with a learning disability and/or autism to become more independent, as well as providing the current placement with updated skills and knowledge as appropriate;
d. Reduce the number of avoidable admissions into specialist hospitals;
e. Reduce the number of inappropriate admissions to more restrictive settings;
f. Reduce the number of avoidable out of area placements
g. Provide support or informal carers when a customer has reached or approaching crisis point in relation to their mental health and / or behaviours.
h. Provide support to domiciliary care providers to develop their skills, knowledge and models of support to support people experiencing crisis or mental health breakdown.

5 Quality Standards

5.1 The Quality Standards that the Council requires the Crisis Support Service to achieve include all those contained within the following Service Specifications:

a. Supported Living and Domiciliary Care for Adults with learning Disabilities

And

a. Services are delivered in the least restrictive manner possible using a Positive Behavioural Support approach.

6 Aims and Objectives of the Service

6.1 The aims and objectives of the Service is to provide a preventative service, with a focus on supporting people before a person's home situation has completely broken down wherever possible. It will:

a. Deliver specialist Domiciliary Care to assess, stabilise, de-escalate and develop existing arrangements to appropriately meet the Customer's needs and help them to remain in their own home.
b. Develop / Enhance current Positive behaviour support plans in respect of those needs and implement them through a multidisciplinary approach
c. Provide expert assessment, care and/or support to Customers with highly complex behavioural needs, including the evaluation of both psychological and physiological needs
d. Where Customers needs can only be supported in the crisis flat / residential care environment:
    i. Work jointly with to the Council, or an organisation authorised to act on its behalf, to enable them to return successfully to their homes as soon as they are able, or
    ii. Provide specialist advice and/or support to the Council, or an organisation authorised to act on its behalf, to arrange alternative services to meet the Customer's needs and preferences or
    iv. Support for Young Adults approaching the age of 18 that fall within the scope of the service's CQC Registration. If a young person approaching 18 years has a complex behaviour or risk profile the service will provide assessment support to assist in determining future needs in agreement with Commissioners, CAMHS LD specialists, and where appropriate the Rapid Intervention Team.

7 Accessing Services

All referrals – for the purposes of this service specification:

7.1 The ASC Community Teams and the RIT will be responsible for identifying those people in crisis who might benefit from an intervention from the provider Team using the agreed risk criteria and the Somerset Risk Register. Whether a referral will be accepted is to be agreed by way of a multi-agency meeting (which can be done via teleconference) comprising of the provider Team lead, the SCC Lead Commissioner, Somerset CCG transforming care

lead, a representative of the RIT team and the ASC operational Lead. This group will be referred to in this service specification as the "Referral Team".

7.2 The provider Team lead will always need to attend this decision referral meeting as well as at least two of the other three agencies (or their nominated representatives).

7.3 There will be a clear emphasis on contacting the provider at the earliest point once the potential need for someone to access this service has become apparent. This is to ensure the provider is given as much time as possible to make preparations.

7.4 The provider will identify a named individual(s) to be contactable 24/7 for enquiries and receiving referrals. And will be required to respond to all enquiries regarding potential availability immediately.

7.5 ASC Community Teams and the RIT will gather as much information as is possible to inform the provider as part of the referral process and will work in partnership with the provider Team to assess the risks and agree any actions to mitigate these risks. Where possible this will include the person's assessment and support plan, along with any relevant risk assessments / positive behaviour support plans. Professional Choices will be used by all relevant stakeholders to upload the necessary assessments and reviews for background information.

7.6 Where required, and the customer meets its referral criteria, the provider Team will work alongside the RIT to carry out an initial assessment within 24 working hours to identify any additional support that is required. The provider Team will also – where possible – observe the placement for a longer period of time to build up a more detailed understanding of the environment as well as the care and support provided.

7.7 The start date for each individual Customer's service will be agreed with the Customer and/or their representative(s) and the Referral Team, based on the Customer's needs and the urgency of the service.

