Cheshire & Merseyside Transforming Care Plans 2016 - 2019

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Classification: (OFFICIAL)

1. Introduction

1.1. **Purpose**

This document outlines the Cheshire & Merseyside (C&M), (Unit of Planning) local plans aimed at transforming services for people of all ages with a learning disability and/or autism 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). The plans cover 2016/17, 2017/18 and 2018/19.

1.2. **Aims of the plan**

The C&M plans will demonstrate how through coproduction commissioners, stakeholders and system partners will 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.* These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to[1]:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

These planning assumptions have been used by local commissioners to inform the process of planning. They are creative and ambitious underpinned by the Cheshire & Merseyside Learning Disability Health Needs Assessment 2016 alongside a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers that has been informed through coproduction, and on expert advice from clinicians, providers and wider stakeholders.

1.3. **National principles**

The Cheshire & Merseyside Transforming Care Partnerships (CMTCP) have tailored the plans and they are consistent with the following principles:

a. **The plans are consistent** with **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

b. **The plans focus on a shift in power to ensure p**eople 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 will 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 we have coproduced with people with a learning disability and/or autism and their families/carers the transformation plans, and the plans will give people more choice as well as control over their own health and care services. An

[1]The rates per population will be based on GP registered population aged 18 and over as at 2014/15

important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

c. **The plans have strong stakeholder engagement:** providers (inpatient and community-based; public, private and voluntary sector) have been involved in the development of this coherent plan. Wider stakeholders have been engaged in the development of the plans, for example, Employment, Housing, education, third, voluntary and independent sector providers.

Summary of the planning template

2. Planning template

2.1 Mobilise communities

2.2 Governance and stakeholder arrangements

2.2 Cheshire & Merseyside (C&M) is committed to re-shaping services for people with LD and/or autism and/or behaviours that challenge, in line with Building the Right support. We have agreed through system wide discussions One Unit of Planning across the C&M geographical footprint, (one Transforming Care Partnership) to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs (Table 1) to meet the needs of the population of people with Learning Disabilities and/or Autism and/or behaviours that challenge.

Table 1.

C&M Unit of Planning				
Hub	**CCGs**	**Local Authority**	**NHS Provider**	**Total Population**
Hub 1 Cheshire/Wirral	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	Cheshire Wirral Partnership NHS Foundation Trust	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	5 Boroughs Partnership NHS Foundation Trust	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	Merseycare NHS Trust	786,383 population

The C&M Transforming Care Partnership has a good understanding of the local economy and current providers, statutory, independent and voluntary sector contracts.
This includes consideration of:

- Service user preference and expectation
- Existing CCG/LA collaborative commissioning arrangements
- Current clinical pathway service delivery
- Joint purchasing arrangements between some CCGs
- Joint CCG/LA arrangements, including governance for joint decision-making
- Excellent CCG/Provider working relationships
- Provider financial viability and clinical sustainability

***Note**: it is noted that as plans for local authority devolution evolve, and as the market develops the current delivery hub configurations outlined above may change as this programme of work progresses.

2.2.1 C&M have an established Learning Disability Network that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. This Network is well

established and will support the development and delivery of the Cheshire & Merseyside plan, and has supported gathering information to mobilise the community.

2.2.2 Health and Social Care Commissioners, Learning Disability providers, local councillors, Police, Education, Safeguarding, Housing and Employment have formal arrangements in place regionally and locally including the C&M Learning Disability Network, Learning Disability Partnership Boards, Joint Leadership Management Teams and Health and Wellbeing Boards.

2.2.3 The three commissioning delivery hub footprints reflects that of the main C&M NHS Mental Health and Learning Disability Providers, which are:

- Cheshire and Wirral Partnership NHS Foundation Trust (CWP).
- Merseycare NHS Trust
- 5 Boroughs Partnership NHS Foundation Trust (5BP)

2.2.4 There are a range of integrated programmes across health and social care which include developing different commissioning arrangements such as:

- Caring Together (Cheshire East/NHS Eastern Cheshire Clinical Commissioning Group)
- Connecting Care (Cheshire East Council, Cheshire West and Chester Council, NHS South Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group)
- West Cheshire Way (Cheshire West and Chester, NHS West Cheshire Clinical Commissioning Group)
- Wirral 2020 (Wirral Borough Council, NHS Wirral Clinical Commissioning Group)
- Healthy Liverpool Programme (Liverpool CCG, Liverpool Local Authority)
- Staying Local and Together (South Sefton, Southport & Formby CCG's and Sefton Local Authority
- One Halton (Halton CCG and Halton Borough Council)

2.2.5 Partnership working between Clinical Commissioning Groups (CCG's) and Local Authorities (LA's) is evident and all CCG's and LA's are co-terminus except NHS South Cheshire CCG and NHS Vale Royal CCG who have a shared management structure working across two local authorities and South Sefton and Southport & Formby CCG's who have a shared management team that works across one local authority.

2.2.6 Within Social Care Commissioning, all nine local authorities have arrangements in place whereby providers can talk directly with commissioners via regular provider forums or equivalent meetings. For Social care commissioning arrangements - there are a number of care providers within the area who support of people with learning disabilities and/or autism with behaviour that challenge from the use of direct payments to 24/7 care packages. For example Alterative Futures, Brothers of Charity, Carers support network, Registered social Landlords and Job Centre Plus for employment, education and training opportunities.
The aim will be to engage with current providers whilst also developing and engaging with market providers of services, in particular the third, independent and voluntary sector.

2.2.7 Commissioning within the hubs reflects Placed Based Care models; with some areas leading new ways of commissioning. For example:

Cheshire commissioning hub:

- Cheshire West and Chester and the two CCGs within the area are part of a national demonstrator site for Integrated Personal Commissioning, with a focus on people with learning disabilities and/or autism.
- Cheshire East, Cheshire West and Chester and the four Clinical Commissioning

Groups within these authorities, form the Cheshire Pioneer site. www.cheshirepioneer.co.uk

- Cheshire has recently established a collective forum for Learning Disability inclusive of the Clinical Commissioning Groups, Local Authorities and CWP. CWP has put forward proposals a model that embraces the key principles of Transforming Care, including potentially closing one of the two inpatient units within the sub-region.

Mid Mersey commissioning hub

- Mid Mersey has a long established track record of developing and delivering a common model of care for Learning Disability via a Four Borough Commissioning Alliance. Established in 2010, the Alliance co-ordinates commissioning with clear performance measures and meet regularly with its provider, 5 Borough Partnership NHS Trust to review service delivery and performance.

The Transforming Care Partnership Board (TCPB) are cognisant of some key commissioning challenges and opportunities which need to be further developed in line with Building the Right Support, such as pooled, integrated budgets and person centred delivery of care.

- Within NHS CCG commissioning, the 3 main LD providers are commissioned on a block contract basis. Work is being progressed to unpick this in order that a cost can be attributed against the new and bespoke services for people with learning disabilities.

