Introduction

Purpose

The purpose of this local Transforming Care Plan (TCP) is to set out intentions to transform services for people of all ages with a learning disability and/or autism in Cornwall and the Isles of Scilly who display behaviour that challenges, including those with a mental health condition, in line with Building the Right Support – a national plan to develop community services and close inpatient facilities (NHS England, LGA, ADASS, 2015).

Cornwall Council, the Council of the Isles of Scilly and NHS Kernow Clinical Commissioning Group (NHS Kernow) have formed a transforming care partnership to develop and implement the local plan. This presents an opportunity to improve integration between health and social care in Cornwall and the Isles of Scilly, to continue to make improvements in patient care and significantly reshape services where needed.

Scope

The TCP will cover children, young people and adults with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour)
- May have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

The national planning assumptions set out in Building the Right Support do not give a percentage reduction of usage for inpatient services for Cornwall and the Isles of Scilly due to the relatively low level use of inpatient beds. Currently within Cornwall and the Isles of Scilly there are no specialist inpatient beds for people learning disabilities and/ or autism and behaviour that challenges. This approach is based on the belief that hospital care for people with learning disabilities or autism should be delivered within mainstream services and that support for behaviour that challenges should be delivered in people’s own communities.
Aims

- The plan will demonstrate how the national service model will be implemented and how people will be supported out of hospital settings.
- Support and opportunities will be local as far as possible, promoting social inclusion and making best use of community assets
- Services will be consistent with national policy and local commissioning strategies
- The TCP will encompass services commissioned from the external market as well as those directly managed by the CCG and the Councils and continue to shape the market consistent with people’s choices and aspirations
- Services will represent excellent value for money and be affordable both to the commissioning bodies and self-funding clients; with services commissioned within the requirements of the Medium Term Financial Strategy
- Officers will liaise to ensure that the good practice realised by respective client reviews can be shared and inform future commissioning intentions
- The future needs of people with learning disabilities and/or autism will be assessed and the extent to which current facilities and services have the capacity, quality and location to meet these needs; including the potential for alternatives to be developed in association with other related initiatives such as housing with support
- The TCP will support further development of an integrated all-age pathway that will bring together all of the health and social care provision across Cornwall Council and the Council of the Isle of Scilly and Kernow NHS
- The relatively low use of inpatient facilities locally means that this local plan will focus on prevention of hospitalisation and ensuring delivery of outcome focused, person centred and community based support
- The TCP will explore specialist models of care and support to provide crisis accommodation within people’s own communities, in alignment with the Mental Health Crisis Care Concordat.

National principles

a. Plans should be consistent with Building the right support and the national service model developed by NHS England, the LGA and ADASS, published October 2015.

b. This is about a shift in power. People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An
important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

c. **Strong stakeholder engagement:** providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, housing) including people with direct experience of using inpatient services.

The plan will follow the nine core principles identified in the National Service Model and illustrated in the diagram below:

![Diagram of the nine core principles](image)

**Summary of the plan**

The remainder of the document follows the national planning template as shown in the diagram below. (Please see Appendix A for further indicators to monitor quality and progress)
1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Context

The natural geography of a mainly rural peninsula including island communities, bordered by sea with dispersed town settlements, means that Cornwall and the Isles of Scilly has unique challenges as well as assets. Among them are marked disparities of wealth and poverty, which continue to be supported by EU subsidies. Deprivation is a persistent problem - Cornwall and the Isles of Scilly as a whole is not deprived but there are areas where there are very high levels of deprivation and this has not changed for some years.

Cornwall has one city – Truro – and many towns, parishes, villages and hamlets. Many residents in the east of Cornwall rely on health services in Devon (including Derriford Hospital services in Plymouth), while residents on the five islands that make up the Isles of Scilly are wholly dependent upon the Royal Cornwall Hospitals Trust for secondary care needs.

Commissioning Bodies

Cornwall and the Isles of Scilly are covered by one clinical commissioning group (CCG) and two local authorities. These are NHS Kernow, Cornwall Council and the Council of the Isles of Scilly. Both councils co-operate in ensuring provision is made from the mainland alongside a range of island-based services. These partners work collaboratively to commission and provide services for people with learning disabilities and/or autism who have behaviour that challenges.

Cornwall Deal

Cornwall Deal sets out the terms of an agreement between Government, Cornwall Council and Cornwall and Isles of Scilly Local Enterprise Partnership to devolve a range of powers and responsibilities to Cornwall and builds on the Cornwall and Isles of Scilly
Growth Deal. It will empower public and private sector partners in Cornwall to reform services, to make them more effective and efficient. One of the themes within the Deal is the integration of health and social care. The journey to secure transformed health and wellbeing outcomes for the population of Cornwall starts in childhood. Poverty and inequalities continues to matter and mental health and wellbeing contributes to every aspect of a person’s life. Transforming services that delivers our ambition to improve outcomes is extremely challenging. A measured, evidence based, phased 5-year approach is needed to ensure that core business for all partners within the health and social care sector is maintained and improved through the transformation process.

### Annual Expenditure

The local authority Learning Disability service (which includes autism) had an overspend of £2.690m against a budget of £52.212m for 2014/15. Children's Early Help Psychology and Social Care services had an underspend of £3.536m against a budget of £60.618m with the majority of this attributable to vacancy savings (Cornwall Council 2014/15 Annual Financial Report and Statement of Accounts). This expenditure includes contracted services, packages of care, direct payments, internal services and social care assessment and care management.

NHS Kernow has an annual spend of approximately £30m for adults with learning disabilities and/ or autism which includes packages of care under Continuing Health Care, specialist and liaison services, joint funding with Cornwall Council and individual funded specialist placements.

### Joint Commissioning

Cornwall Council and NHS Kernow contribute to a joint fund to support 160 people with learning disabilities who were affected by the 2006 closure of Budock inpatient facilities and the concurrent transformation of NHS provided residential care. This care arrangement is currently under review, with a project established to ensure that the care that they receive is high quality, safe, person centred and developmental. The total spend for this cohort is £19m, with £12m contributed by NHS Kernow and £7m contributed by Cornwall Council which is part of the total spend detailed above.

The ‘Joint-Complex’ group of individuals is comprised of 62 people whose cases challenge straightforward eligibility criteria and fall across NHS Kernow and Cornwall Council. Many of these cases remain ‘without resolution’ around funding and the determination of a lead agency. In many of these cases there is an element of behaviour that challenges and the risk of hospitalisation remains very apparent. A project has also been established to review these cases.

### Adults

The adult provider base in Cornwall and the Isles of Scilly consists of a mixture of private sector and voluntary sector organisations including:

- Cornwall Partnership NHS Foundation Trust (CFT) provides an intensive support service for people with learning disabilities, including those whose behaviour challenges services. CFT is commissioned through a block mental health and learning disability contract with NHS Kernow.
- CFT provide three acute mental health wards (Carbis and Perran Wards located
at Longreach House, Redruth and Fletcher Ward within Bodmin hospital) that can be accessed by people with learning disabilities and/ or autism who require inpatient assessment and treatment for a mental health condition. There are no specialist inpatient beds for people with learning disabilities and/ or autism in Cornwall and the Isles of Scilly.

- Three Learning Disability Liaison Nursing teams provide assistance to individuals and services in ensuring fair and equitable access to mainstream services. The teams are divided into Primary Care, Acute Care and Mental Health.
- Seven providers deliver care and support to people with learning disabilities and/ or autism in supported living settings under a framework agreement.
- Twenty-four providers deliver care and support to people living at home on a generic basis through a framework agreement.
- 209 residential care homes provide 4,959 beds. 2,974 of these beds are care without nursing and 1,985 with nursing. 718 places are available to people with learning disability, 4,241 for older people and 2,871 for people with dementia.
- A specialist diagnostic service for people with autism who do not have a learning disability is commissioned by NHS Kernow from a local specialist provider (Outlook Southwest). There are currently no contracted specialist intervention services for people with autism without a learning disability.
- Cornwall Council both provides 16 in-house day services and purchases externally a range of community and support provision (day opportunities) for adults with an eligible support need; including people with learning disabilities and/ or autism.

Children and Young People

- There is an autism support team for school aged children provided by Cornwall Council and funded through schools
- CFT provides an autism diagnostic service for under 18 year olds
- CFT provide specialist respite care for children with behaviour that challenges in a two bed unit in central Cornwall
- CFT provide a children’s learning disability nursing team, alongside a clinical psychologist and consultant psychiatrist who also specialise in learning disability related issues

Special Educational Needs and Disability (SEND)

The SEND Code of Practice (2014) outlines four broad areas of need which should be considered in assessing support requirements for young people who may also meet the TCP criteria. SEN support could be offered to children and young people who have issues with:

- Communication and interaction
- Cognition and learning
- Social, emotional and mental health
- Sensory and/or physical
The majority of children and young people with SEN have their needs met in mainstream settings and schools but the following specialist settings are available for those with the most complex needs:

**Child Development Centres (CDCs):** There are five CDCs in Cornwall that: facilitate multiagency assessment, use the Early Support model to support families, provide outreach support and ensure a smooth transition into school.

**Area Resource Bases (ARBs):** There are twenty ARBs in Cornwall. They are integral to the mainstream schools that host them and enable inclusion.

**Local Authority (LA) Special Schools:** Four in Cornwall. They cater for children and young people with complex or severe and profound learning difficulties.

**Additional Provision Academies (APAs):** Previously known as Pupil Referral Units and Short Stay Schools are attended by many children and young people who have Statements of SEN or EHC plans.

**Out of County Provision:** Due to their very complex needs, a small number of children and young people are educated in independent specialist provision.

**FE Colleges:** All FE colleges in Cornwall make a wide range of SEN provision for young people with additional needs.

**Describe governance arrangements for this transformation programme**

A Transforming Care Partnership Board will be set up to oversee the TCP development and implementation. Membership of the board will include children's and adult representatives from:

- Kernow Clinical Commissioning Group
- Cornwall Council Education, Health and Social Care (EHSC)
- Council of the Isles of Scilly Social Care
- Carers
- People with a lived experience of services

Wider planned representation for involvement when needed will include:

- Cornwall Council Housing
- Cornwall Safeguarding Boards
- Devon and Cornwall Police
- Cornwall Probation
- Youth Offending Service
- The Cornwall Provider Forum (social care)
- The Voluntary Sector Forum

The governance arrangements can be seen in the diagram below.
Working groups will be set up to take forward each of the workstreams that will report to the Transforming Care Partnership Board.

The complete Terms of Reference of the TCP group can be found in Appendix B.

Describe stakeholder engagement arrangements

During the production of this plan there will be a planned programme of events, as well as the continued use of existing groups, to co-produce the aims and intended outcomes with people with learning disabilities and/or autism and families/carers. The TCP
members will also arrange a number of events to engage both with wider statutory services, voluntary and community sector based services and independent care and support providers. Initial contact with care and support providers has been positive, with an evidenced interest from major providers wanting to be involved in the further development and implementation of the plan. It will be crucial to work in partnership with people with a lived experience of services as well as carers, providers and other stakeholders to develop and implement the plan so as to ensure care is really transformed in Cornwall and the Isles of Scilly.

**Current stakeholder engagement activity**

During January 2016 an event was organised as a sub-group of the Carers Partnership Board specifically with carers of people with learning disabilities and/or autism to discuss the plan and identify what was important to them. The plan was also discussed at the Big Health Group meeting (a sub-group of LDPB) on the same day. Further family carer events took place in March and April 2016. Future events will be planned throughout Cornwall to minimise travel for people where transport and access can be an issue.

Below is an example of the responses from people in Cornwall with a lived and current experience of caring for a person who has learning disabilities and/or autism and behaviour that challenges.

![Notebook page with hand-written notes]

The existing groups and boards listed below will continue to be utilised where possible to inform the development and delivery of the plan:
**Cornwall People First (CPF) Forums**

Cornwall People First (CPF) are a local charity, funded by Cornwall Council, that provide forums for people with learning disabilities and autism in order to develop self-advocacy skills enabling people to have a louder voice and greater power with commissioning bodies and provider agencies. CPF forums include up to 400 individuals over each year. CPF ensure that self-advocates views are reported to both the Learning Disability Partnership Board and the Cornwall Autism Partnership.

**The Learning Disability Partnership Board (LDPB)**

This group is co-chaired by Cornwall Council’s lead Councillor for Adult Social Care and a person who has a lived experience of services. The LDPB provides oversight of services against stated strategic objectives, informs strategy and commissioning direction, ratifies policies that have a direct effect on people with learning disabilities and provides a regular platform for self-advocacy feedback. The group is comprised of people with lived experience of services, family carers, people with learning disabilities, advocacy groups, carers groups representatives, alongside service providers and commissioners. Issues and concerns are fed through to the Learning Disability Leadership Group and the Forums for action.

**The Cornwall Autism Partnership (CAP)**

These groups are co-chaired by NHS Kernow and Cornwall Council, although it is hoped that the adult group will be chaired by an individual with autism in the near future. The boards include representation from family carers, NHS Kernow and Cornwall Council, as well as other interested professionals. The adult CAP is supported by Cornwall People First who support self-advocates to have input into the meeting. The CAP is used primarily as a consultative body, as well as a forum where information about individual’s lived experience can be heard and influence policy direction.

The Children’s CAP is chaired by a Consultant Community Paediatrician with an interest in autism and attended by education; voluntary sector; CFT provider; parent representative; and an NHS Kernow commissioner. The CCAP is used as a networking opportunity and aims to develop more consistent pathways. A children’s autism strategy is being developed as part of the CCAP work plan.

The CAP Core Group discusses and takes action regarding issues and concerns raised at the CAP.

**The Big Health Group**

This group is co-chaired by the NHS Kernow clinical lead for learning disability, alongside a public health professional (member of the CHAMPs team) who has a learning disability. The group provides guidance and consultation on health issues that particularly affect people with learning disabilities. This group is a sub-group of the Learning Disability Partnership Board. The group comprises of people with learning disabilities with an interest in health matters, NHS professionals (including people with learning disabilities), family carers and other interested parties.
Carers Partnership Board

In Cornwall and the IOS, the Carers Partnership Board was set up in response to national strategies designed to ensure carers are able to access the support and services they need to remain in their caring role for as long as they wish. The purpose of the board is to:

- Monitor the Cornwall Carers Strategy 2014-2016
- Discuss and address issues of common concern to carers in Cornwall
- Raise awareness and improve understanding of the role carers play in supporting other people
- Exchange ideas, strengthen skills and share examples of good practice in developing support and services so carers can remain in a caring role for longer

The Cornwall Provider Forum

The Cornwall Provider Forum meets on a quarterly basis and gives a voice to a broad range of providers across Health and Social care services, a number of which provide care and support for individuals who may be within the scope of the TCP. The forum has oversight from the Commissioning, Performance and Improvement Service within Cornwall Council. The Provider’s Forum is currently under review over the next 6-12 months to improve opportunities for engagement and co-production.