7.8 The provider Team will be responsible for assessing each referral in a timely manner and making the decision to accept the referral. This will include advising how quickly they can respond to making the service available. They will aim to give a decision on accepting/declining within 2 hours of referral, subject to receipt of adequate information from the ASC Community Teams and the RIT to make an informed decision based on risk and appropriateness of placement.

7.9 The provider will maintain accurate records regarding all referrals received, accepted and reasons for refusal including timescales for performance monitoring.

7.10 The ASC and RIT will be responsible for carrying out any duties relating to assessing a person's capacity to agree to access this service and make sure that the requirements under The Mental Capacity Act are complied with.

7.11 On Referral, the ASC Community Team will work with the RIT to appoint the relevant named professionals that the provider will work with to support the

Customer, including agreeing who will be the lead professional responsible for co-ordinating the care and/or support requirements of the Customer, including any multi-agency work that is required.

7.12 On Referral the Customer and/or their representative will be made aware of the Independent Advocacy services that they are able to access.

7.13 On Referral, or as soon as possible thereafter, the lead professional will arrange a multidisciplinary meeting attended by ASC, The provider and the RIT. The format and participants in this meeting will vary depending on each Customer's individual circumstances but other attendees could include:

a. The Customer's Family
b. Independent Advocates
c. Existing care providers
d. The Council's DOLS Coordinator
e. Specialist staff to advise on specific areas of need as required, including psychology, psychiatry, occupational therapy, speech and language therapy and restrictive interventions
f. The responsible commissioner

7.14 The purpose of this meeting will be to agree the initial assumptions about the cause of the Customer's behaviour and consider appropriate Positive Behaviour Support strategies. It will separate individual characteristics from environmental concerns; allow for an evaluation of investigations or treatment plans so far; and allow for the development of a risk profile.

7.15 The meeting will also agree the frequency of multidisciplinary reviews, as required. This will be recorded in the Customer's Person-Centred Plan.

7.16 Where the Customer has and/or will be admitted to the Crisis Flat / Residential Care element of the service, The provider will also use the outcomes of this meeting to initiate the discharge planning process.

8 Reviews

All referrals

8.1 The standard criteria for this service will be that the care and/or support arrangements of all Customers will be reviewed:

a. After 24 or 48 hours
b. A minimum of every 7 calendar days thereafter by the lead professional and Registered Manager (or nominated member of staff with knowledge of the customer and authority to make decisions behalf of the Registered Manager) in person, along with any other attendees, for example NHS staff, as appropriate.

8.2 All reviews will include consideration of the implementation of the Positive behaviour support plan and progress.

8,.3 A full multi-disciplinary review will take place every 2-4 weeks as agreed at the initial multidisciplinary meetings and recorded in the Customer's Person-Centred Plan, or more frequently if required. This will include a discharge planning element.

8.4 Where referral has been accepted to the Residential Care element of the service, the Provider will notify the nominated ASC Senior Manager and Strategic Commissioning Manager – LD of the service in writing of all Customers where:

a. The anticipated length of stay is considered likely to exceed 8 weeks.

This notification must be made immediately once the likelihood is identified.

b. An admission has exceeded 8 weeks, and on a weekly basis thereafter, until the Customer has been discharged.

9 Service Provision

9.1.1 The provider will provide sufficient staffing, trained in Positive Behavioural Support techniques, to meet the needs of Customers requiring Crisis Support. Untrained and/or inexperienced staff must never support Customers on a one-one basis at any time.

9.1.2 With the exception of interventions made as part of an immediate response to keep a person safe where there is no Positive behaviour support plan available, the provider will ensure that any restrictive interventions carried out by staff are limited to those recorded in the Customer's Positive behaviour support plan, and only used under the conditions specified in the Plan. Any restrictive intervention will be performed only by staff who have received appropriate training and been assessed as competent to carry them out.