- There is variance in pooled budget arrangements.

- The North Mersey Commissioning Hub needs to build on and develop collaborative commissioning opportunities.

- Strengthening connections and working arrangements with Children and Family Services and providers.

- There is overlap on the geographical borders with Greater Manchester sharing some inpatient provision from CWP.

- Due to geographical configuration of South Cheshire, some patients are placed in services provided in Staffordshire and Wales as this is closer to their home.

- Consideration to commissioning arrangements moving forward will allow placements at scale within and across the Cheshire Mersey footprint

2.3 Describe governance arrangements for this transformation programme

To ensure robust governance arrangements C&M Transforming Care Board brings together 3 local delivery hubs (North Mersey, Mid Mersey and Cheshire) to oversee and support the transformation and delivery of learning disability service provision across the Cheshire and Mersey footprint as outlined in Table 1.

This governance arrangement will include good communication and engagement channels as described below, and provide a way of listening to people with lived experience of services, including their families/carers; with an aim to have a shift in power in the way services are delivered.

To achieve this the CCG Accountable officers have nominated one Accountable officer to the SRO role, The local Authorities have also nominated one Director of Adult Social Services lead as co-chair. Alongside this C&M Transforming Care Board have key partners have been identified and nominated to lead the programme of delivery.

- Alison Lee, Accountable Officer, West Cheshire CCG has been nominated by the Cheshire & Merseyside CCG Accountable Officers to act on their behalf as the Senior Responsible Officer for this programme of work.
- Jonathon Hurley (Expert by Experience) has been nominated by the C&M Self Advocates group to support the SRO as Co-Chair of the C&M TCP.
- Sue Wallace-Bonner, Director of Adult Social Care Halton Council has been nominated by her ADASS peers to be deputy chair.

2.3.1.The national governance structure to support delivery of the national plan is outlined in Table 2

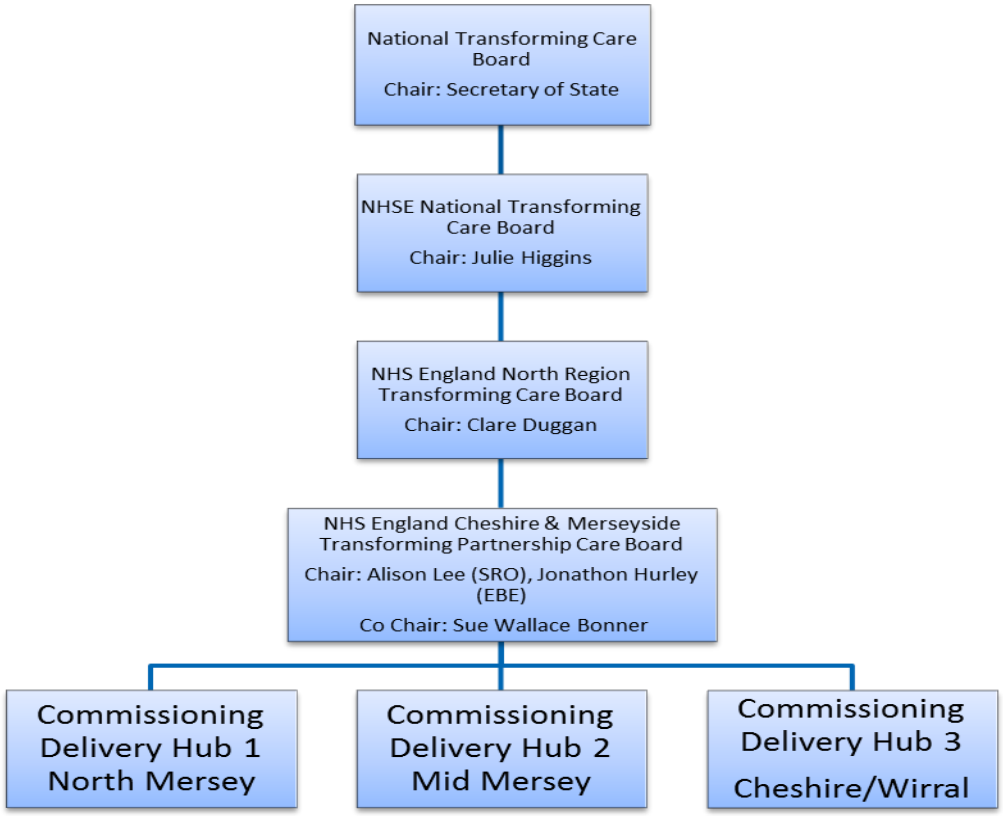


Table 2:

2.3.2 The local governance structure to support local delivery of the national plan is outlined in Table 3:

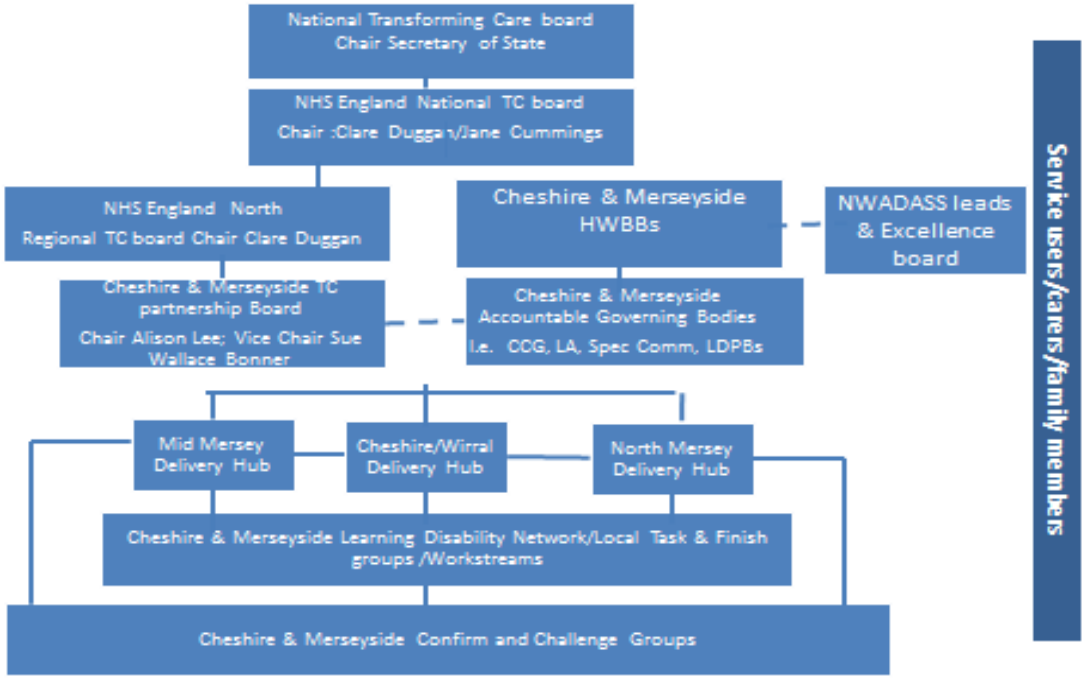


Table 3

The C&M TCP board is accountable to carers and individuals with a learning disability, C&M HWBBs and NHS England North TC board for delivery of its local plans. Critically each Delivery Hub will engage with, seek support from and approval of plans from the relevant local governing bodies/committees , learning disability partnership boards (LDBPs) and Health and Wellbeing Boards. This will include ensuring engagement with children and young people services and strengthening networks in the hubs and Cheshire & Merseyside.