Cornwall Voluntary Sector Forum (VSF)

VSF is umbrella organisation for voluntary and community organisations in Cornwall and the Isles of Scilly. The aim is to work with others to create a thriving voluntary sector that effectively serves Cornwall and its people.

Emotional Wellbeing and Mental Health Programme Board (EWMH)

The EWMH Board is a partnership that includes a range of statutory provided and commissioned agencies with voluntary organisations to transform mental health through prevention, early identification and intervention, care, treatment and support across 0-18 year olds. There is a CAMHs Shadow Board comprising of young people and the Boards meet to discuss service improvement; commissioning intentions and engagement.

The Special Educational Needs and Disability (SEND) Board

The SEND Board has carer and young person representation and reports to Cornwall’s Children’s Trust Board via the Education, Health and Social Care Services Directorate Leadership Team of Cornwall Council and Maternity and Children’s Programme Board of NHS Kernow. It reports to the Cabinet member for Children and Young People via Head of Service, the Learning and Achievement (Chair). The Cabinet member sits on the Health and Well Being Board of the Cornwall’s Children’s Trust Board. As its key activities, the SEND Board:

- Evaluates the outcomes and provision for children and young people with SEND
- Ensures that SEND priorities are identified and represented in Cornwall’s SEN Strategy
• Confirms the Strategy Action Plan that addresses priorities within Cornwall’s SEN Strategy
• Monitors progress on actions within the Strategy Action Plan
• Challenges and supports the achievement of actions within the Strategy Action Plan
• Reports to Cornwall’s Children’s Trust Board.

HeadStart Kernow Partnership Board

A multi-agency group with representation from Schools, NHS Kernow, Cornwall Partnership Foundation Trust, Public Health and the Voluntary Community Sector on behalf of the Children’s Trust Board. HeadStart Kernow is a Big Lottery funded project aimed at 10 to 16 year olds aiming to achieve the following outcomes:

• Young people are better able to cope in difficult circumstances and do well in school and in life
• Improved resilience to prevent the onset of common mental health problems
• Development of an evidence base for service re-design and for investment in prevention

National guidance require local strategies to be developed in partnership with young people and to be sustainable beyond their investment effecting change and influencing key decision makers in the local area in addition to influencing changes in policies and services at a national level. Cornwall Council is leading on the project on behalf of the HeadStart Kernow Partnership Board

Other relevant existing groups will be explored as the TCP progresses.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

General Guiding Principles

The Social Care Institute for Excellence has produced a guide that explains how to put co-production approaches into practice in organisations and projects. The guide breaks down co-production into four areas: **culture, structure, practice and review** (please refer to Appendix C for details). These will be used to help the TCP to ensure that the development and implementation of the plan is co-produced against national best practice standards in Cornwall and the Isles of Scilly. The Communication and Engagement work stream will utilise these principles to develop a strategy/ plan for co-production.

It is recognised that the group of people within the scope of the TCP can often have significant communication difficulties which could make the use of more mainstream engagement and co-production methods less effective. As such, the TCP in Cornwall will also use the ‘Five Good Communication Standards: Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings’ (Royal College of Speech and Language Therapists 2013) as a guide to inform all interactions and planned engagement activity. It
is the aim that these standards will filter down into core service delivery with providers and practitioners:

**Standard 1:** There is a detailed description of how best to communicate with individuals.

**Standard 2:** Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.

**Standard 3:** Staff value and use competently the best approaches to communication with each individual they support.

**Standard 4:** Services create opportunities, relationships and environments that make individuals want to communicate.

**Standard 5:** Individuals are supported to understand and express their needs in relation to their health and wellbeing.

**Current co-production activity**

- A person with learning disabilities and two family carers will sit on the TCP programme board; further work is being carried out to increase the number of people with learning disabilities and/or autism and family carers on the board.

- Events described above taking place with people with learning disabilities and/or autism and family carers; further events are being planned.

- A Communication and Co-production Strategy will be developed that will focus on people with lived experience of services and include families and carers. The strategy will also utilise existing groups where possible to co-produce the development and delivery of the TCP. The events will continue throughout 2016 to ensure co-production in the development of our services and commissioning models.

**Cornwall people First Quality Checkers** are commissioned to check the services that people with learning disabilities receive, such as day centres, residential homes, supported living and hospitals to find out what is good and what could be better. The CPF Quality checkers will be engaged in supporting the TCP agenda locally and champion the involvement of people who currently use services in any proposed changes. CPF have input into a number of boards and steering groups already described.

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**Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership**

(Please see attached Activity and Finance template)

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2.**Understanding the status quo**

**Baseline assessment of needs and services**

**Provide detail of the population / demographics**
**Cornwall in Context**

Cornwall has an estimated 541,320 residents according to the 2013 ONS mid-year estimates. 23.2% are aged over 65 and 16.9% are aged 0-15 years. Cornwall is the second largest local authority area in the South West region, covering an area of 3,559 sq. km, and has the longest coastline of all English counties at 697 km. It is an area of many contrasts; with varied landscapes including remote rural, coastal and environmentally sensitive areas, interspersed with villages and historic market towns; where affluence sits alongside some of the most disadvantaged areas in England.

**Isles of Scilly in Context**

The population of the Islands was recorded as 2,203 at the last census in 2011 and is spread over five inhabited Islands. The vast majority of the population, 1,600, lives on St Mary’s with approximately 175 on Tresco, 135 on St Martin’s and 85 on both Bryher and St Agnes. More than 35% of the population are aged over 55 making the islands one of the most rapidly ageing communities in the country. Approximately 270 (8%) of the total population are school aged and on role at the Five Island School.

**Data Estimates**

The Cornwall and Isles of Scilly TCP area does not currently record the five needs groupings within its minimum data set. The plan will include the data capture of these groups within the JSNA process, continuing under regular reporting.

POPPI and PANSI data (accessed February 2016) has been used to predict the number of adults with moderate or severe learning disabilities, learning disabilities and behaviour that challenges and autism spectrum disorders in Cornwall. Further POPPI and PANSI data can be found in Appendix D.

- Total population aged 18-64 predicted to have a moderate or severe learning disability for 2016 is **1,733** increasing to **1,748** by 2020
- Total population aged 65 and over predicted to have a moderate or severe learning disability for 2016 is **385** increasing to **406** by 2020
- Total population aged 18-64 with a learning disability, predicted to have behaviour that challenges for 2016 is **142** increasing to **143** by 2020
- Total population aged 18-64 predicted to have autistic spectrum disorders for 2016 is **3,082** increasing to **3,119** by 2020
- Total population aged 65 and over predicted to have autistic spectrum disorders for 2016 is **1,264** increasing to **1,363** by 2020

According to the GP QOF register for 2014/15 there were **2,876** adults with learning disabilities in Cornwall and the Isles of Scilly.

A snapshot report from Cornwall Council’s Performance Data Team showing self-directed support with an active purchase order for learning disabilities and/or autism as of 31/03/16 is shown in the table below.
People with learning disabilities and/or autism receiving funding through adult social care

<table>
<thead>
<tr>
<th></th>
<th>Direct Payments only</th>
<th>Part Direct Payment and part Personal Budget (managed by the Council)</th>
<th>Personal Budget only (managed by the Council)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>371</td>
<td>188</td>
<td>551</td>
<td>1110</td>
</tr>
</tbody>
</table>

Data from the Local Authority EMS One report as of 28/08/15 2015 shows that there were:

- **806** children aged 5 – 10 resident in Cornwall with a Statement or EHC plan
- **1,018** young people aged 11 – 15 resident in Cornwall with Statement or EHC plan
- **359** young people post 16 in Further Education provision with a Statement / EHC plan or Learning Needs Assessment
- There are currently no children or young people with learning disabilities and/or autism placed in residential schools for 52 weeks by Cornwall or the Isles of Scilly.

The TCP in Cornwall acknowledge that these figures do not adequately identify children and young people who would fall within the scope of the TCP (in terms of the five categories). Further extrapolation gives us the working figures for the following groups who have a Statement of SEN or EHC who *may* fall within scope:

### Statement/EHC

<table>
<thead>
<tr>
<th></th>
<th>5-10 yrs.</th>
<th>11-15 yrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Emotional/MH</td>
<td>89</td>
<td>213</td>
</tr>
<tr>
<td>Severe Learning Difficulty</td>
<td>169</td>
<td>131</td>
</tr>
<tr>
<td>PMLD</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>232</td>
<td>283</td>
</tr>
</tbody>
</table>

### Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Cost to CCG (NB if unclear then approx.)</th>
<th>Current placement e.g. family home; residential home; residential school</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td>0 - 5</td>
<td>Approx. £1100 per week</td>
<td>0 - 5 child in residential home</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 - 5 child in residential school</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 - 5 at family home</td>
</tr>
<tr>
<td>16-17</td>
<td>0 - 5</td>
<td>Approx. £3100 per week</td>
<td>All at home currently</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analysis of inpatient usage by people in Scope of Transforming Care Partnership

The national planning assumptions set out in Building the Right Support do not give a percentage reduction of usage for inpatient services for Cornwall and the Isles of Scilly due to the relatively low level use of inpatient beds.

- NHS Kernow commission a hospital placement for one adult with a learning disability and behaviour that challenges in an out of county placement.
- NHS England commissions inpatient services for nine adults with learning disabilities and/or autism who originate from Cornwall within specialist, secure assessment treatment units. Discharge plans are in place or being developed for all the identified patients.
- There are no children in specialist inpatient services.
- NHS Kernow has not commissioned an out of county placement for any new admission to services for over two years. During this time, three existing inpatients have been repatriated from out of county. The TCP programme area relies on robust, specialist community provision to prevent the necessity for hospitalisation. The future model includes the consolidation of this service and the development of a specialist autism service.
- Individuals within the NHS Kernow area who have learning disabilities and/or autism and behaviour that challenges utilise generic mental health beds, with augmented liaison support, if they are requiring inpatient treatment for a mental health need. These admissions are part of the established mainstream mental health pathway and are for short length of stays.
- Recently, one young person has relocated from an in-patient assessment and treatment unit and returned to Cornwall. This was achieved using person centred planning and positive behaviour support approaches, with a package of care co-produced with his family.

Describe the current system

The current system is illustrated here in terms of the current services provided in Cornwall and IOS as set against the nine core principles described in the ‘Service Model for Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition’ (ADASS/LGA/NHSE, October2015). Further information on the descriptors from National Service Model can be found in Appendix E.

1. I have a good and meaningful everyday life

Early Support services work with children and young people with Special Educational Needs and disabilities, a coordinated approach which brings together families and professionals in a Team Around the Child. This ensures that a child or young person’s needs are met not only in education but in all aspects of development. At a Team Around
the Child (TAC) meeting, an Early Support Plan is written that identifies and addresses the child/young person’s and parent/carer’s priorities including goals around education, socialisation and sports/leisure activities. An additional service that provides an Early Support Worker is also available. This person acts as the key worker for families who have been receiving support from the Disabled Children and Therapy Service but who no longer need the direct support of their social worker.

The Autism Spectrum Team (Cornwall Council) works with young people with a diagnosis of autism including those with behaviour that challenges. Individual casework may be based in mainstream educational settings and/or within the home. The team’s role is to provide consultation, model good practice, carry out limited direct work with young people and deliver training as required. The expectation is that as a result of this input the professionals and carers in the young people’s environment will be enabled to continue to support them when the Autism Spectrum Team ends their involvement. The team offers parent workshops rather than direct work in the home except in the most challenging circumstances. There are young people with autism across the ability range in mainstream educational settings in Cornwall, and the Autism Spectrum Team carries out joint work around young people with behaviour that challenges with both CAMHS and CAMHS (LD) on occasion, as well as joined up work with various Social Care teams.

The Social Care Innovations Project is a pilot project that has been co-developed by the Parent Carer Council and Cornwall Council. The aim is to support families with children aged 0-18 that have additional needs and disabilities to find the support they need locally. SCIP trained volunteers enable parent carers to gather information about the child and their family, creating a solution focused action plan that allows the family to build confidence and access opportunities that are available to them in their local community. The joint work will involve the Early Support Workers who as part of the Local Authority, will take referrals and coordinate the tailored support that is identified as being required by the trained parent volunteers, accessing services and organisations, which are part of the Local Offer. They can also allocate a professional key worker and call Team around the Child (TAC) meetings.

Transition Workers (Cornwall Council) ensure the smooth transition of children and young people into adulthood, including those with behaviours that challenge. Cornwall Council is currently preparing a proposal for a more developed transition system (see project plan).

Community Support Services (day opportunities) for adults are currently being reviewed to ensure that people are supported to access services, support and activities in their local community. This will include education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2. My care and support is person-centred, planned, proactive and coordinated

Get a Plan is a service delivered by the Foundation of People with Learning Disabilities that supports people to develop Person Centred Plans (PCP) with their circle of support. This includes people with learning disabilities and/ or autism and behaviour that challenges. All social care staff members have been trained by Get a Plan in developing PCPs with people with eligible social care needs. This service is currently commissioned by Cornwall Council and NHS Kernow to undertake PCP and is being reviewed to ensure the service is meeting needs.
Social Care Locality Teams have a legal duty under Section 47 of the National Health Service and Community Care Act (1990) to assess people’s social care needs. Since The Care and Support (Eligibility Criteria) Regulations (2014) under the Care Act came into effect in April 2015, a further duty to assess the needs of carers has been brought into scope. Once assessed as eligible for support, the Council will assist the person in arranging housing, support, work, education and other placements via a person-centred support plan delivered by a personal budget (including the option for direct payment). The teams also respond to crisis, safeguarding referrals and emergency situations.

Whilst eligibility on the basis of a diagnosis is a central factor in considering who receives a service, the Local Authority can include support for individuals who would otherwise not be eligible for social care support if this was deemed a preventative measure i.e. support that would help maintain wellbeing and independence, and potentially delay a situation where longer-term care and support might be required.