9.1.3 All restrictive interventions will be recorded immediately after they occur.

9.1.4 Whilst people accessing the service may be subject to Deprivation of Liberty Safeguards (DOLS) or future Liberty Protection Safeguards, the impact of these orders on other Customers must be considered.

9.1.5 The provider will enable Customer choice in the staff who support them and provide continuity of staff, as far as is practicable.

9.1.6 The provider will ensure staff work with, and take direction from, Health and Social Care Professionals employed by the NHS and/or the Council in order to provide the appropriate level of care and/or support to each Customer

9.1.7 With the exception of changes made as part of an immediate response to keep a person safe, the provider will ensure that changes to Positive behaviour support plans are, where the customer has an open referral

to the Rapid Intervention team, discussed with, and approved by, the Rapid Intervention Team prior to implementation, and that the Rapid Intervention Team is contacted immediately about any changes made under exceptional circumstances.

9.1.8 The Service must be person centred, flexible and responsive ensuring that all Customers are able to exercise choice and control over the services that they receive, wherever possible, and are at all times treated with kindness, dignity and respect and regarded as equal partners in the delivery of their care.

10 Geographical Area and Availability

10.1 The crisis support outreach service will be available within and across the whole of the Somerset County Council area.

10.2 The provider is required to fully operate the care and support services specified from a CQC registered Office to be ideally situated within Somerset County Council area. The office must be appropriately situated to deliver services to residents of Somerset in a high quality and efficient manner.

10.3 A nominated point of contact and telephone number shall be made available to the Referral Team and Commissioners and be staffed 24/7, 365 days per year.

11 Performance Indicators

11.1 The Following Key Performance Indicators have been identified – to be provided for both elements separately:

1) Number of enquiries received (monthly)
2) Number of referrals received (monthly)
3) Number of referrals accepted (monthly)
4) Number of Referrals Declined and Reasons (monthly)
5) Speed of Referral to decision to accept/decline (monthly)
6) Speed of Referral to Mobilisation of service, (i.e. outreach provided or when person could move in) (monthly)
7) Adherence to review timescales
8) Number of people successfully supported as linked to the service outcomes set out in section 4.
9) Effective reduction of formal Safeguarding concerns

10) Complaints received
11) Good news stories
12) Prevention of hospital admission
13) Successful discharge transition
14) Service user and family feedback
15) To remain up to date with new legislation, training and national Transforming Care policy

12Termination of Individual Placements

The Service Provider is not expected to withdraw from the provision of services to an individual User of the Service other than in exceptional circumstances. The Service Provider will retain supportive evidence of all reasonable steps taken to avoid such a termination. The Service Provider will advise the User of the Service that they will terminate the service only after this has been agreed with the Service Purchaser.
Should the Service Provider reasonably believe that it is unreasonable to continue to provide care for a User of the Service this must be discussed with the appropriate care management team. If the Service Provider is planning to withdraw delivering care they must give one full month's notice to the User of the Service or their representative and the Service Purchaser.
On the death of a User of the Service the care service shall terminate immediately and either party shall notify the other of such event at the earliest opportunity.

Hospital Admissions and Discharge
In the case of temporary absence from the service, due to a hospital admission; the Service Provider is expected to communicate with the hospital about the expected discharge date and any change in User of the Service's needs.
Unless there is a significant change in need, if the User of the Service is discharged within **14 days** following admission the Service Provider is expected to be in a position to deliver any required care and coordination. The Service Provider will be paid to hold the existing package open during this period and must liaise with the Hospital regarding discharge plans
If the User of the Service is discharged after **14 days** an MDT discussion will take place, similar to the format for allocating new service users but will also include the Hospital Discharge Team and will confirm whether it is appropriate to hold the space or allocate to another service user.

Appendices

Appendix A – Used for Residential Spec only

Appendix B – Supported Living and Domiciliary Care specification

App B - Supported Living & Domiciliary