C&M has a strong history of working in partnership to improve care for people with learning disabilities across the C&M footprint which has enabled many of the key partnerships to be brought together and engage in the development of this plan. Key partners involved in the TC programme and represented at the C&M TC board include;

- Service users, Experts by experience, family members, self-advocates
- Health and Social care commissioners;
  - 12 Clinical Commissioning Groups
  - 9 Local Authorities
  - NHS England Specialist Commissioning
- Providers organisations:
  - Cheshire Wirral Partnerships NHS Foundation Trust
  - Merseycare NHS Trust
  - 5 Boroughs Partnership NHS Foundation Trust
- Cheshire & Merseyside NHS England Learning Disability Network
- Public Health England, Directors of Public Health Cheshire & Merseyside
- NHS Health Education North
- C&M Confirm and Challenge Groups supported by Pathways/NWTDT
- NHS England North (Cheshire & Merseyside) Nursing Directorate

Representations are from senior leaders from each organisation who have the autonomy and authority to deliver the transformation programme. All partners are committed to delivering new models of care and support for people with a learning disability and/or autism.

This will be achieved with people with learning disabilities, their families and advocates and will be provided through more detailed co-produced plans. C&M TCP board approved Terms of reference are available.

2.4 Describe stakeholder engagement arrangements

The strategy for engagement includes using existing networks within C&M. Where there are gaps, for example in children and young people we aim to strengthen the networks.
A full stakeholder communication and engagement plan will now be developed involving service users and advocacy groups in all aspects of transformational planning.

Examples of communication and engagement:

2.4.1 C&M Learning Disability Network
There is an established and historic Cheshire & Merseyside Learning Disability Network with CCG, LA, public health, LD Provider and service user representation that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. This network is currently continuing with the delivery of its strategic work plan based on gaps identified via service user feedback and the Learning Disabilities Self-Assessment Framework. Discussions through this network resulted in an agreement that they will become the delivery vehicle for pathway redesign, standards and quality.

2.4.2 Stakeholder day
A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local 'ask' of the National Transforming Care programme across the Cheshire & Merseyside footprint. This was an opportunity to start engagement and develop the Cheshire & Merseyside plan to meet local need.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Health watch, advocacy, housing, and experts by experience, family members and carers. Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. On the day we identified gaps in stakeholder attendance and will be planning further engagement and communication strategies.

Co-production is strong in the North West and Local advocates from the North West Co-Production group reminded stakeholders that Co-production must be central to the work we undertake in improving services for individuals with a learning disability including the development of our local transforming care plans. Details from the event have been collated and shared with all of the stakeholders present for wider dissemination and discussion at local level the details of which have supported the development of the C&M TCP.

2.4.3 Best practice event
Following the stakeholder day a best practice event has been planned for 11 March 2016 for all stakeholders.

2.4.4 Cheshire & Merseyside Delivery Hubs
All 3 local delivery hubs have established a local stakeholder group to develop this plan to date. All hubs have recognised that their groups is not yet fully inclusive enough as currently there is limited representation from service users and carers, advocacy, children's services, housing etc.

It is their intention to undertake ongoing discussions with regard to the plan over the coming weeks. This will include engagement with Learning Disability Partnership Boards and local

self-advocacy groups as well as discussions with other professionals. Feedback will be incorporated into a later draft of the document along with details of how we have gained this. We are using the opportunity to talk to self-advocates at this year's North West Self Advocates conference about the plan and will continue to invite input from a range of partners.

2.4.5 Healthwatch
Following a meeting with the Northwest Health watch lead officers in August 2015 , we are in the progress of establishing a number of key Healthwatch leads across C&M who are supporting us in involving the harder to reach cohorts to ensure their voice is captured in our local TC plans

2.4.6 C&M LD Network, Workstreams and TCP board
The Director/ CEX NWTDT/ Pathways represent the Expert Hub, along with other team members at meetings of the C&M LD Network and are a core member of the TCP board.

2.4.7 North West Confirm and challenge group
The North West Confirm and Challenge Group replaced the Regional Valuing People Programme Board and have representation from health, social care, self-advocate, families, other services and support networks etc.

To facilitate coproduction we have committed to working in partnership with 3 local advocacy teams to develop further the leadership skills of experts by experience within the C&M confirm and challenge groups with the aim of building a sustainable peer advocacy forum. This has now been commissioned and work has commenced on a Cheshire Mersey Footprint.

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

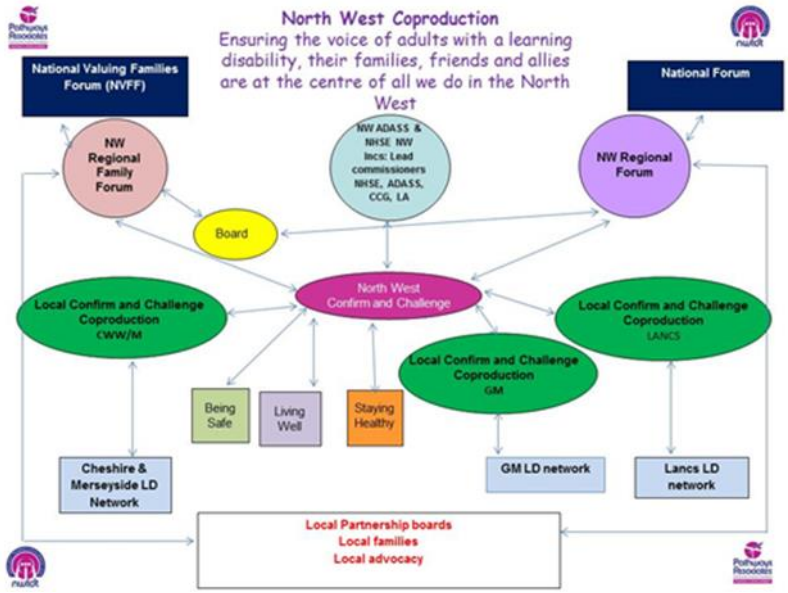
Co-production is strong, and we have coproduction structure groups in place (Table below). NWTDT/ Pathways have worked closely over the last 18 months to support the development and engagement in the Coproduction, Reducing Health Inequalities and Safe and Responsive Services Work streams lead by the C&M LD network. The role of the experts by experience at these meetings is to ensure the plans developed are based on the feedback and information from people with learning disabilities, their families, and friends and allies so that the plan is truly coproduced in a meaningful way.