3. I have choice and control over how my health and care needs are met

The Family Information Service (FIS) supports families across Cornwall by offering free and impartial information and advice. They also host the community directory of services, Care and Support in Cornwall, which offers information and advice for people who use services across all age ranges. As a central point of contact for parents/carers and the professionals supporting them, the team can offer guidance on a range of matters including parenting, behaviour, education, activities and family support services. The FIS also assist with other childcare enquiries and are the official source of all Ofsted registered providers available in the county. Advice on funding options to help pay for this care is also available. The service exists to help families with children and young people aged 0 – 19, or 25 if the young person has a special educational need or disability (SEND)

Special Educational Needs Disability Information Advice and Support Service (SENDIASS) provide information, advice, support and training for young people and parents/carers of children with special educational needs and/or disabilities (age 0-25). This includes: Information and guidance on the Special Educational Needs Code of Practice, exclusions from school of children with special educational needs and/or disabilities, school admissions, referring and signposting to other relevant services, training opportunities for parents and professionals, support for groups of parents/carers and young people, accessing impartial resolution and mediation services, arranging support at relevant meetings, referring to Independent Supporters for help with the Education, Health and Care Plan (EHCP) process, information on local policy and practice such as the Local Offer

Disability Cornwall a charitable organisation initially founded as the Cornwall Disability Forum, deliver a range of information, advice and support services, facilitate workshops, conferences and training events, all to further and enhance the disability movement in Cornwall. The membership currently stands at 400 individual disabled people and 60 organisations. The Disability Cornwall team work closely with statutory services to improve access and develop best practice around service user involvement. They carry out research and campaigning. They also manage the administrative aspect of personal social care budgets for a small monthly fee to support more people to access them and thus have greater control over how their care and support is delivered.

Living Well is a programme pioneered in Cornwall as a partnership of the local health,
social care and voluntary and community sectors. It aims to support those people most at risk from unscheduled use of health and social care to avoid unplanned acute admissions to hospital, frequent need for crisis management and utilising health and social care services as a social crutch. The programme targets changing service user behaviours toward a more planned use of services and greater engagement with health and social care services over the long term. This is achieved through a theory of change that focuses on proactive case finding, use of guided conversations and motivational interviewing techniques, enhanced access to volunteer and community based support and locality based working.

**Integrated Personalised Commissioning (IPC)** takes Living Well forward as it is an approach that puts people in control and focuses on their goals and aspirations for the future. Person centred care and support planning is at the heart of the IPC programme and it involves joint-working between individuals, families and practitioners to set health and wellbeing outcomes that matter to them. IPC includes the ‘guided conversation’ which aims to identify outcomes with individuals which if met through a Personal Health Budget (PHB), may avoid them from having to use crisis and emergency services to meet their ongoing needs. The IPC model takes a whole system approach to support delivery and as such also considers how health and social care needs interact. Currently the PHB does not factor in the indicative funding that a person may be entitled to in terms of their social care needs met through a local authority Personal Budget. This means that individuals could in theory hold both budgets. In the future, in line with greater integrated working, a joint budget may be piloted so that a single Health, Social Care and Wellbeing budget is held to meet a range of needs but this depends on the findings from the pilot schemes.

**Advocacy** in Cornwall as per the Care Act (2014) is offered to any person who has substantial difficulties in being actively involved in their care planning or reviews without a suitable appropriate person to support them. The areas that an independent advocate must be provided under the Care Act (2014) are from point of assessment information gathering, during assessments, support plans and care reviews. An independent advocate may also be required through the safeguarding process from point of enquiry through to review. As well as a number of non-statutory providers, there are currently four advocacy providers who cover particular advocacy functions in Cornwall.

4: I am supported to live in the community and my family/ carers and paid staff get the help they need to support me

**Cornwall Carers Service** is a partnership of 3 organisations who work together to deliver the service. The Carers Service is hosted by Cornwall Rural Community Charity, and is supported by Disability Cornwall and Age UK Cornwall. The service is jointly funded by Cornwall Council and NHS Cornwall and Isles of Scilly and is free to all unpaid and informal carers in Cornwall. The service provides:

- Carer support workers who can help with access to services and benefits.
- Forums, an opportunity to have a say about what’s good, bad or not working from a carer perspective in order to inform NHS services, Local and National Government and to influence change.
- Helpline available 8am to 6pm, operated by caring and knowledgeable people
- Website with useful information for carers.
Support Groups formed and attended by carers to share experiences, be supportive and proactive

Community Drop-ins one-to-one support and information from a carer Support Worker.

Residential Short Breaks for Children and Young People with Disabilities. The Short Break Service provides county wide planned residential short breaks for children and young people with learning disabilities and associated complex needs. The short break provision aims to provide a positive experience for each individual, and offers each child or young person the opportunity to join in a variety of fun activities, alongside promoting social inclusion, and positive outcomes for young people as in the Every Child Matters agenda. Each individual service has a registered manager and is regularly inspected by Ofsted, and there is a clear referral process to ensure each placement meets that young person’s individual needs.

Shared Lives Short Breaks is a service for adults with LD and their families who need occasional or regular breaks which include some care and support in a home-from-home setting. Short breaks can be anything between a day-time break, or a long weekend, or can run right up to a 28 day stay. A short break can also provide a ‘taster’ of longer term services.

Cornwall Foundation Trust provide specialist respite care for children with behaviour that challenges in a two bed unit in central Cornwall

Paid care and support staff are trained and experienced in supporting people who display behaviour that challenges. Within the more specialist services, Positive Behaviour Support and Person Centred Planning are recognised approaches and local specialised provider workforces are trained in its application.

5: I have a choice about where and with whom I live

Cornwall Council’s Long Term Accommodation (LTA) Strategy for People with Eligible Care Needs 2015-2018 is currently being refreshed and will include the outcomes for TCP. The section detailing the ‘current estate’ below provides more detail.

Supported Living Services (SLS) currently offer housing with care and support the majority of which is shared accommodation. The housing is provided separately from the care and support.

Housing with Support Schemes offer self-contained accommodation with access to support (some of this support is shared).

Extra Care housing schemes are for people with age related needs (including older people with learning disabilities and/ or autism). Extra Care offers self-contained accommodation with communal areas and personalised care and support that is accessible 24 hours a day, 7 days a week.

Social housing can be accessed by people with learning disabilities when appropriate, with care and support arranged separately.

Shared Lives is a model of service delivery that offers both long and short term placements for vulnerable adults, including people with needs related to learning disabilities, mental health and/ or autism. It is an alternative form of accommodation with
care and support which is provided by individuals or families in the local community.

**Long term supported accommodation (LTSA)** services support people in an appropriate accommodation environment to live independently. People accessing the services have support needs related to mental health, learning disabilities and/or autism. Residents may or may not have eligible social care needs.

6. I get good care and support from mainstream NHS services

**A Primary Care Liaison Nursing team** is commissioned by NHS Kernow to improve access to GP practices and other primary care. This includes facilitation of access for people with behaviours that challenge, as often an individual’s behaviour may escalate due to the stresses of medical intervention. The Primary Care Nursing Team will refer individuals through to the specialist community services if the level of intervention required exceeds that available through a facilitation role.

**The Acute Liaison Nursing Team** is based within the two acute hospitals that serve the Cornwall and Isles of Scilly population. Although they provide a service to the whole population of people with learning disabilities and/or autism, in common with the Primary Care Liaison Team, they will make reasonable adjustments for people with behaviour that challenges. The Acute Liaison Nursing Team receives referrals from the Referral Management System, where primary care flags are placed to alert the acute hospital to specific needs. A flagging system with acute care ensures that further admissions are notified to the nursing liaison team immediately.

**Hospital Passports** are used successfully with this client group. These person centred documents identify key information that the person wishes to share with people who are involved in their treatment. It includes information about the person’s preferred communication needs and useful contacts. The Liaison teams promote open and easy access to hospital services for patients with learning disabilities in Cornwall. They work to address the management of the interface between mainstream general hospital services, primary care services and community specialist disability services and support involvement of carers as potential experts in the care planning process.

**The Mental Health Liaison nurse** ensures that mental health services, particularly inpatient facilities, are accessible, safe and effective for people with learning disabilities, and when an individual has an identifiable mental health problem. This service often provides a key step in the management of crisis, preventing escalation or longer term admission to a specialist facility. The mental health service culture, working alongside the mental health liaison nurse, is that of inclusion and accessibility for people with learning disabilities.

**Health Checks and Health Action Plans.** The Primary Care Liaison Team, working alongside GP practices across Cornwall and the Isles of Scilly, have led the implementation of Annual Health Checks for people with learning disabilities. In 2014 – 2015, the uptake level for individuals aged 14 and upwards was 62%. A dedicated working group continues to look at ways that the quality and uptake levels can be improved for individuals, especially those who are particularly “hard to reach”, such as individuals who have borderline learning disabilities or additional mental health issues.
The CHAMPS Team employs and trains people with a lived experience of disability to help to make sure patients with a learning disability in Cornwall and Isles of Scilly get equal access to health services. Champs work includes: Checking that health services are accessible and making reasonable adjustments, seeing how staff talk to people with learning disabilities to make sure that they communicate in the best way for that person; Checking that staff know about key people who can help them to provide a good service for people with learning disabilities, (like Primary Care and Acute Liaison Nurses). Helping staff to understand the law that relates to learning disability, (like the Equality Act and Mental Capacity Act). Checking that services have ‘easy to understand’ information about important things like Advocacy and Comment or Complaints procedures and checking that the service is flexible wherever possible.

Other CHAMPS work includes: Planning and running engagement events like the ‘Big Health Day’, gathering feedback on services in different ways such as easy to understand forms and questionnaires as well as video interviews, training health staff about the needs of people with learning disabilities alongside the Liaison Nurses, attending meetings as advisors to people within the NHS and other organisations. Such meetings include The Accessible communications group, the Learning Disability Partnership Board, the Big Health group, the Learning Disability Leadership group and Learning Disability Awareness Week planning meetings.

7: I can access specialist health and social care support in the community

The CAMHS (LD) Team is a small specialist multi-disciplinary team who are integrated within the wider CAMHS service. The team consists of LD nurses, Occupational Therapists, Clinical Psychologists, Speech and Language Therapist, Community Support Worker and Child Psychiatrist. The team see children with moderate to severe learning disability who are presenting with mental health concerns and/or complex behavioural difficulties. They complete multi-disciplinary assessments within the structure of a care pathway model and actively work with families and other agencies in a range of settings to develop formulation, recommendations and interventions. They work in a person centred way to support families and agencies with Positive Behaviour Support Planning.

Adult Community Learning Disability Team (CLDT) is commissioned by NHS Kernow and delivered by Cornwall NHS Foundation Trust (CFT) across Cornwall and the Isles of Scilly. The CLDT accepts referrals concerning individuals with learning disabilities who are experiencing functional difficulties outside of the usual lived experience and that have health aetiology. The CLDT (which is divided between West and East Cornwall) provide episodic health interventions across a wide range of discipline. For the TCP cohort, the CLDT offers a multi-disciplinary approach to help individuals who are experiencing distress or other events that are causing behaviour that challenges. The team adopt a range of approaches, including counselling, psychotherapy, chemotherapy and Positive Behaviour Management. Working alongside regular carers and providers, the team aims to keep interventions effective and brief, rather than keep an ongoing caseload. The CFT learning disability service has demonstrated a culture of positive risk taking and commitment to community placement for individuals whose behaviour challenges. CFT is supported by Cornwall Council, who works in partnership with CFT to provide specialist accommodation and support. We have developed a way of working that does not assume that high risks require hospital care. Instead we promote sophisticated, innovative and person centred care, which is more effective and in the medium and longer term, better value.
**Intensive Support Team (IST)** provided by CFT delivers the specialist services that cater for individuals who need more intense intervention and are at higher risk of hospitalisation. The IST provides expert assessment, intervention and treatment to individuals experiencing high levels of functional difficulty related to distress or mental health issues, coupled with significant behaviours that challenge. The IST carries a small caseload capacity, with the aim of brief and effective intervention at times of intensive need and crisis. The IST also provides training and advice related to individuals for staff teams and family members where necessary. The IST is also a multidisciplinary team, covering the whole of Cornwall and the Isles of Scilly.

**Social Care Locality Teams** include co-located staff from Health and Social Care authorities in the East, Mid and West of the county. Their remit includes social care management duties for adults with learning disabilities and/or autism and behaviour that challenges. Where it is identified that there is a need for specialist input around behaviour that challenges and/or autism due to an unmet need or risk, various options are available to the Social Care assessing staff via inter-agency routes of referral. As such a range of professionals including clinical psychologists and psychiatrists who have expertise in understanding and assessing behaviour that challenges and/or autism could be engaged. Speech and language therapists and occupational therapists are also commonly engaged to complete functional analyses and communication needs. It should be noted that the Council does not in and of itself provide behavioural management plans as this remains a Health related domain. It is common however for behavioural support to be identified in assessments/support plans in order to produce a single coherent care plan. A number of services commissioned by the Council often have requirements to deliver behavioural support within the service specification. Such support still needs to be agreed and overseen by NHS Kernow as part of a multi-agency team approach around the person.

**Autism diagnostic services** are provided by CFT for people under 18. If someone over 18 has a severe learning disability or a severe / enduring mental health need and may have autism, and is under the care of CFT, they are able to offer a diagnostic service. If someone over 18 may have autism but does not have a learning disability or a mental health need, Outlook South offer a diagnostic service. There are currently no contracted specialist intervention services for people with autism without a learning disability.

**Care services** are delivered by a mix of voluntary and private providers. There are a number of care providers within Cornwall who specialise in the provision of services to individuals with behaviour that challenges. These services are utilised by local health and social care commissioners and significant numbers of out of area commissioners. The Care at Home and in the Community Framework Agreement utilises a call-off procedure to put packages of care in place for people, including those living in the community, supported living (shared housing) or specialist housing schemes. There is a clause in the contract that relates specifically to ensuring that the needs of behaviour that challenge are met. The framework is currently being reviewed to ensure that it is person centred and outcome focused.

**8: When needed, I am able to get support to stay out of trouble**

**The Together for Families Programme** (the national Troubled Families Programme) is preparing for transition into Phase Two of delivery. Cornwall will be expected to identify, engage and achieve positive outcomes for 4,050 families between April 2015 and March 2020. The criteria for Phase Two are:
- Families affected by crime and anti-social behaviour
- Children not attending school regularly
- Children who need help
- Families affected by domestic abuse and violence
- Parents and children with a range of health problems (the majority are most likely to be alcohol, drugs, mental health and learning disability, but this can be wider)
- Adults out of work/financial exclusion/young people at risk of worklessness

The Forensic Community Team is a mainstream service for the general population that is also accessible to people with learning disabilities or autism. This has been achieved by the inclusion in the team of two qualified learning disability nurses who are also forensic specialists. The team accepts referrals concerning people with learning disabilities who have had contact with the criminal justice system and who remain an enduring and significant risk to the public. The service provides case management, with the necessary risk assessments and care planning, to meet the individual’s needs.