A full stakeholder communication and engagement plan will now be developed involving service users and advocacy groups in all aspects of transformational planning. To achieve this wider engagement and co-production there will be an accessible easy read C&M plan.

Arrangements for co-production include:

2.5.1 NW Confirm and Challenge Group.
Membership is from elected self-advocates and family members, working alongside relevant officers and partners. Information flows from self-advocate/ families and lead forums to assist in identifying the important issues to people in the North West which can sometimes differ from those outlined in nationally policy but require equal attention.

Table 4



Detailed conversations, governance and scrutiny of local plans and activity takes place at the sub groups (Staying Safe, Being Healthy and Living Well) who report to the NW Confirm and Challenge Group.

The NW Confirm and Challenge Group maintain an overview of the general work plan and identify cross cutting issues and required action. The Regional Board provides links to professional bodies and agrees the funding resources in relation to suggested work plans. The Regional Board feedbacks to the self-advocate/ families and lead forums.

Self- Advocates, Families and Lead Officers forums meet quarterly and have elected representatives at the National Forum and National Valuing Families Forum.

The Regional Board has elected, nominated representatives from NW ADASS, CCG's, NHSE, Self-Advocates, Families, Public Health and DCSS.

2.5.2 C&M Confirm and challenge group

The C&M Confirm and Challenge Group established in September 2015 in order to assist build the necessary relationships to support good coproduction of local plans. This arrangement builds on existing co-production work and strong relationships between experts by experience, commissioners and the North West Training and Development Team/Pathways. This will included developing further networks with wider groups such as children and young people, and people not currently engaged with services.

2.5.3 Learning Disability Partnership Boards

All nine local authorities have Learning Disability Partnership/disability Partnership Boards accountable to their Health and Wellbeing Boards. All commissioning hubs areas are actively involved in their local LDPBs. As an example of best practice Cheshire East Learning Disabilities Partnership Board is working with 'Think Local Act Personal'.

2.5.4 Voices

Pathways Associates and the North West Training & Development Team have reported that C&M have, without really noticing, coproduced their plans. They comment it is something that has been done naturally and are now planning to find ways to support the experts by experience who have been involved to date having opportunities to share and develop the plans coproduced to date with the wider C&M community. Service users have reported that they have felt listened to and supported in the delivery hubs to coproduce the development

of the local plans.

2.5.5 NW Regional Forum Conference
The NW Regional Forum hosts an annual Conference for people with a learning disability from across the NW. The conference runs in February, in Blackpool. The agenda is developed by the Regional Forum and draws national, regional and local speakers. Issues in relation to Transforming Care have been high on the agenda particularly since the conference in 2012, post Panorama. A link to the agenda/ presentations from conference in 2015 can be found at http://blog.pathwaysassociates.co.uk/wp-content/uploads/2015/04/agenda-conf-15-links4.pdf

The agenda for Conference in February 2016 has been developed by the Regional Forum and is entitled; 'Coproduction – Transforming (our own) Care'. As of 22 January 2016, 62 of the 168 delegates are coming from the C&M region funded through a variety of sources including some people funding themselves or through doing sponsored events in the Summer of 2015 to raise the funding to come.

NHS England C&M has made a sponsorship contribution to the Regional Forum Conference which has meant that delegate fees were reduced to £145 per person. Members of the C&M LD Network will be joining the final day of conference to listen to what people have to say and to spend time with delegates from C&M to further confirm, challenge and coproduce Delivery Plans for the Transforming Care Assurance Board. NHSE C&M have also co-funded a 'leadership award' to be presented at conference in 2016.

2.5.6 Expert Hub:
In November 2015 C&M Commissioners collectively with NHS England North (C&M) and NHS England Specialised Commissioning, commissioned NWTDT/ Pathways to provide the independent experts by experience and Clinical Advisers to support the CTR's. From November 2014 to January 2016 NWTDT/ Pathways supported over 360 CTR reviews.

Experts by Experience were present at all C&M CTRs. CTR templates were completed collectively following each review together with feedback on their experience and CTR process. This has fed into the plans developed across C&M to actively include the voices of people who were involved in the review including the individuals and their families.

Together with NHS England C&M nursing team, Pathways have also been involved in the delivery of education and training to provider organisations, enabling them to develop skills and competency as clinical reviewers in the CTR process.

2.5.7 Showcasing Coproduction
Experts by experience have been involved in the delivery of workshops to show case the work they have been undertaking with C&M in respect of co-production and patient experience at the regional RCN conference in November 2015.
In December 2015 experts by experience also supported a shared event in C&M. Presentations available if required.

From the coproduction work undertaken by Pathways Associates and the North West Training & Development Team the following are areas that our services users and carers have described as being the areas that they wish us to concentrate on with them:

"A Long Term Relationship NOT a One Night Stand"

- It's an opportunity to make a real difference
- Interested in how people with learning disabilities, families, friends and allies can drive this agenda

- Commitment to working to achieve this together
- Ensuring that the voice of people with learning disabilities and their family carers and friends are at the centre of all we do
- Want to see all the things that they have identified as being important in our plans!
- Transforming care must be about social care too
- You should only buy services that you would be delighted for members of your family to use
- If people are having a crisis they should be able to stay closer to their community not have to go far away – out of sight out of mind!
- Some people should never be 'closed' to community learning disability teams. Some people will always need help and support in their lives. You must be ready.
- This is about our lives, you must keep working with us
- Keep doing what you're doing you'll keep getting what you're getting and it's not good enough
- Commissioners should not be taken by surprise in their own communities – know the people in your area
- This is about death by indifference and health and inequalities for us all too
- Transforming care is not just about the small number of people who live away from home. It's about all of us, everywhere
- Staying Health, Living Well, Being Safe – aren't they what we all want? We should all be angry that there are such human rights and equality issues in 2015 that affect people with learning disabilities and their families.

We continue to engage and coproduce our work through the following mechanisms:

- Experts by experience – involved in over 360 Care and Treatment Reviews
- Learning Disability Self-Assessment Framework and peer review panel at the NW Regional Forum
  - Laughing Boy workshops at the Regional Forum conference
  - Development of LDSAF plans
  - Co Production of TC plans
- Green paper consultation
- Transforming Care Partnership
- C&M Confirm and challenge groups

2.5.8 Delivery hub meetings

To facilitate coproduction we have committed to working in partnership with 3 local advocacy teams to develop further the leadership skills of experts by experience within the C&M confirm and challenge groups with the aim of building a sustainable peer advocacy forum.

2.5.9 Gaps in Co-production

An identified area that requires further work is in undertaking meaningful engagement with children and young people. We are currently in discussions with organisational Communication leads and CCG/LA children's Commissioners, patient experience leads and family forum to develop a plan of action to address this. We will also be expanding our contacts with people with Autism and their families. As such a mapping exercise has been undertaken and completed by our local Co production group, identifying our missing cohorts to be contacted.

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

Clinical Commissioning Groups:

NHS Liverpool

NHS South Sefton

NHS Southport & Formby
NHS Knowsley
NHS St Helens
NHS Halton
NHS Warrington
NHS East Cheshire
NHS South Cheshire
NHS Vale Royal
NHS West Cheshire
NHS Wirral

3. Understanding the status quo

3.1 Baseline assessment of needs and services

Provide detail of the population / demographics

In the development of the C&M plans we have been cognisant of including the 5 needs groupings identified in the national service model:

- Children, young people or 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 with personality disorders, which may result in them displaying behaviour that challenges.
- Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
- Children, young people or adults with a learning disability and/or autism who 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).
- Children, young people or adults with a learning disability and/or autism, often with 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.
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who 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.

3.1 NHS England commissioned Liverpool John Moore's University and Public Health England to undertake a Joint Strategic Needs Assessment of Learning Disabilities and/or Autism across C&M region.

This health needs assessment reviews adults and children across Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, Wirral, Cheshire East, Cheshire West and Chester Local Authorities. It tries to determine the health and wellbeing needs of people with learning disabilities and/or autism and/or behaviours that challenge living in C&M. The findings have been used to develop a set of recommendations for local commissioners.

For this needs assessment, estimates of the expected number of people with learning disabilities have been taken from the Learning Disability Observatory 'Improving Health and Lives' website (IHAL) and the PANSI website (Projecting Adult Needs and Service Information system).

Data on those known to services, where available, has been taken from the NHS Information Centre (numbers reported by social services), GP QOF data and directly from each local authority, Clinical Commissioning Group and NHS England. Data on service use and provision has been accessed directly from the three providers across C&M (Cheshire and Wirral Partnership, Mersey Care and 5 Boroughs partnership). This breadth of data has ensured we have incorporated any known information on heard to reach groups, disadvantaged groups and vulnerable groups for inclusivity. For the purposes of this needs assessment, the definition of learning disability is used in the white paper 'Valuing People Now: A New Strategy for Learning Disability for the 21st Century' (DH, 2001).

PANSI have used Emerson and Hatton's (2004) paper to calculate estimate true prevalence of learning disability amongst adults for each local authority. Figure 1compares these estimates for C&M with the number of adults known to each local authority taken from IHAL. Estimates relate to total learning disabilities (including mild, moderate and severe).

3.2 Estimated prevalence

The total numbers for C&M are 35,896 (estimated true prevalence) and 7,775 (number probably known to services) aged 18-64 years.

Table 5:own prevalence and true prevalence estimates (numbers with learning disability age 18-64)

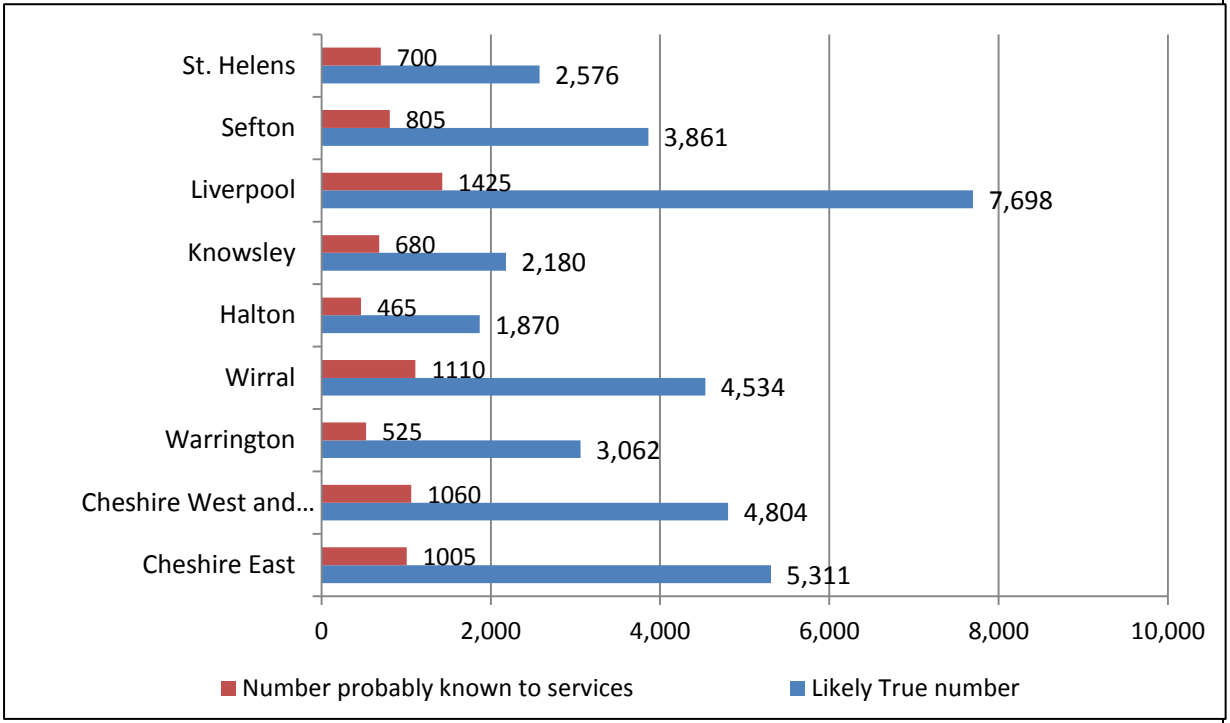


Table 5 Source: PANSI, 2015

The estimates do not take into account local variations, so there will be an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community (Emerson and Hatton, 2004). In C&M, there are relatively low

proportions of people of South Asian origin.

Table 6 below shows the prevalence across C&M by 10 year age bands. In Liverpool, the proportion of people aged 25 and under estimated to have learning disabilities is relatively high (1,780). This reflects the high proportion in this age group amongst the general population in Liverpool (67, 297, 14%).