9. If I am admitted for assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high quality and I don’t stay there longer than I need to

Three acute mental health wards (Carbis and Perran Wards located at Longreach House, Redruth and Fletcher Ward within Bodmin hospital) provided by CFT can be accessed by people with learning disabilities and/or autism who require inpatient assessment and treatment for a mental health condition. There are no specialist learning disability or autism inpatient facilities within the TCP area. Where individuals are subject to detention under the Mental Health Act but who do not have a diagnosed mental health condition (under the Mental Health Act (2007) i.e. under the “abnormally aggressive or seriously irresponsible” clause), it may be necessary for them to be admitted to a longer term assessment and treatment facility. The process for detention will usually involve the IST or CLDT. Where possible, a pre-admission CTR will take place. Following admission, a local care coordinator will be allocated who will be responsible for care monitoring and discharge planning for the individual. As with locked inpatient provision, secure inpatient provision is used as a last resort and is only accessed via a Hub Assessment by the local secure service based in Bodmin. Following agreement to admit and a pre-admission CTR, the individual is admitted into an NHSE commissioned bed. A local case coordinator is retained to ensure that the out of area process does not result in a loss of local connection for the individual.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Residential Care and Family Home

High levels of people with learning disabilities and/or autism are living with family/friends. Historically there has been substantial use of residential settings for adults with learning disabilities and/or autism when family support has broken down. Cornwall Council recognises that additional specialist support designed to work within the family environment is limited and that this is likely to be one of the many contributing factors to
the over use of more institutional settings.

It is a common view amongst practitioners and experts in the field that residential settings can tend towards more paternalistic, restrictive or risk-averse models of support which in turn can lead to a reproduction of some of the conditions experienced by adults in secure in-patient settings. This level of restriction and supervision has come under close scrutiny since the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards have been applied to residential homes. Within the county, the scale of Best Interest Assessment requests from residential care providers has increased as a result of recent test cases. At the point of writing this report, the current waiting list for DOLS authorisation within the county stands at 2007 individuals. This presents interpretation of this statistic is that it is likely to be a combination of two factors: 1) there are a large number of people who have temporary authorisations (up to a maximum of 7 days) under DOLS; 2) there may be an equally large number of people who are not authorised and thus assumed to be deprived of their liberty outside of the legal framework.

**Supported Living - Shared Housing**

Within the estate there is limited self-contained accommodation with the majority of properties being shared living. Cornwall Council does not own any housing assets for this cohort. Asset management is currently taking place with the housing providers of shared living supported accommodation to ensure that properties are fit for purpose. In some cases the accommodation is no longer in good repair and needs to be sold; some are only partially occupied as some of the tenants are unable to share; some have been earmarked for remodelling or complete demolition and redesign. NHS England has agreed in principle that the capital money released from the sale of properties during our review of supported living services can be recycled within the TCP area. This money will be ring fenced for reinvestment into accommodation provision, some of which will be for people whose behaviour challenges. Care and Support is delivered through the Care at Home and in the Community Framework Agreement.

**Supported Living - Housing with Support Schemes**

Our strategic direction during this time has also changed and new accommodation solutions are now focused on independent living with access to support (some of this support is shared). The Council’s approach to improving choice through additional housing options as outlined in its Long Term Accommodation (LTA) Strategy for People with Eligible Care Needs 2015-2018 includes a number of recent site developments in collaboration with both private landlords and those within Cornwall Council’s family of businesses (e.g. Cornwall Housing Limited).

- **Harriets Close** is a new build scheme consisting of 6 self-contained flats, 2 semi-detached bungalows and 3 semi-detached houses for people with learning disabilities and/or autism. It is a development on a brown field site within a residential area of Camborne. Care and support is delivered through the Care at Home and in the Community Framework Agreement.

- **Tolvean** is a scheme of 16 individual flats built to HAPPI principles for adults with a learning disability and/or age related needs. The scheme is in a central position between Redruth and Camborne with easy access to local facilities. The service is currently occupied by people who have a learning disability and mental health needs. Within this there is a broad range of support requirements including support for those who have formerly lived in inpatient hospital settings and small
group homes and who were previously inappropriately housed. Care and support is delivered through the Care at Home and in the Community Framework Agreement.

- **Hendra Parc** is still in development and is a refurbishment project which used existing Cornwall Housing Limited stock re-purposed to meet the housing needs of adults with learning disabilities and/or autism in the east of the county. It offers 14 self-contained flats and a two bedroom shared property with a large communal space to encourage community and peer led activities. The care and support contract for this service is going out to open tender and will be a pilot for the new outcome focused, person centred approach to housing with support.

- **Warfelton** is a further refurbishment property that is also still in development, designed to specifically meet the housing needs of two individuals with autism and complex needs including behaviour that challenges. A decision is yet to be made regarding the commissioning of care and support for this service.

**Other accommodation options**

**Extra Care** housing schemes are for people with age related needs (including older people with learning disabilities and/or autism). Extra Care offers self-contained accommodation with communal areas and personalised care and support that is accessible 24 hours a day, 7 days a week. Care and support is provided through block contracts linked to the accommodation.

**Social housing** can be accessed by people with learning disabilities when appropriate, with care and support arranged separately through the Care at Home and in the Community Framework Agreement.

**Shared Lives** is a model of service delivery that offers both long and short term placements for vulnerable adults, including people with needs related to learning disabilities, mental health and/or autism. It is an alternative form of accommodation with care and support which is provided by individuals or families in the local community. The Council commissions a provider to manage the Shared Lives services.

**Long term supported accommodation (LTSA)** services support people in an appropriate accommodation environment to live independently. People accessing the services have support needs related to mental health, learning disabilities and/or autism. Residents may or may not have eligible social care needs. Housing related support is commissioned through block contracts and care is commissioned through the Care and Support in the Community Framework Agreement.

**Strategy**

Cornwall Council’s LTA Strategy is currently being refreshed and will include the outcomes for TCP. It will link into Cornwall Council’s wider Housing Strategy for Cornwall. The strategy will include the development of more independent accommodation models like Hendra Parc to provide a viable alternative to residential care and provide more settled accommodation. Using the Better Care Fund (BCF) we have already commissioned specialist accommodation to meet the specific needs of people whose behaviour challenges.

The Council of the Isles of Scilly does not currently provide any accommodation for any
individuals within the TCP cohort, as none of the population requires this currently. The Isles of Scilly provide a bespoke, rather than strategic approach to individuals within the TCP scope, if and when an individual moves to the islands. NHS Kernow is in communication with the Isles of Scilly Social Care department regarding any potential future housing needs. The TCP will explore future links with housing opportunities on the mainland (through the Accommodation and Support workstream).

What is the case for change? How can the current model of care be improved?

1: I have a good and meaningful everyday life

- Children’s services for individuals who have behaviours that challenge are effective and wide reaching. However, a more coherent and integrated system is needed to ensure equity both geographically and across service boundaries. A programme of change to ensure that the pathway for children and young people (within the scope of TCP) is integrated will be developed by Cornwall Council, The Council of the Isles of Scilly and NHS Kernow.

- In response to The Children and Families Act 2014 and The Care Act 2014 Cornwall’s multi-agency Transition Protocol has been reviewed. The aim of this reviewed protocol is to ensure a joined up approach which includes co-production, holistic planning and multi-agency working. This Preparing for Adulthood (Transition) Protocol aims to better support young people as they prepare for adulthood and move into adult services, ensuring they achieve good outcomes. A project is being established to ensure that the Transitions service is meeting needs.

- Community Support Services (day opportunities) for adults are currently being reviewed to ensure that people are supported to access services, support and activities in their local community. This will include education, employment, social and sports/leisure; and support to develop and maintain good relationships. Links will be developed to supported employment.

- The Wellbeing, Universal, Prevention and Early Intervention Team are working with other commissioners to ensure that mainstream services are making reasonable adjustments to make them accessible.

2. My care and support is person-centred, planned, proactive and coordinated

- There is a lack of parity in commissioning processes and eligibility criteria between the three main commissioning agencies in Cornwall and the Isles of Scilly. This contributes to difficulty in achieving integrated, person centred approaches to commissioning of services and packages of care and support. Ongoing work is taking place at a strategic level to develop and implement integrated commissioning supported by pooled budgets and joint governance arrangements.

- Cornwall Council will be reviewing the Get a Plan service, which offers training on person centred approaches and supports the development of person centred assessments and support plans for more complex cases. Alongside this the Council will develop arrangements to pilot Individual Service Funds, in order to achieve person centred outcomes for people with learning disabilities and complex
needs, including behaviours that challenge.

- Currently there is a lack of available data on the five cohorts detailed in the TCP. Strategic learning disability commissioners should risk stratify their local population of people with a learning disability and/or autism. This will be considered by the Crisis and Intensive Support workstream.

3. I have choice and control over how my health and care needs are met

- Information and advice in Cornwall is well provided for across the age ranges as already described. However the key aim of the TCP is to ensure that these processes are accessible to the TCP cohort. This will mean direct involvement of stakeholders in identifying where there are reasonable adjustments to existing systems that need to be made.

- Integrated Personalised Commissioning (IPC) is being led by NHS Kernow, in partnership with the local authorities. NHS Kernow is a demonstrator site and the programme involves person centred care and support planning which puts people in control and focusses on their goals and aspirations. A programme of implementation, including people within the scope of the TCP, is being developed. IPC facilitators have been employed and are commencing work with individuals over the next 12-18 months. The main aspect of this approach is the 'guided conversation' which aims to identify outcomes with individuals which, if met through a Personal Health Budget, may avoid them from having to use crisis and emergency services to meet their ongoing needs. IPC takes a whole system approach to support delivery and as such also considers how Health and Social Care needs interact.

- The Wellbeing, Universal, Prevention and Early Intervention Team are given further consideration to identifying funding for non-statutory advocacy on an ongoing basis with the existing budget pressures.

- Cornwall’s Local Offer includes the services, support and provision requested by families as well as those listed in the SEND Code of Practice. It will include support from:
  - universal services such as schools and GPs
  - targeted services for children/YP with SEND who need short-term support that is over and above that provided by universal services
  - specialised services for children and young people with SEND who require specialist and long term support.

- The Transformation Challenge Award team are currently reviewing the Voluntary, Community and Social Enterprise Sector (VCSE) contracts with the Council in order to improve procurement from the VCSE sector. The team will be working with commissioners to consider what additional or different local services are available and needed from the VCSE sector to ensure that people with eligible needs, including those with direct payments, have a range of services to choose from achieve outcomes.

4. My family/ carers and paid staff get the help they need to support me

- Currently, there is no area-wide approach to the teaching and application of
Positive Behaviour Support and Person Centred Planning and the training is largely restricted to more intensive care services. There is no training available for other services, such as the police, mainstream health services or other bodies that are likely to require awareness with the increase in community based care for individuals who present risk. NHS Kernow, Cornwall Council and the Council of the Isles of Scilly will develop a staged training programme available to all public services and care providers, increasing awareness and skills in the larger workforce of the principles of Positive Behaviour Support and Person Centred Planning.

- People that are being supported to live in the community need to be supported to understand and manage risk. This includes knowing where to go or who to speak to if they do not feel safe. The intention is to extend the Safe Places scheme so that people have somewhere in their local community that they can go when they are feeling unsafe.

- Respite services are currently being reviewed to ensure that people with eligible needs and families/carers are able to access flexible and creative short break/respite options.

- The local authority is currently deliberating on the Strategies and Market Position Statements that will be developed to ensure that all client groups are covered, including people with learning disabilities and/or autism and behaviour that challenges.

5. I have a choice about where and with whom I live

- People with learning disabilities have historically had little or no choice about with whom and/or where they live. In the case of those people with learning disabilities who also have behaviour that challenges, choice of accommodation has been even more limited. It is widely accepted that the challenge locally is to provide a range of suitable housing options, across tenures, that people with learning disabilities will choose to live in, with access to the appropriate level of support as required. An approach to improving choice through additional housing options will be developed including:
  - A number of recent site developments in collaboration with both private landlords and those within Cornwall Council's family of businesses (e.g. Cornwall Housing Limited)
  - Identification of further sites for development of self-contained accommodation with support
  - A review of the needs of people living within the supported living (shared housing) properties alongside asset management of the housing stock
  - Working with Cornwall Housing to ensure that people have access to social housing, through ensuring people are able to register and bid on properties
  - Consideration of the need for a housing brokerage service

- The refresh of the Long Term Accommodation (LTA) Strategy for People with Eligible Care Needs 2015-2018 is being undertaken in collaboration with the Council's Strategic Housing team.
6. I get good care and support from mainstream NHS services

- LD Liaison Nurses are going to broaden the scope of Hospital Passports so that they can be used as a communication tool when accessing mainstream health services in the local community, such as GPs and Dentists.
- Services to support people with autism to navigate and have choice and control over their own treatment and care need to be improved.
- Annual Health Checks and Health Action Plans need to be offered to those within the cohort as soon as possible within the treatment pathway.
- Green Light for Mental Health is contractually required from NHS Kernow's commissioned mental health services. This is effective within inpatient services for people with learning disabilities and has prevented unnecessary out of area referrals. Further work will be undertaken to ensure compliance with Green Light across the wider service, including individuals with autism.
- People with behaviour that challenges need to have better access to mainstream settings for primary healthcare. This will involve local services working with person centred planners more directly to formulate best practice guidance that relates directly to the local health and care context.

7. I can access specialist health and social care support in the community

- People with autism, without a learning disability, who experience distress and behaviour that challenges are unable to access specialist services to address this, unless they have an identifiable mental health need. Individuals who require specialist treatment can only access this through the NHS “exceptional treatment” route as one off interventions. This leads to individuals not being eligible for any intervention services specific to their needs, which is referred to as “falling through the gaps” in the Autism Act (2009). There is evidence that individuals who do not receive early intervention and help are far more likely to escalate with the current system and this puts them at serious risk of hospitalisation. A core specialist, multidisciplinary service for people with autism and related complex needs will be provided. The service will cater for people who require autism specific interventions to help increase the individual's functioning and reduce behaviour that is challenging and that poses a risk to themselves or others. The service may provide case coordination for individuals with autism who are in specialist care (usually NHS funded), such as hospitals, specialist residential units or highly restrictive care packages.
- The care and support provider workforce in Cornwall is currently experiencing difficulties in recruitment and retention. This presents challenges in providing services in a timely way, particularly where experienced staff members are needed for people with behaviours that challenge. Similarly, within statutory services, recruitment and retention of skilled personnel remains challenging. These challenges are exacerbated by the location and geography of Cornwall. An ongoing care at home project is working collaboratively with local providers to support the recruitment and development of care staff, as well as a review of the commissioned framework.
- Further consideration to be given to the current support available to ensure that people of all ages with learning disabilities and/ or autism with behaviour that challenges are able to access required health and social care support in the
community; on an ongoing basis as well as during crisis.