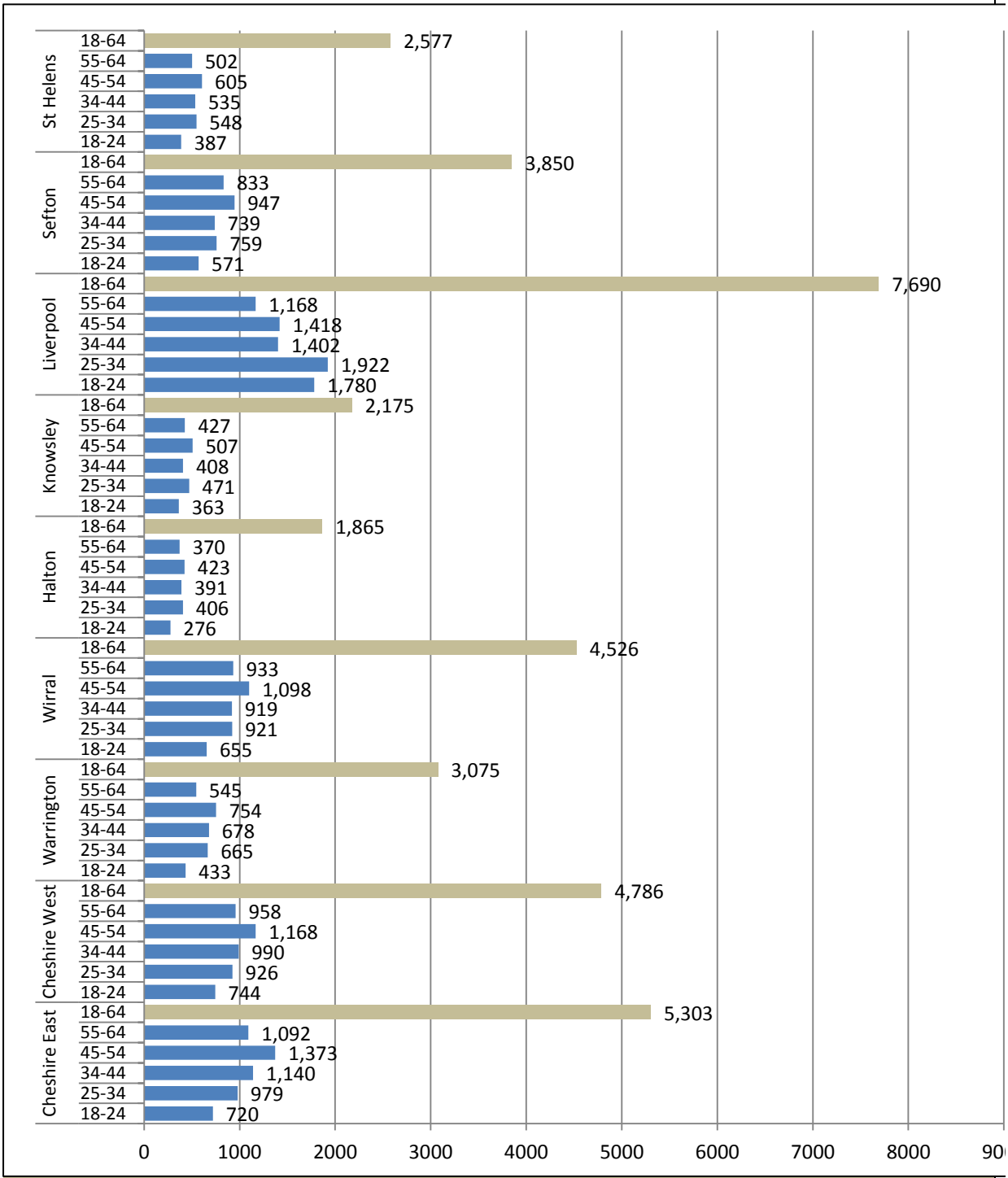


Table 6: Source: PANSI-8

Analysing the data it is evident that people with learning disabilities and autism are a very diverse population, with differing needs and are one of the most vulnerable groups in society, experiencing health inequalities, social exclusion and stigmatisation.

The data highlights to us that amongst those with more severe learning disabilities, there have been considerable life changes for many, with the closure of learning disability hospitals (IHAL, 2012). Following the enquiry and reports after the closure of Winterbourne View Hospital (DH, 2012) and the development of the government's 'Valuing People Now' strategy (DH 2009), there are now clear guidelines in place covering all aspects of the health needs of people with learning disabilities.

Under the Disability and Equality Act (2010), 'reasonable adjustments' are required in all practices and procedures to ensure that discrimination against people with learning disabilities does not occur. The data would show you that this continues to require further investigation and will be part of our developments.

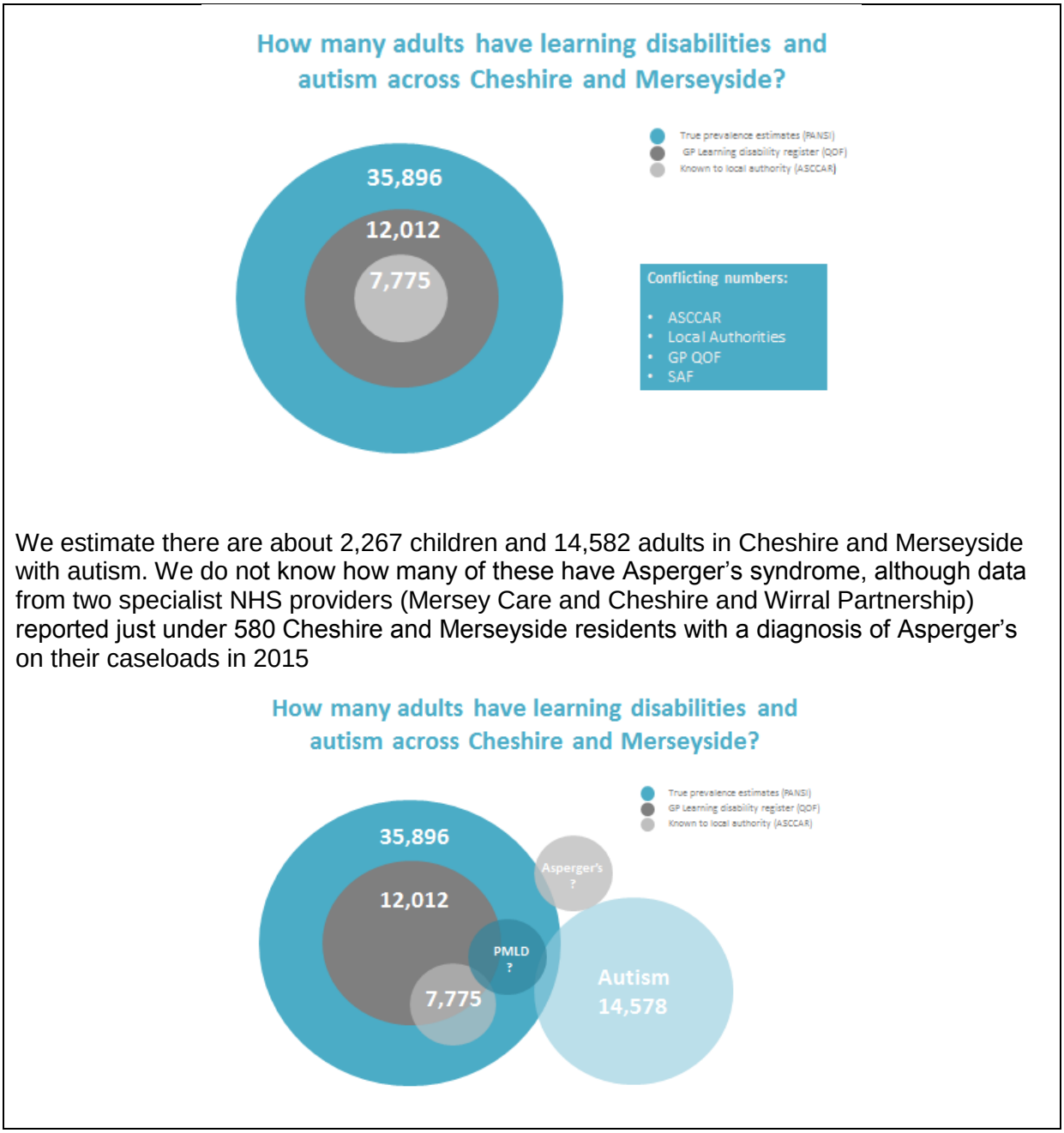
Due to the availability of data, the health and social profile sections of this report have focussed more on learning disability than autism. This will be addressed further via the commissioning hub plans.

We still have questions about how many people have learning disabilities and autism across Cheshire and Merseyside. In particular into understanding our cohorts. It is important to consider the hidden population with learning disability – those not using services with potentially unmet need and low level needs. This is because although about 4.6 people per 1,000 in the population are known to have a learning disability; research suggests there may actually be around 20 people in every 1,000 with a learning disability.

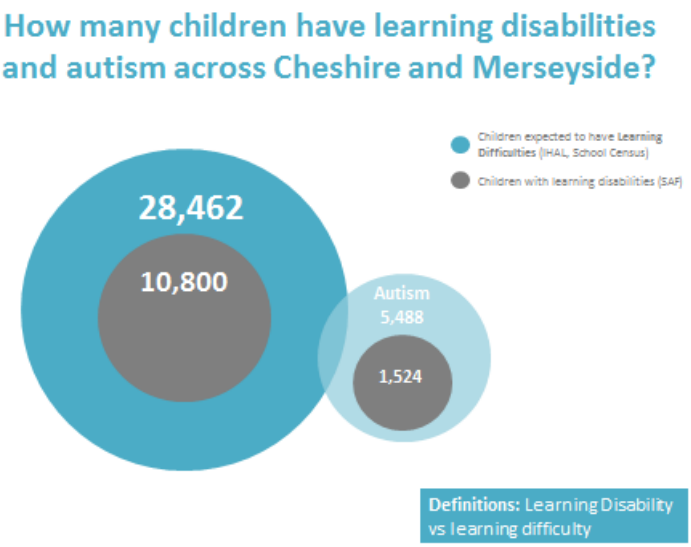
There is no consistently collected data on the number of children with learning disabilities. However we do know how many children locally have been identified as having a learning difficulty. It has been estimated that just over three and a half children in every 1,000 has a severe learning difficulty. Those classified as having a severe learning difficulty may well have a learning disability but we cannot say this for certain and this needs to be considered with regard to the children with severe learning disabilities and challenging behaviour.

More positively the number of adults with learning disabilities known to GPs is broadly similar to the numbers local authorities have on their registers. However, there is a lot of variation in GP figures across practices and self-assessment framework (SAF) data does not always give an indication of the total population. There are far fewer people known to these services than we estimate live in our local communities. This means significant numbers are not receiving any help and therefore could be living independent active lives.

In Cheshire and Merseyside, there are an estimated 35,896 people with a learning disability aged 18 and over, but there are only 7,775 who are known to services (2014/15). There is no data available on the numbers actually known to have profound and multiple learning disabilities (PMLD).



We estimate there are about 2,267 children and 14,582 adults in Cheshire and Merseyside with autism. We do not know how many of these have Asperger's syndrome, although data from two specialist NHS providers (Mersey Care and Cheshire and Wirral Partnership) reported just under 580 Cheshire and Merseyside residents with a diagnosis of Asperger's on their caseloads in 2015



It is acknowledged and requires further investigation to how many of these people have low level needs and/or are involved with the criminal justice system.

3.3 Health of people with learning disabilities and autism

People with learning disabilities face a number of challenges in using health services. These include understanding literature they have been given, keeping appointments and following treatment regimes

People with learning disabilities tend to be less physically active and a higher proportion of them are obese compared to the general population. Local BMI information is limited which makes comparison to the local population difficult. However, high proportions of adults with learning disabilities do seem to be obese with the proportion in each local authority ranging from 34% in Cheshire East to 53.7% in Knowsley; this compared to an England average of 24%.

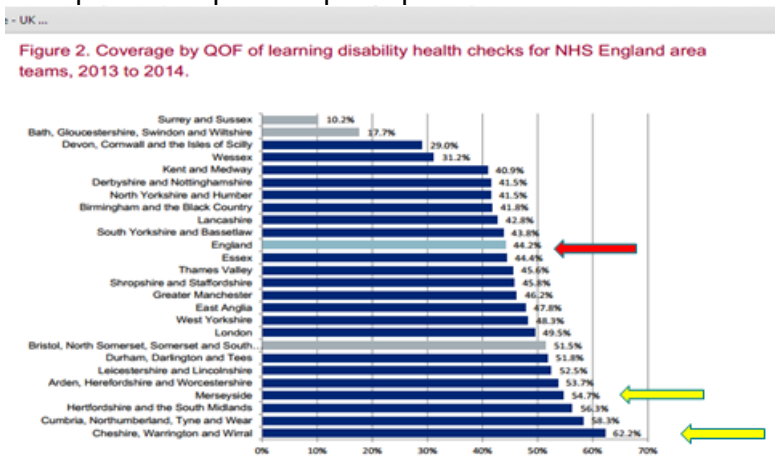
Information on other co-morbidities is not routinely collected/reported with few areas able to provide details on additional diagnoses amongst people with learning disabilities. However rates of some conditions appear to be high including;

- Epilepsy – rates are high locally and nationally research shows epilepsy is at least 20 times higher amongst those with learning disabilities than for the general population.
- The other most common additional health conditions were asthma (four out of seven LAs which provided data) and dysphagia (difficulty swallowing; three out of seven which provided data).
- Coronary heart disease was the most common co-morbidity in one local authority which report 7.7% of people with learning disabilities in the area having CHD.

Local data on mortality of people with learning disabilities was very limited with the only data available coming from the LDSAF. However, this only included number of deaths in the previous 12 months and any values under 5 were supressed. Therefore total number of deaths in each LA is not available. No causes of death or age at death were available.

As well as lifestyles, another major reason for poorer health could be worse access to health promotion and early treatment. The health checks that are available either help to prevent people from developing illnesses or treat them early to make it easier and more likely to recover. Cheshire and Merseyside as a region is performing substantially better than the

England average on uptake and practice participation of health checks.