8. When needed, I am able to get support to stay out of trouble

- Together for Families programme will need to identify the key areas for development around anti-social behaviour and offending in the next five years and link this directly to the TCP agenda. This should align with an approach focussed on early intervention and prevention but also consider the requirements of those already involved in the CJS, forming strong relationships with partner agencies.

- Link to the community LD Forensic Teams for people with learning disabilities and/or autism at risk of developing risky behaviour needs to be improved and partner agencies across Health and Social Care need to be engaged with more effectively.

- Risk registers need to identify the cohort adequately and include a system of prioritisation to best focus limited specialist resources. This in turn will mean that work to develop/review information sharing protocols with CJS/ HMPS/ Probation/ Police and other agencies needs to be committed to.

- Safeguarding teams will need to take a more proactive role in identifying people in scope of TCP and work to inform the dynamic risk register. This means that potential perpetrators of abuse are offered TCP intervention/support through the process of safeguarding.

9. If I am admitted for assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high quality and I don’t stay there longer than I need to

- There is a need for short term, intensive crisis accommodation which will provide a viable alternative to hospitalisation. Crisis accommodation will also need to be able to support intensive assessment of the individual locally and be geared towards achieving long term community provision as the primary goal.

- Reintegrating people who have been to hospital back into local communities has always proved difficult to do well. In order to promote better outcomes for those within the scope of the TCP, community based services will have to improve their in-reach into hospitals to prepare individuals for return.

- Hospitals should equally seek to promote independence and recovery within their care plans rather than focus on clinical treatment and support whilst on ward. This would enable a smoother transition back into the community.

- NHS Kernow will continue to include a comprehensive quality checklist alongside reporting and monitoring requirements in contracts for out of area hospital placement.

Please complete the 2015/16 (current state) section of the ‘Finance and Activity’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information
### 3. Develop your vision for the future

**Vision, strategy and outcomes**

**Describe your aspirations for 2018/19.**

The aspirations for the TCP in Cornwall and Isles of Scilly are:

- To utilise the nine core principles identified in the National Service Model for people with learning disabilities and/or autism and behaviour that challenges.

- To examine and map the existing services across the Health and Social Care Economy using the local Joint Strategic Needs Assessment and client record systems and national data sets for Cornwall and the Isles of Scilly.

- To assess the future needs of people with learning disabilities and/or autism and behaviour that challenges, utilising the five cohorts as described above. This includes early detection of support needs and future accommodation needs throughout childhood and transition to adulthood.

- To utilise the assessment and mapping evidence to commission services for people with learning disabilities and/or autism to ensure people have access to:
  - universal community services;
  - autism diagnostic services and post diagnostic support;
  - all age intensive support;
  - short term crisis accommodation;
  - transition support from children to adulthood;
  - independent advocacy;
  - support planning for outcome based, person-centred plans;
  - housing with support solutions;
  - educational, social communication and behavioural support services;
  - work-based placement services.

- To ensure that support and opportunities are local as far as possible, promoting social inclusion and making best use of community assets.

- To commission services for people with a learning disability and behaviour that challenges consistent with national policy and local commissioning strategies.

- To encompass services commissioned from external market as well as those directly managed by the NHS Kernow and Cornwall Council and the Council of...
the Isles of Scilly so as to continue to shape the market consistent with people’s choices and aspirations.

- To develop services which represent excellent value for money and are affordable both to the Council and self-funding clients.

- To assess the resources the Cornwall Council, the Council of the Isles of Scilly and NHS Kernow will require to meet needs over the next 3 years and the extent to which current facilities and services have the capacity, quality and location to meet needs.

- To liaise to ensure that the good practice realised by respective client reviews can be shared and inform future commissioning intentions.

- To ensure that people in receipt of care and support are supported to understand their options for the future, including timely access to independent advocacy.

- To co-produce the development and implementation of the TCP with people with learning disabilities and/or autism and family/carers.

- To actively involve key stakeholders and partner agencies including: Cornwall Council, the Council of the Isles of Scilly, NHS Kernow, Learning Disabilities Partnership Board, Cornwall Autism Partnership, Carers Partnership Board, Carer Parent Council, Housing, Police, Probation, Education, the voluntary sector and service providers.

**Outcomes and Outputs**

The Transforming Care Partnership will develop a mechanism for monitoring the outcomes and outputs below:

**Improved quality of care**

- Joint assessments for all individuals within the scope of the TCP
- Shared data between the three main commissioning bodies, with shared registers
- Shared budgets through the Better Care Fund and formal agreements.
- Integrated Personalised Commissioning implemented across Cornwall and the Isles of Scilly
- Improved and increased choices – improve the range of housing options – reduce reliance on residential care and shared living
- Positive Behaviour Support and Person Centred Support Planning training for all staff working with people within the scope of the TCP

*Training is vital and should involve everyone in the organisation*

- Co-production with people who use our services, families carers and informal carers
• An enhanced service developed for people with autism in Cornwall and the Isles of Scilly

### Improved quality of life

- Person centred, outcome based commissioning
- A individual strengths-based approach to how people experience care and support, focussing on increasing resilience and independence
- Promoting access and equity of opportunity in education, employment and training
- Build on the strengths of local communities and informal networks of support to enable individuals to feel more included and valued

### Reduced reliance on inpatient services

- A developed tiered system of preventative support for individuals with, or at risk of developing, behaviours that challenge
- Commissioned specialist advocacy services, working across care system settings, ensuring that individual communication needs are met
- Consolidated and aligned Intensive Support Services, with a clear, all age pathway
- Mental health services to be fully compliant with a refreshed Green Light for Mental health (2005) policy document.

### How will improvement against each of these domains be measured?

#### Improved Quality of Life

- **NHS Kernow** has commissioned the adoption of the Health Equalities Framework, which has been partially implemented across Cornwall Foundation NHS Trust. This will be used to measure intervention efficacy and improved life quality.
- **Cornwall Council** is adopting the Adult Social Care Outcomes Framework with consideration of the Care Act wellbeing outcomes. This will be embedded in service specifications and commissioning strategy.
- The TCP will engage with the Living Well and Integrated Personalised Commissioning projects across Cornwall to utilise their quality of life measures.
- **JSNA for adults and children**
- **Numbers of personal budgets and direct payments, both health and social care**
- **Number of Individual Service Funds**

#### Improved Quality of Care
• Quality Checking (involving CHAMPS team and other individuals with lived experience)
• Quality Audit Framework to check provider delivery
• Contract management (outcome focussed commissioning model)
• Joint Person Centred Reviews
• Uptake and access to specialist advocacy services and self advocacy

**Reduced Reliance on Inpatient Services**
• Numbers of individuals using inpatient services, both locked and secure
• Numbers of individuals admitted following a CTR or Blue Light process
• Reduced reliance on anti-psychotic medication (measured against existing baseline)
• Comparative length of stay in mainstream mental health services

**Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.**

The development and implementation of the TCP will follow the nine core principles identified in the National Service Model for people with learning disabilities and/or autism and behaviour that challenges:

- I have a good and meaningful everyday life
- My care and support is person-centred, planned, proactive and coordinated
- I have choice and control over how my health and care needs are met
- I am supported to live in the community and my family/carers and paid staff get the help they need to support me
- I have a choice about where and with whom I live
- I get good care and support from mainstream NHS services
- I can access specialist health and social care support in the community
- When needed, I am able to get support to stay out of trouble
- Assessment and treatment in hospital settings is high quality and I don’t stay there longer than I need to

Services will be outcome focused and person centred, with consideration being given to the following outcome frameworks when designing and commissioning services:
Please complete the Year 1, Year 2 and Year 3 sections of the ‘Finance and Activity’ tab and the ‘LD Patient Projections’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

4. Implementation planning

Proposed service changes (incl. pathway redesign and resettlement plans for long stay patients)

Overview of your new model of care
The new model of care planned for Cornwall and the Isles of Scilly retains the strengths of the existing services, with some service consolidation, some new services and areas of lessened activity. The model focusses on access to existing mainstream service pathways, being made accessible by expert liaison, as well as discreet specialist services where mainstream pathways are not able to offer specific intervention.

<table>
<thead>
<tr>
<th>Early Detection</th>
<th>Assessment, Planning, Management and Crisis Prevention</th>
<th>Crisis</th>
<th>Assessment, Planning &amp; Crisis Management</th>
<th>Discharge</th>
<th>Management/Review</th>
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**ADULTS**

- Adult Intensive Support Team
- NHS Community Learning Disability Teams
- Adult Social Care Locality Teams
- Home Treatment Teams (Mental Health)
- Short Term Enablement and Planning Service (STEPS)
- Autism Diagnostic
- Autism Post Diagnostic Support Services
- Learning Disability Forensic Team
- Mental Health Liaison
- Adult Mental Health Services (Inpatient)
- Primary Care Liaison

**CHILDREN**

- Transitions Service
- Acute Children and Adult liaison team (acute hospital based)
- Special Educational Needs and Disabilities (SEND) Support
- Specialist Respite Care
- Children and Adolescent Mental Health Services (CAMHS) and CAMHS LD Team
- Autism Spectrum Team (children 5-15 years)
What new services will you commission?

- **Autism Service** - An intervention and liaison service for adults on the autism spectrum with behaviour that challenges or people at risk of developing behaviour that challenges as described in the five cohorts above. The service will provide a suite of interventions that assist individuals with autism in leading more independent and fulfilled lives. These will include:
  - Autism specific counselling and psychotherapy
  - Occupational therapy approaches, including sensory focussed assessment and intervention
  - Speech and Language assessment and intervention
  - Psychiatry and pharmacological input
  - Liaison with mainstream health and social care services
  - Co-ordination of access to preventative community based support and activities

Any new service provision related to specialist intervention and assessment for people with autism will include accessibility to the Isles of Scilly, enforced through the Contract. Currently, specialist intervention can be accessed through the Individual Funding Request route, but will be incorporated into the new service model.

- **Workforce development** - A programme will be commissioned to deliver training and awareness of Positive Behaviour Support and Person Centred Planning across Cornwall and the Isles of Scilly. Consideration will also be given to the training needs of Personal Assistants to ensure that the workforce needed to support people with behaviour that challenges is available.

- **Short term, intensive crisis accommodation** – This will be explored both through the existing asset management of housing stock that could be used to support people within the scope of the TCP and through engagement with specialist housing and support providers to develop new schemes.

What services will you stop commissioning, or commission less of?

- "Respite facilities should be available"
- "Crisis beds needed instead of hospital beds."
- "Assessors need proper training."
- "Training for anyone involved with autism and learning disability."
- "Gap in services between mental health and learning disability."
- "Need an autism service for older people"
- **Individual Funding Request** purchased specialist interventions for people on the autism spectrum

- **Care and support services** that do not engage with the TCP programme or are incompatible with the new Service Model, including the training and awareness programmes. Services will not be commissioned that do not offer outcome focussed person centred support that enable clients to live independently, safely and that meet minimum standards which improve quality of life choice and control.

- **Hospital beds** for people with learning disabilities or autism where it can be evidenced that good care can be provided in the community under alternative legal frameworks.

### What existing services will change or operate in a different way?

- **Accommodation** - Cornwall Council is developing and refreshing its Long Term Accommodation Strategy to improve and increase housing solutions by working closely with the Local Development Plan to secure new sites for development and a partnership agreement with local housing developers to build and redevelop current housing provision. This will be aligned with a review of the current care and support framework agreement for people living in supported living/ housing with support schemes. A fixed term project will also assess and review individuals within the current SLS shared living cohort to determine appropriate housing options and care and support solutions.

  “More supported living opportunities near families.”

- **The Intensive Support Team (IST)** – NHS Kernow will commission a new pathway that follows the Service Model, including working with partners to ensure a 24 hour, 7 day a week crisis response that will aim to prevent unnecessary hospital admissions across all ages.

- **Children and Young People** - services that work with children and young people with autism or learning disabilities will come together to provide consolidated care along a single pathway, across agencies. A project will be undertaken to review the Transitions Service to ensure that young people are prepared for adulthood (see below). The Together for Families Programme will be developed to maximise the impact of interventions in enabling families to achieve positive and sustained outcomes.

- **Co-production** - All commissioned specialist services will be required to demonstrate how they have involved individuals and informal/family carers in coproduction, strategy development and leadership within their organisations. All commissioned services will be co-produced with people with learning disabilities and/ or autism, family/ carers and other key stakeholders.

  “Involve parents for their expertise”

- **Person Centred and Outcome Focused** - All statutory reviews of existing care
packages will be required to demonstrate how they are person centred and deliver developmental and measurable outcomes.

- **Integration** - NHS Kernow, Cornwall Council and the Council of the Isles of Scilly will build on existing integrated approaches to further improve commissioning and delivery of health and social care services. Move towards a more unified governance of all organisations by one governance process supported by the Integrated Commissioning Board.

- **Data** - Develop more pragmatic arrangements for data sharing across the Health and Social Care Economy in order to better identify need. Develop processes for better identification of housing need (early on - prior to crisis) through the transitions and the statutory assessment processes. Develop a dynamic risk register to keep a record of the people within the 5 cohorts at risk of hospitalisation. Ensure links to the annual Joint Strategic Needs Assessment and other Public Health Data on population projections to inform commissioning – from ONS, POPPI and PANSI, National Data Sets.

### Describe how areas will encourage the uptake of more personalised support packages

**Personal Health Budgets**

The TCP intends to promote more personalised care and support packages through the increased use of the Personal Health Budget (PHB) which mirrors the trend in Social Care towards Personal Budgets. The PHB is an amount of money used to support a person’s individual health and wellbeing needs. The person’s health and well-being needs are set out in a person led care plan directed as much as possible by the individual. Currently people eligible for Adult Continuing Healthcare (ACHC) and Children’s Continuing Care (CCC) have the “Right to have” a PHB. Children and young people with a learning disability who are eligible for an Education, Health and Care plan should also be considered for a PHB, particularly for those in transition and those in 52-week placements.

Planning for 2015/16 states that to give patients more direct control, CCGs are expected to expand their offer and delivery of PHBs beyond people eligible for Adult Continuing Healthcare and Children’s Continuing Healthcare to people, where evidence indicates they could benefit. Including people with long term conditions, mental health issues and learning disabilities. CCG’s are required to publish their “Local Offer” for PHB’s in the joint Health and Well-being Strategy. NHS Kernow has started consulting and engaging with a range of stakeholders in the local communities of Cornwall and Isles of Scilly to have open and honest discussions at what we want to be doing differently and who are not well served by current services. Stakeholders include patients, health professionals, providers, voluntary community sector (VCS) and local Healthwatch. This is a start of our journey and NHS Kernow is planning more events over the next 12 months to develop the “Local Offer” further.

NHS Kernow will monitor its delivery of PHB’s internally and report to the Governing Body and will also report nationally to NHS England. NHS Kernow also welcomes feedback from people and their families about their experience of PHB’s and will use this
information to improve the delivery and roll-out of PHB’s in the future.

**Integrated Personalised Commissioning (IPC)**

Cornwall and the Isles of Scilly is part of the Southwest regional demonstrator site for Integrated Personalised Commissioning (IPC). The programme is aimed at groups of individuals who have high levels of need, who often have both health and social care needs, where a personalised approach would address acknowledged problems in current care provision, help prevent people from becoming more unwell, and enable people to retain their independence. Including:

- Children and young people with complex needs
- People with multiple long-term conditions
- People with learning disabilities with high support needs
- People with significant mental health needs

IPC is an approach that puts people in control and focuses on their goals and aspirations for the future. Person centred care and support planning is at the heart of the IPC programme and it involves joint-working between individuals, families and practitioners to set health and wellbeing outcomes that matter to them.

The IPC programme is currently working with small numbers of people in all the above groups to look at who may benefit from a PHB in the future; helping people to live the lives they want to. This includes a person with severe learning disabilities and behaviour that challenges; where practitioners are working with his family to enable them to have the choice and control over the care and support to meet his complex health and care needs.

NHS planning guidance 2016/17-2020/21 calls for a major expansion of integrated budgets and implementation of choice. NHS Kernow will include the roll-out of PHB’s in its’ planning including contracting and commissioning cycles and through IPC will also be developing capacity in the Voluntary, Community and Social Enterprise (VCSE) sector and stimulating the market to look at opportunities for providers to create new support options.

**Direct Payments and Individual Service Funds**

Direct payments are available to anyone who has been assessed as eligible for social care or to their parent or carer. Cornwall Council is further developing its personalisation model to include Individual Service Funds. This model will scope and incorporate (wherever possible) local community and peer led alternatives to formal support and use a person centred, outcome focussed plan as its guide.
**What will care pathways look like?**

The basic care pathway can be seen in the diagram below – this will be developed further by the TCP partnership.

NHS Kernow, Cornwall Council and the Council of the Isles of Scilly follows a strategy of utilising mainstream services with reasonable adjustments where at all possible, only introducing specialist services for autism and/or learning disabilities when adjustments will impede the functioning of the service for all and would therefore not be seen as reasonable.
How will people be fully supported to make the transition from children’s services to adult services?

Cornwall and the Isles of Scilly health and social care commissioners do not currently commission any 52 week placements for children or young people within the scope of the TCP.

Transition Pathway

Cornwall Council is developing a remodelled transition service, building on the existing work completed within the SEN Pathfinder work. The timetable for the remodelling of the service is shown in the attached project plan. The vision for the Transition Service is joint working across agencies to create and ensure a holistic and inclusive approach across the 0-25 years pathway to transition into adulthood, which puts young people at the heart of the process.

“If it isn’t broke don’t change it! Transition must be looked at as a whole and carried forward effectively.”

Quality Provision

There is also a CQUIN for 2015/16 for Transition for Royal Cornwall Hospitals Trust (RCHT), Cornwall Partnership Foundation Trust (CPFT). In order to achieve the CQUIN the care providers must submit the following.

- Assessment of compliance against Your Welcome quality standards or EEFO registration.
- Named Executive lead for transition
- Identification of the relevant set of patients (patients aged 14 to 17 years
- Copy of the first draft policy
- Evidence of completed patient survey
- Analysis of profile of ages by specialty
- Evidence of agreed method of tracking completed transition assessments
- Analysis of patient survey including areas for action
- Identification of 3 priority service areas/ specialities for improving completion of transition assessments. To include LD/ CAMHS
- Signed off transition policy
- Evidence of transition pathway in use across priority service lines as above.
- Evidence that 50% of eligible patients (of those identified and agreed in Q3) have entered transition with plans in place in relevant specialties/ service areas.


- Evidence of family inclusion in transition plans - to include case studies and also a consistent data collection method to ensure families have been actively engaged and their feedback used to inform improvements.

- Develop action plan for roll out to all specialists and how it can be monitored through a dashboard on a regular basis back to the CCG.

There are gaps in the preparation of young people for adulthood not addressed by the CQUIN, outlined below are the objectives for a project to address this.

- For the learning disabilities liaison nurses to become part of the local authority SEND preparing for adulthood work stream working with adult social care transition lead to take forward the project.

- Establish the processes and documentation which link into the EH&C plans

- Embed the Ready, Steady, Go transition planning tool across the acute and primary care setting.

- Ensure there is a named physician within acute adult services.

- Become active members of the SWSCN long term conditions work stream in order to share practice and learn from other areas.

- Fill the gaps not covered by the CQUIN i.e., the 16 to 25 year age group but also providing the overlap and supporting the Children’s services by signposting from age 14 years. This will assist children’s services in understanding adult provision.

- Liaison with the GP who may need to take over the role of the community paediatrician.

- Identify existing barriers to accessing adult provision and ways to overcome them.

**How will you commission services differently?**

The informal pooled budget for the care and support for people living in supported living (shared housing) is currently being reviewed in order to implement formal arrangements. Consideration is being given to extending the pooled fund to include others with learning disabilities and/ or autism outside of the existing cohort who require funding from health and social care.

Services commissioned under the TCP will be jointly commissioned where appropriate and arrangements will be made for pooling funds.

The TCP will include the development of Joint Health and Social Care budgets that will be part of the development of the IPC programme. NHS Kernow is leading the IPC initiative for Cornwall and the Isles of Scilly (see above). IPC will be focused on adults and children in higher risk groups, presenting an offer of personalised budgets and direct payments.
How will your local estate/housing base need to change?

Housing Strategy

Cornwall Council Social Care Commissioning Team is working with Strategic Housing and the Planning departments to ensure the needs of clients are reflected in the Local Development Plan and strategies reflect these needs. The current housing stock is being evaluated and examined with current landlords and a process of deregistration of care homes is also taking place. Cornwall Council commissioners are currently decommissioning housing that does not meet the needs of this client group and new developments are being identified so that shared housing in poor condition is no longer being commissioned and landlords are working with commissioners to reinvest in self-contained accommodation and develop outcome focussed person centred support where there is support for 24 hours per day over 7 days per week. NHS England has agreed in principle that the capital money released from the sale of properties during our review of supported living services can be recycled within the TCP area. This money will be ring fenced for reinvestment into accommodation provision, some of which will be for people whose behaviour challenges. Further capital funding is also being identified within Social Care budgets and the Housing Solutions Aids and Adaptations budget to incentivise housing providers to develop sites for people with eligible social care needs.

Needs Assessments

Cornwall Council through the assessment process will ensure that a person’s housing need is identified and recorded on the client record system which is then to be shared with the TCP members. Through the assessment process the client will be assisted by their care coordinator to register on the Cornwall Housing register so that we are able to better understand the housing needs of people with a learning disability and/or autism and behaviour that challenges.

Isles of Scilly

The Isles of Scilly do not have any individuals who fall under the TCP scope, but ongoing planning will be put in place to understand the unique housing challenges of the islands and, in particular, how high intensity staffing could be found and accommodated should it be needed.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve ‘resettling’ people who have been in hospital for many years. What will this look like and how will it be managed?

NHS Kernow and NHS England Specialised Commissioning currently commission a total of nine beds for people with learning disabilities and / or autism who have behaviours that challenge. Three individuals have been in hospital care out of area since before 31st March 2009. Discharge planning is place for all three individuals. These individuals all require highly individualised packages of care and specialised accommodation.

NHS Kernow employs a clinical review officer who works in conjunction with NHS England to expedite discharge when possible. The clinical review officer works closely
with local clinicians to ensure local services are prepared and have capacity to provide clinical support to discharge.

Resettlement and rehabilitation is jointly led by NHS Kernow and Cornwall Council. Accommodation and support is procured following multi professional assessment and clear, person centred support planning.

As the numbers of individuals who are considered “long stay” are low in the TCP area, sourcing accommodation and support is less challenging. Cornwall Council supports the process by ensuring the correct legal frameworks are used, particularly in cases where extensive restrictive practice, especially during initial discharge periods, is undertaken.

How does this transformation plan fit with other plans and models to form a collective system response?

The TCP Plan has been developed to use existing plans and frameworks as much as possible, minimising the need for whole system change and service reconfiguration. Other local plans and models include:

- Cornwall and Isles of Scilly Crisis Care Concordat Local Plan
- Cornwall Council Long Term Accommodation Strategy for People with Eligible Social Care Needs (currently being refreshed)
- Wellbeing, Early Intervention and Prevention Strategy (currently being refreshed)
- The SLS Cohort review project
- The Cornwall and Isles of Scilly Integrated Personalised Commissioning Demonstrator
- The Cornwall Autism Strategy and Cornwall Autism Partnership
- The transfer Statements of SEN into Education, Health and Care plans

Any additional information

5. Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?

To reflect the requirements of the commissioners in Cornwall and the Isles of Scilly, the six work streams are aligned with strengthening community services and increasing local resilience throughout the care pathway. [The work streams are][WM1]  

- **Accommodation and Support** – focusses on housing and ongoing care and support within individuals’ homes. A project group is currently being established that will focus on developing self-contained accommodation with support for all
client groups; potentially this existing project will be expected to ensure inclusion of the five TCP cohorts rather than a separate group being established.

- **Workforce Development** – focus on increasing the skills and awareness in specialist provision and wider public sector groups, ensuring that staff members are trained in Positive Behaviour Support and Person Centred Planning. Ensuring that Personal Assistants have the training needed to offer support to people with behaviour that challenges.

- **Crisis and Intensive Support** - focus on ensuring that existing “mainstream” crisis and acute services are accessible to people with learning disabilities and/ or autism and behaviour that challenges of any age; including 1) consolidation of existing intensive support services; 2) development of short term crisis accommodation; and 3) increasing understanding and case management of individuals at risk of contact with the criminal justice system.

- **Communication and Engagement** – focus on coproduction and informed leadership across commissioners and providers. Ensuring that the shift in power is understood and that the necessary cultural change takes place.

- **Personalisation** – focus on the increase of individuals and people close to them taking control of their care and support. Increasing the uptake of personalised budgets, ensuring true Person Centred approaches during all contacts with services. Potentially the IPC programme will be asked to ensure that the needs of the five cohorts are covered rather than a separate group being established.

- **Autism Services** – focus on the introduction of intervention services for adults on the autism spectrum with behaviour that challenges or at risk of developing behaviour that challenges. The service will provide a suite of interventions that assist individuals with autism in leading more independent and fulfilled lives.

### Who is leading the delivery of each of these programmes, and what is the supporting team.

Local leadership is supported across the commissioning agencies by the SRO and deputy SRO arrangements. Leads for each of the workstreams will be agreed at the Transforming Care Partnership Board meeting.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Lead</th>
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<tbody>
<tr>
<td>Accommodation and Support</td>
<td>Cornwall Council</td>
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<tr>
<td>Workforce Development</td>
<td>Cornwall Council</td>
</tr>
<tr>
<td>Crisis and Intensive Support</td>
<td>NHS Kernow</td>
</tr>
<tr>
<td>Communication and Engagement</td>
<td>Cornwall Council</td>
</tr>
<tr>
<td>Personalisation</td>
<td>NHS Kernow</td>
</tr>
<tr>
<td>Autism Services</td>
<td>NHS Kernow</td>
</tr>
</tbody>
</table>

### What are the key milestones – including milestones for when particular services will open/close?

Please see attached high level project plan.
What are the risks, assumptions, issues and dependencies?

Assumptions:

- The TCP will deliver service improvement and service model compliance within the existing cost envelope for services delivered to individuals who are in the scope of the TCP.

Key Risks:

- The low number of individuals for repatriation from out of area hospitals means that there will not be significant release of funding to support the TCP plan.

- Block contracted services are challenging in terms of understanding the spend on services within the block, making disaggregation and reallocation more challenging. This may mean that the projected necessary spend on service change is unachievable until funding is identified.

- Project management of the TCP requires significant input and capacity. Currently, this role is being covered by the Clinical Lead for learning disability at NHS Kernow. An increase of capacity will be required.

Issues:

- Many individuals and families in Cornwall and the Isles of Scilly have had experience of substandard and abusive services, some from the Budock Hospital scandal and Winterbourne View.

- As engagement with key stakeholders continues, the TCP will require adaptation and revision, leading to challenging project management.

In all aspects of the TCP planning process, groups at risk of exclusion, such as individuals from BME backgrounds, will be accounted for in service development. It is recognised that levels of communication will need to be adapted to different groups within the TCP scope.

What risk mitigations do you have in place?

The TCP plan is not expected to require investment, meaning that all service change will need to be balanced and phased to allow for financial sustainability.

NHS Kernow engages with CFT throughout the commissioning cycle and is renewing clinical involvement in service development and planning.

A full communication and engagement plan is in development (timescale in attached project plan) to ensure that local individuals and families are aware of the programme, the expected outcomes, how they can get involved and where to express any concerns.

Individuals and families that are part of vulnerable groups or affected by excluding factors will be included in the engagement and co-production when required and necessary.
Project management within NHS Kernow will be looked at to assess capacity to ensure the TCP project is prioritised and well managed.

**Any additional information**

The TCP will incorporate the following information when it is received.

- Specialised commissioning spend for patients originating from Cornwall and the Isles of Scilly who are in the scope of the TCP
- Further demographic data for children, young people and adults, in particular around the five groupings
- Further family carer input, gathered through regularised engagement and events
- Further input from individuals with lived experience. Some engagement has been undertaken, but individuals in the scope of the TCP will require specialised engagement and co-production plans.

“Family voice disempowered by:

- Lack of knowledge
- Fear
- Professional judgement
- Application of legislation/safe guarding without consideration
- Imbalance of power
- Lack of transparency and clandestine decision making.

Set of principles needed, professionals/services etc. start with understanding that:

- Families know their loved one best
- Families have the best interest of their loved one at the centre of their concerns
- Families love and care about each other
- Families bring a wealth of knowledge about their loved ones and solutions to meet their unique needs.
- Professionals need to demonstrate their consideration of these principles and be accountable when things go wrong as a result of not taking the family into account.”

**6. Finances**

Please complete the activity and finance template to set this out (attached as an annex).

**End of planning template**
Appendix A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Appendix A gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.¹

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

¹ Please refer to the original source to understand the extent to which people with autism are categorised in the data collection
<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator</th>
<th>Source</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| 1            | Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator | Mental Health Services Data Set (MHSDS) | Average census calculation applied to:  
- Denominator: inpatient person-days for patients identified as having a learning disability or autism.  
- Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType ‘Review’) within the preceding 12 months. |
| 2            | Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator) | Short and Long Term Support statistics | This indicator can only be produced for upper tier local authority geography.  
Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only.  
Numerator: all those in the denominator excluding those on commissioned support only.  
Recommended threshold: This figure should be greater than 60%. |
| 3            | Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital | Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - | HES is the longest established and most reliable indicator of the fact of admission and readmission.  
- Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism  
- Numerator: admissions to psychiatric inpatient care within specified period |

2 Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.
Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.

The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent.

NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.

<table>
<thead>
<tr>
<th>4</th>
<th>Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)</th>
<th>Calculating Quality Reporting Service, the mechanism used for monitoring GP Enhanced Services including the learning disability annual health check.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Waiting times for new psychiatric referral for people with a learning disability or autism</td>
<td>MHSDS. New referrals are recorded in the Referrals table of the MHSDS.</td>
</tr>
</tbody>
</table>

Two figures should be presented here:

- Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP’s learning disability register
- Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available
- Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme

- Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism
- Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
|   | Proportion of looked after people with learning disability or autism for whom there is a crisis plan | MHSDS. (This is identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE) | Method – average census.  
- Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities  
- Numerator: person days in denominator where there is a current crisis plan |
### Background

As a response to Winterbourne View, the Government is currently developing a Transforming Care Plan and national service model. The paper includes a direction to local commissioners to develop Transforming Care Partnerships of sufficient size and scope to enable the implementation of their local Transforming Care Programmes by 1st April 2016. Plans should demonstrate how areas plan to fully implement the national service model by March 2019 and close inpatient beds, starting with the national planning assumptions set out in *Building the Right Support*.

This programme aims to transform the way services are commissioned and delivered to stop people being referred to hospital inappropriately, provide the right model of care, and drive up the quality of care and support for people with behaviour which challenges. The TCP board is focused on making sure that there is a sustained reduction on the reliance of inpatient care for people with learning disabilities and/or autistic spectrum conditions who may also have a mental health condition and/or behaviour which challenges.

### Current Situation

NHS Kernow, Cornwall Council and the Council of the Isles of Scilly already have systems in place that have supported people with learning disabilities to remain in their local areas and receive treatment and care that has prevented hospital admissions. Currently there are 6 out of county placements 5 of which are in secure settings.

As a result of this success, the particular focus of the Transforming Care Partnership in Cornwall and Isles of Scilly will be to further develop services, systems and culture to consolidate and improve the existing care and treatment available. These plans will ensure that our focus starts at prevention and early intervention to help individuals live as independently as possible.
<table>
<thead>
<tr>
<th>Purpose</th>
<th>For the board to oversee and monitor the implementation of the Transforming Care Partnership action plan.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The Transforming care partnership requires key actions in the following areas:</td>
</tr>
<tr>
<td></td>
<td>- Create the conditions by which there are sustainable low levels of behavioural and mental health related hospital admissions for people with learning disabilities and/or autism in Cornwall.</td>
</tr>
<tr>
<td></td>
<td>- Ensure the provision of a range of community based treatment options, including 24 hour crisis care, available locally to prevent further breakdown or admission</td>
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<tr>
<td></td>
<td>- To deliver person centred plans for all individuals within the scope of the project that guide their care and treatment available to them, allowing the voice of the individual and their families to be heard</td>
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<tr>
<td></td>
<td>- To commission accommodation that meets the diverse needs of people with learning disabilities and/or autism, including those most at risk of hospitalisation</td>
</tr>
<tr>
<td></td>
<td>- To increase access to and the use of individual budgets, personal health budgets and direct payments for people with complex needs</td>
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</tbody>
</table>
## Membership

The core membership of this group is as follows:

- Kim Dowsing (Senior Commissioning Manager EHSC)
- Karen Kay (Director of Commissioning KCCG)
- Gareth Peters (Senior Officer Adult Social Care Isles of Scilly)
- Andrew Ford (Head of Learning Disability Services CFT)
- Nory Meneer (Clinical Lead and Programme Manager, Learning Disabilities KCCG)
- Martha Warrener (Commissioning Manager EHSC)
- Ben Martin (Commissioning Officer EHSC)
- Service User Representatives for LD and Autism (TBA)
- Carer Representative (TBA)
- Jude Bowler (Senior Commissioner Children’s Services)
- Angie Andrews (Senior Commissioning Manager EHSC)
- Yvette Yates (Senior Manager Disabled Children and Therapy Service)

<table>
<thead>
<tr>
<th>Role</th>
<th>Function</th>
<th>Position filled by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Responsible Officer</td>
<td>Senior ownership and sponsorship with partner organisations, families and people with lived experience.</td>
<td>Karen Kay, Director of Commissioning, NHS Kernow</td>
</tr>
<tr>
<td>Deputy Senior Responsible Officer</td>
<td>Additional leadership position, deputising for the SRO when required</td>
<td>Kim Dowsing, Senior Manager, Education, Health and Social Care (EHSC), Cornwall Council</td>
</tr>
<tr>
<td>Programme Manager</td>
<td>Management across organisations resolve issues and build consensus</td>
<td>Nory Menneer, Clinical Lead and Programme Manager (Learning Disabilities), NHS Kernow</td>
</tr>
<tr>
<td></td>
<td>Coordination and management of the individual workstreams to deliver the plan</td>
<td></td>
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</tbody>
</table>

### Chair

Kim Dowsing/ Karen Kay

### Quorum

The group is an overarching steering group thus all agencies should send representation to progress the agreed work plan.

### Frequency of meetings

Monthly
The Transforming Care Partnership Board will provide assurance to the following groups, providing exception reports and 6 monthly detailed progress updates.

- Learning Disabilities Partnership Board
- Cornwall Autism Partnership
- The Big Health Group
- Cornwall Council Senior Management Team
- Cornwall Council Directorate Leadership Team
- NHS Kernow Executive Management Team
- Council of the Isles of Scilly
- Integrated Commissioning Board
- Health and Wellbeing Board

Progress against Stakeholder action plans
‘Community’ feedback and supporting evidence
External assurance e.g. CQC/HMIC

The key responsibility of this group is to set the strategic direction and oversee the implementation of the local Transforming Care Partnership Plan. Please refer to additional information provided with this document.

<table>
<thead>
<tr>
<th>Reports Assurance to</th>
<th>Assurance Received from</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Transforming Care Partnership Board will provide assurance to the following groups, providing exception reports and 6 monthly detailed progress updates.</td>
<td>Progress against Stakeholder action plans</td>
<td>The key responsibility of this group is to set the strategic direction and oversee the implementation of the local Transforming Care Partnership Plan. Please refer to additional information provided with this document.</td>
</tr>
<tr>
<td>- Learning Disabilities Partnership Board</td>
<td>‘Community’ feedback and supporting evidence</td>
<td></td>
</tr>
<tr>
<td>- Cornwall Autism Partnership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The Big Health Group</td>
<td></td>
<td></td>
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<tr>
<td>- Cornwall Council Senior Management Team</td>
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<td></td>
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<tr>
<td>- Cornwall Council Directorate Leadership Team</td>
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<tr>
<td>- NHS Kernow Executive Management Team</td>
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<tr>
<td>- Council of the Isles of Scilly</td>
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<td></td>
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<tr>
<td>- Integrated Commissioning Board</td>
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<tr>
<td>- Health and Wellbeing Board</td>
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</tbody>
</table>

Review date: April 2017
Appendix C – SCIE Co-production Guide Domains

<table>
<thead>
<tr>
<th>Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that co-production runs through the culture of services involved in developing and delivering the TCP.</td>
</tr>
<tr>
<td>Ensure that this culture is built on a shared understanding of what co-production is; develop a set of principles for putting the approach into action and the benefits and outcomes that will be achieved with the approach.</td>
</tr>
<tr>
<td>Ensure that organisations develop a culture of being risk aware rather than risk averse when developing and implementing the TCP.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve everyone who will be taking part in the co-production from the start by inviting people with a lived experience of services, carers and other stakeholders to the TCP programme board meetings.</td>
</tr>
<tr>
<td>Value and reward people who take part in the co-production process – this does not need to be a monetary reward but can be ensuring that people are given a purpose, listened to and can see that their contribution is valuable.</td>
</tr>
<tr>
<td>Ensure that there are resources to cover the cost of co-production activities – expenses should be covered at the least and so a budget will need to be identified for this.</td>
</tr>
<tr>
<td>Ensure that co-production is supported by a strategy that describes how things are going to be communicated – this will be covered by the Communication and Engagement work stream.</td>
</tr>
<tr>
<td>Build on existing structures and resources; including utilising existing groups such as LDPB, CAP, the Big Health Group and the Carers Partnership Board</td>
</tr>
</tbody>
</table>
## Practice

Ensure that everything in the co-production process is accessible to everyone taking part and nobody is excluded; including developing the plan and other products in easy-read.

Ensure that everyone involved has enough information to take part in co-production and decision making.

Ensure that everyone involved is trained in the principles and philosophy of co-production and any skills they will need for the work they do – this will need to be considered by the Communication and Engagement work stream as well as the Workforce Development work stream.

Think about whether an independent facilitator would be useful to support the process of co-production – the EHSC Co-production Officer will lead on this work stream.

Ensure that frontline staff are given the opportunity to work using co-production approaches, with time, resources and flexibility.

Provide any support that is necessary to make sure that the community involved has the capacity to be part of the co-production process.

Ensure that policies and procedures promote the commissioning of services that use co-production approaches.

Ensure that there are policies for co-production in the actual process of commissioning and services are co-designed.

## Review

Carry out regular reviews to ensure that co-production is making a real difference and that the process is following the agreed principles.

Co-produce reviews and evaluations.

Use the review findings to improve ways of applying the principles of co-production, so that continuous learning is taking place.

During reviews and evaluations, work with people who use services and carers, to think about ways of showing the impact that co-production has, as well as the processes that are involved.
# Appendix D – POPPI and PANSI Data

## LD - Moderate or severe 18-64

People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>People aged 18-24 predicted to have a moderate or severe learning disability</td>
<td>275</td>
<td>275</td>
<td>273</td>
<td>270</td>
<td>262</td>
<td>259</td>
<td>290</td>
<td>6.62%</td>
</tr>
<tr>
<td>People aged 25-34 predicted to have a moderate or severe learning disability</td>
<td>299</td>
<td>303</td>
<td>310</td>
<td>316</td>
<td>324</td>
<td>332</td>
<td>317</td>
<td>7.46%</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have a moderate or severe learning disability</td>
<td>380</td>
<td>375</td>
<td>371</td>
<td>368</td>
<td>374</td>
<td>399</td>
<td>425</td>
<td>10.68%</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have a moderate or severe learning disability</td>
<td>408</td>
<td>411</td>
<td>411</td>
<td>408</td>
<td>392</td>
<td>360</td>
<td>360</td>
<td>-11.55%</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have a moderate or severe learning disability</td>
<td>365</td>
<td>369</td>
<td>374</td>
<td>380</td>
<td>396</td>
<td>417</td>
<td>397</td>
<td>9.37%</td>
</tr>
<tr>
<td>Total population aged 18-64 predicted to have a moderate or severe learning disability</td>
<td>1,727</td>
<td>1,733</td>
<td>1,739</td>
<td>1,742</td>
<td>1,748</td>
<td>1,766</td>
<td>1,789</td>
<td>3.95%</td>
</tr>
</tbody>
</table>

Source: PANSI accessed February 2016

## LD - Moderate or severe 65+

People aged 65 and over predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age

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<tr>
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</thead>
<tbody>
<tr>
<td>People aged 65-74 predicted to have a moderate or severe learning disability</td>
<td>261</td>
<td>267</td>
<td>269</td>
<td>270</td>
<td>268</td>
<td>260</td>
<td>285</td>
<td>12.20%</td>
</tr>
<tr>
<td>People aged 75-84 predicted to have a moderate or severe learning disability</td>
<td>85</td>
<td>86</td>
<td>88</td>
<td>91</td>
<td>101</td>
<td>127</td>
<td>130</td>
<td>56.63%</td>
</tr>
<tr>
<td>People aged 85 and over predicted to have a moderate or severe learning disability</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>35</td>
<td>37</td>
<td>45</td>
<td>57</td>
<td>83.87%</td>
</tr>
<tr>
<td>Total population aged 65 and over predicted to have a moderate or severe learning disability</td>
<td>377</td>
<td>385</td>
<td>391</td>
<td>397</td>
<td>406</td>
<td>432</td>
<td>472</td>
<td>28.26%</td>
</tr>
</tbody>
</table>

Source: POPPI accessed February 2016

## Autistic spectrum disorders 18-64

People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2030

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<tbody>
<tr>
<td><strong>Autistic Spectrum disorders - all people</strong></td>
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<tr>
<td>People aged 18-24 predicted to have autistic spectrum disorders</td>
<td>446</td>
<td>446</td>
<td>446</td>
<td>441</td>
<td>427</td>
<td>418</td>
<td>467</td>
<td>5.66%</td>
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</tbody>
</table>
### People aged 25-34 predicted to have autistic spectrum disorders

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</thead>
<tbody>
<tr>
<td>People aged 25-34</td>
<td>556</td>
<td>564</td>
<td>580</td>
<td>590</td>
<td>609</td>
<td>630</td>
<td>601</td>
<td>8.88%</td>
</tr>
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</table>

### People aged 35-44 predicted to have autistic spectrum disorders

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<tbody>
<tr>
<td>People aged 35-44</td>
<td>595</td>
<td>590</td>
<td>584</td>
<td>580</td>
<td>590</td>
<td>629</td>
<td>674</td>
<td>12.33%</td>
</tr>
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</table>

### People aged 45-54 predicted to have autistic spectrum disorders

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</tr>
</thead>
<tbody>
<tr>
<td>People aged 45-54</td>
<td>756</td>
<td>757</td>
<td>753</td>
<td>746</td>
<td>714</td>
<td>649</td>
<td>644</td>
<td>-14.81%</td>
</tr>
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</table>

### People aged 55-64 predicted to have autistic spectrum disorders

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</tr>
</thead>
<tbody>
<tr>
<td>People aged 55-64</td>
<td>717</td>
<td>724</td>
<td>734</td>
<td>748</td>
<td>778</td>
<td>820</td>
<td>780</td>
<td>8.94%</td>
</tr>
</tbody>
</table>

### Total population aged 18-64 predicted to have autistic spectrum disorders

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</thead>
<tbody>
<tr>
<td>Total population</td>
<td>3,070</td>
<td>3,082</td>
<td>3,097</td>
<td>3,105</td>
<td>3,119</td>
<td>3,145</td>
<td>3,166</td>
<td>3.26%</td>
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Source: PANSI accessed February 2016

### People aged 65 and over predicted to have autistic spectrum disorders, by age and gender, projected to 2030

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<tbody>
<tr>
<td>People aged 65-74</td>
<td>724</td>
<td>739</td>
<td>749</td>
<td>750</td>
<td>745</td>
<td>715</td>
<td>786</td>
<td>11.33%</td>
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### People aged 75 and over predicted to have autistic spectrum disorders

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<tbody>
<tr>
<td>Total population</td>
<td>1,238</td>
<td>1,264</td>
<td>1,290</td>
<td>1,314</td>
<td>1,363</td>
<td>1,500</td>
<td>1,656</td>
<td>37.54%</td>
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Source: POPPI accessed February 2016

### People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030

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<tbody>
<tr>
<td>People aged 18-24</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>19</td>
<td>19</td>
<td>18</td>
<td>20</td>
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### People aged 25-34 with a learning disability, predicted to display challenging behaviour

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<tbody>
<tr>
<td>People aged 25-34</td>
<td>25</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>27</td>
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</table>

### People aged 35-44 with a learning disability, predicted to display challenging behaviour

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<tbody>
<tr>
<td>People aged 35-44</td>
<td>28</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>27</td>
<td>29</td>
<td>31</td>
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### People aged 45-54 with a learning disability, predicted to display challenging behaviour

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<tbody>
<tr>
<td>People aged 45-54</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>34</td>
<td>30</td>
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### People aged 55-64 with a learning disability, predicted to display challenging behaviour

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</thead>
<tbody>
<tr>
<td>People aged 55-64</td>
<td>33</td>
<td>34</td>
<td>34</td>
<td>35</td>
<td>36</td>
<td>38</td>
<td>37</td>
</tr>
</tbody>
</table>

### Total population aged 18-64 with a learning disability, predicted to display challenging behaviour

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<tbody>
<tr>
<td>Total population</td>
<td>141</td>
<td>142</td>
<td>142</td>
<td>142</td>
<td>143</td>
<td>144</td>
<td>145</td>
</tr>
</tbody>
</table>

Source: PANSI accessed February 2016
Appendix E – Descriptors from National Service Model

1.1 Children, young people and adults with a learning disability and/or autism, should be included in activities and services (such as early years services, education, employment, social and sports/leisure) that enable them to lead a good and meaningful everyday life. They should have choice and control over the activities in which they participate, facilitated through person-centred care and support plans/ Education, Health and Care (EHC) plans and personal budgets/personal health budgets (see principles 2 and 3) – any restrictions imposed (Ministry of Justice/MAPPA) will need to be considered but should not adversely affect the individual experiencing, where possible and under appropriate supervision, a fulfilling and meaningful life.

1.2 Everyone should have access to education, training and employment (including supported internships) which they can access within their local area. To enable this, support providers and specialist multi-disciplinary health and social care teams (see principle 7) should provide training and support to mainstream service staff and/or provide support to individuals and their families/carers that enables them to participate in mainstream services, and to access education and training within local schools and colleges. Commissioners should also seek to ensure that supported employment/ training services meet the needs of this group.

1.3 Everyone should have the opportunity to develop and maintain good relationships with people. Commissioners should be mindful of the importance of relationships to keep people safe and well, and should therefore seek to offer good support to families/ carers, friends and others (see principle 4). This should form a key part of people’s person-centred care and support plans (see principle 2).

2.1 Local health and care services should develop a dynamic register based on sophisticated risk stratification of their local populations. This will enable local services to anticipate and meet the needs of those people with a learning disability and/or autism who display behaviour that challenges, or who are at risk of developing behaviour that challenges, ensuring local services plan appropriately and provide early interventions, including preventative support.

2.2 Everyone should have a single person centred care and support plan, incorporating a range of other plans, including behaviour support plans where appropriate, as well as crisis and contingency plans, which they have been involved in drawing up and which they have a copy of. Plans should focus on what is important to the individual. For children and young people up to the age of 25 with a special educational need (SEN), this should take the form of an Education, Health and Care (EHC) plan.

2.3 Everyone should be offered a named local care and support navigator or keyworker to coordinate and ensure timely delivery of a wide range of services set out in the person centred care and support plan, working closely with the person and their families/carers where appropriate and ensuring a consistent point of contact.

3.1 Everyone should receive information about their care and support in formats that they can understand and should receive appropriate support to help them communicate, in keeping with the new Accessible Information Standard.

3.2 Individuals, and where appropriate families/carers, should be integral partners in care and support planning discussions (see principle 2). Even where people lack capacity to make specific decisions, they should be involved in care and support planning discussions wherever possible and any decisions taken on their behalf should be made in their best interests. These discussions and the final plan should be person-centred and focused on what is important to the individual. Increasingly, people should expect to be offered a
personal budget, personal health budget, or integrated personal budget across health and social care, and should have access to information advice and support to help them understand the choices available to them, exercise these choices and to help them plan how to use and manage their budget. Many will already have a right by law to personal budgets or personal health budgets, but commissioners should be rapidly and ambitiously extending this offer beyond rights guaranteed in law.

3.3 At key points in their interaction with health, education and care services, people should have access to different types of independent advocacy. In addition to the legal right to advocacy, people should also be offered non-statutory advocacy, which should be available to them either at key transition points and/or for as long as they require at other times in their lives. This will include in preparation for and on leaving a specialist hospital. Both statutory and non-statutory advocacy should be delivered by services that are independent of the organisations providing the person’s care and support.

4.1 All families or carers who are providing care and support for people who display behaviour that challenges should be offered practical and emotional support and access to early intervention programmes, including evidence-based parent training programmes, and other skills training, in line with NICE guidance and which is targeted to meet their specific strengths, challenges and needs.

4.2 All families or carers who are providing care and support for people who display behaviour that challenges should be offered information about carers’ assessment and advocacy support in their own right, access to short breaks/respite suitable for people whose behaviour challenges and which meets their own needs, and support to care for the person from specialist multi-disciplinary health and social care teams (see principle 7).

4.3 Alternative short term accommodation (available for a few weeks) should be available to people, as and when it is needed, to be used in times of crisis or potential crisis as a place where they can go for a short period, preventing an avoidable admission into a hospital setting. It might also provide a setting for assessment from teams providing intensive multi-disciplinary health and care support (see principle 7) where that assessment cannot be carried out in the individual’s home.

4.4 Everyone who is getting a social care package should have access to paid support and care staff trained and experienced in supporting people who display behaviour that challenges, and those who may have come into contact with or are at risk of coming into contact with the criminal justice system. These staff should be able to deliver proactive and reactive strategies to reduce the risk of behaviour that challenges, in line with NICE guidelines.

4.5 Local authorities should use Market Position Statements with an explicit focus on people with a learning disability and/or autism. They should identify a group of preferred providers, which can demonstrate minimum quality standards and competencies. These providers should be seen as genuine partners of specialist multi-disciplinary health and social care teams (see principles 7 and 8.3) as part of multi-agency working. Commissioners, along with the providers, should develop competency frameworks, such as that provided by Health Education England. These competency frameworks need to include requirements for staff training, for example person-centred approaches, communication and Positive Behaviour Support (PBS), in line with the PBS competency framework.

5.1 People should be offered a choice of housing, including small-scale supported living. This choice may be circumscribed by the Ministry of Justice (MOJ) in some instances if the individual is on an offender pathway. Choice about housing should be offered early in any planning processes (e.g. in transition from childhood to adulthood, or in hospital discharge planning) and should be based on individual need and be an integral component of a
person’s person-centred care and support plan (see principle 2). Where people live, who they live with, the location, the community and the built environment need to be understood from the individual perspective and at the outset of planning.

5.2 Everyone should be offered settled accommodation. This should include exploring home ownership, or ensuring security of tenure.

5.3 Commissioners need to work closely with housing strategy colleagues to ensure that the future needs of this group are understood, considered and planned for strategically and form part of local housing strategies.

6.1 Everyone with a learning disability over the age of 14, should be offered an Annual Health Check. This is particularly important for those with communication difficulties. Everyone should have a Health Action Plan, which identifies how any physical and mental health needs will be met, and this should form an integral component of a person’s person-centred care and support plan (see principle 2). Where appropriate it should include a ‘Hospital Passport’ to help mainstream NHS services make the reasonable adjustments required by law (including meeting the needs of people who display behaviour that challenges) and ensure equity of health outcomes for people.

6.2 Everyone should expect universal NHS services to employ clearly identified and readily accessible primary and secondary healthcare ‘liaison’ workers who have specialist knowledge and specific skills in working with people with a learning disability and/or autism which enable them to advise those services on how to make effective adjustments.

6.3 Everyone should expect ‘quality checker’ schemes to be in place ensuring that mainstream services serve them appropriately.

6.4 Everyone should expect mainstream mental health services to regularly audit how effective they are at meeting the needs of people with a learning disability and/or autism. The Green Light Toolkit should be used to both evaluate services and to agree local actions to deliver real improvements. In many instances this will require investment in mainstream mental health services (such as Child and Adult Mental Health (CAMHS) Services, Improving Access to Psychological Therapies (IAPT) and services that are helping to deliver against the Crisis Care Concordat). In other instances there will be new initiatives to support mainstream mental health services to make reasonable adjustments to their pathways of care and support, and to improve access to those services.

7.1 Everyone should have access to integrated, community-based, specialist multidisciplinary health and social care support for people with a learning disability and/or autism in their community that is readily accessible, when needed, by children, young people and adults with a learning disability and/or autism, including those who may have come into contact with or are at risk of coming into contact with the criminal justice system (see principle 8). Key functions of this specialist support should include: support to enable people to access mainstream health and social care services, work with mainstream services to develop their ability to deliver individualised reasonable adjustments, support to commissioners in service development and quality monitoring, and the delivery of direct assessment and therapeutic support.

7.2 Specialist support might be provided by a range of services, and often across services (e.g. children’s services, Child and Adult Mental Health Services (CAMHS), learning disability CAMHS teams and specialist community learning disability teams). Support should be built around the needs of the individual through a ‘Collaborative Care’ model, or by combined teams (e.g. all age, learning disability and autism). Individuals should expect continuity of care and support through close collaboration between services/agencies,
including between specialist and mainstream services. Access to and provision of support should be based on need.

7.3 Anyone who requires additional support to prevent or manage a crisis should have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home, or in other appropriate community settings, including schools and short break/respite settings. This support should be delivered by members of highly-skilled and experienced multi-disciplinary/agency teams with specialist knowledge in managing behaviours that challenge. The interface between specialist routine multi-disciplinary support services (described above) and this type of intensive support service should be seamless.

8.1 People who have come into contact with, or may be at risk of coming into contact with the criminal justice system, should have access to the same services aimed at preventing or reducing anti-social or 'offending' behaviour as the rest of the population. They should expect services (including those provided by youth offending teams, liaison and diversion schemes, as well as troubled family schemes and programmes such as those for drug and alcohol misuse) to identify people with a learning disability and/or autism amongst the people they support, and to make reasonable adjustments so they can effectively support those people. This should be achieved through collaboration with specialist multi-disciplinary health and social care services for people with a learning disability and/or autism (see principle 7, and 8.3 below).

8.2 Liaison and diversion schemes should seek to support people through the youth or criminal justice system 'pathway' enabling people to exercise their rights and/or where appropriate, diverting people to appropriate support from health and social care services. Clear pathways for diversion to health and social care services should be established through local multi-agency protocols.

8.3 When required, people should have access to specialist multidisciplinary health and social care support for people who have come into contact with or may be at risk of coming into contact with the criminal justice system (i.e. offering a community forensic function for people with a learning disability and/or autism) including the expertise to manage risks posed to others in the community. The interventions offered by these services will depend on the needs of the individual and the level of risk they pose, from individual and group offence-specific interventions, to specialist assessment and established links with other services aimed at facilitating appropriate pathways away from the criminal justice system. It is likely that some people will be best served by mainstream forensic services able to work with people with a learning disability and/or autism, and some by specialist multi-disciplinary health and social care services for people with a learning disability and/or autism. In some areas, specialist community forensic learning disability and autism teams or hospital outreach teams work with small numbers of people who pose a more significant risk to others, usually spanning several localities.

9.1 Everyone who is admitted to a hospital setting for assessment and treatment should expect this to be integrated into their broader care and support pathway, with hospitals working closely with community mental health, learning disability/autism and other services, including those providing intensive community and/or forensic support (see principles 7 and 8).

9.2 When people are admitted for assessment and treatment in a hospital setting they should expect support to focus on proactively encouraging independence and recovery. Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Hospitals should not become de facto homes; discharge planning should start from the point of admission - or earlier for a planned admission. Care and treatment should
be regularly reviewed, in line with NHS England Care and Treatment Review guidance and CPA requirements. Services should be as close to home as possible and provide care and treatment in the least restrictive setting.

9.3 People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community. They should have access to high quality assessment and treatment in non-secure hospital services with the clear goal of returning them to live in their home. Sometimes people will be detained under the Mental Health Act if the necessary conditions are met. 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.

9.4 Admission to secure inpatient services should only occur when a patient is assessed as posing a significant risk to others. Often they will be detained under Part III of the Mental Health Act (‘patients concerned in criminal proceedings or under sentence’) and in contact with the criminal justice system, with or without restrictions from the Ministry of Justice. Some patients, however, may be detained in secure settings under Part II of the Mental Health Act where they pose an equivalent level of risk to others and this risk cannot be managed safely in less secure settings. 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. In line with the Mental Health Code of Practice, only patients who require a combination of enhanced physical, procedural and relational security should be placed in secure services.

9.5 Everyone, other than those following diversion or direction from the criminal justice system, should expect a community (pre-admission) Care and Treatment Review (CTR). In urgent situations where there is not time to convene a CTR then there should be a ‘Blue Light’ meeting, in line with NHS England policy and guidance. Admissions should always be with a clear stated purpose and set of expected outcomes. In the event of an urgent admission, where a CTR has not been carried out, then this should take place within 10 working days of their admission. After six months they should expect a mandatory CTR. Additionally, at any stage in hospital, should there be concerns about care and treatment, the person themselves, their family, advocate, commissioner or clinical team have a ‘right to request’ a CTR.

9.6 For all inpatient provision (secure or not) children admitted to hospital should be placed in an environment suitable for their age and must have access to education. For adults, provision of single-sex accommodation is essential.