Screening data were available from most areas and shows a similar pattern to national research including:

- High rates of people with learning disability refuse or do not attend cervical cancer screening, compared to the population of all eligible women.
- Screening uptake for breast cancer was lower in women with learning disabilities compared to all eligible women; though higher than cervical cancer screening uptake.
- Bowel cancer screening varied between local authorities and in some areas was higher amongst people with learning disabilities compared to the general eligible population
- Information on uptake of contraception and sex and relationships education (SRE) for people with learning disabilities is limited.

3.3 Social issues for people with learning disabilities and autism

People with learning disabilities do not just face challenges with healthcare. Many live in poverty and are unable to secure employment. National research suggests only 15% of people with autism are in full-time employment and only 7% of people with a learning disability are in either part-time or full-time employment.

Locally, all areas apart from Cheshire East and St Helens have below the national average levels of employment for people with learning disabilities. The wide variation in employment locally suggests there may be different definitions of work

National research has shown many local authorities believe the type of housing people with learning disability and autism are in does not meet their needs. Although the levels in 'settled accommodation', across Cheshire and Merseyside are generally high, this does not tell us about the quality and suitability of their accommodation.

National research also shows that people with learning disabilities and autism are at increased risk of becoming victims of violence and abuse. Local data shows the number of people with learning disabilities referred to social services safeguarding teams is higher than the regional and national average in seven out of nine local authorities.

Many people with learning disabilities and autism have little or no contact with friends. One research study found that 31% of adults with a learning disability having no contact with friends, compared to 3% of adults without a learning disability.

Six out of 10 women with learning disabilities who become a parent have their children taken in to care. Data available on parental status is limited but the available data suggests that numbers of parents are small in each local authority, roughly 10-30 in each area. However, they are likely to have complex and on-going support needs.

3.4 Service Use and Provision

There are three NHS providers; Mersey Care, Cheshire and Wirral Partnership (CWP) and 5 Boroughs Partnership, providing both community based and inpatient specialist care for people with learning disabilities.

Two of three providers (Mersey Care and Cheshire and Wirral Partnership) supplied data for this needs assessment. Each provider had between 1,500 and 2,000 individuals with learning disabilities on their caseload in 2015. The client profile reflected the demographics of those known to Local Authorities and CCGs with the majority being male, white and aged between 21 and 60 years old. The largest proportion of referrals was made by GPs; prominently for people with learning disabilities and/or challenging behaviour and/or mental health issues.

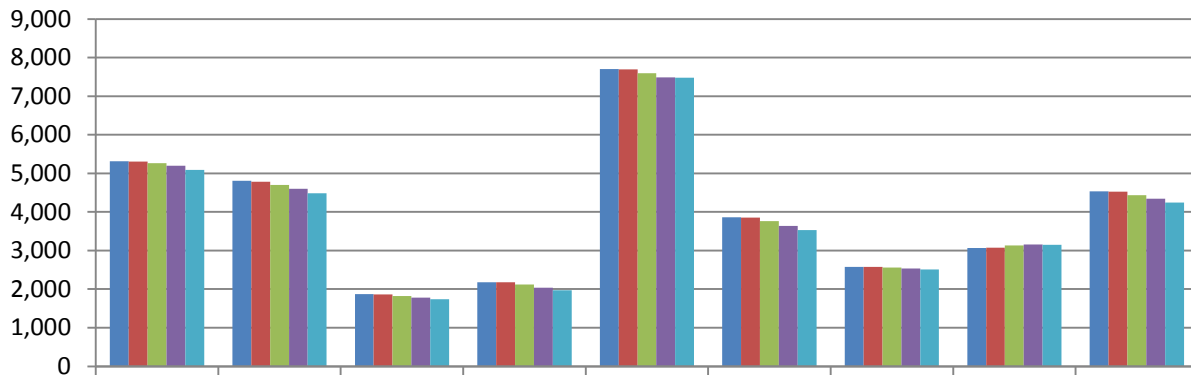
The number of mean learning disability inpatient days per patient per year at Mersey Care and CWP were 12.5 and 18 days respectively, with Mersey Care seeing a rise in the number of mean patient days and CWP seeing a decline. There were approximately 30,000 contacts per provider in 2014/15 of which two thirds were face to face and just under one in ten were unsuccessful; unsuccessful contacts include DNAs, appointments that were cancelled by the patient or provider and instances where the patient declined. This data is extremely important as it highlights the need of people who are at most risk of admission/not engaged with services and vulnerable groups as identified in our cohorts.

The following section gives some diagrammatical data to support our local analysis.

3.5 Projections

Projections of future numbers of people with learning disabilities are presented in the PANSI database. Amongst those aged 18-64, the numbers with a learning disability are predicted to decrease slightly across all local authorities with the exception of Warrington where a small increase is predicted. Although the numbers in those aged 65 are considerably smaller (Table 8) they are predicted to increase steadily for each local authority between 2014 and 2030.

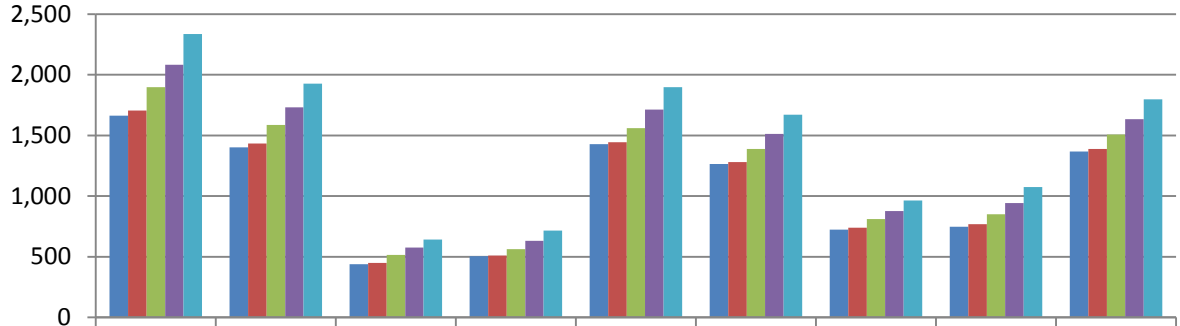
Table 7: Projections to 2030 of numbers of people aged 18-64 predicted to have a learning disability



	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
2014	5,311	4,804	1,870	2,180	7,698	3,861	2,576	3,062	4,534
2015	5,303	4,786	1,865	2,175	7,690	3,850	2,577	3,075	4,526
2020	5,261	4,698	1,818	2,122	7,597	3,762	2,561	3,128	4,436
2025	5,200	4,601	1,778	2,041	7,484	3,639	2,536	3,155	4,339
2030	5,090	4,483	1,742	1,974	7,475	3,529	2,510	3,147	4,245

Source: PANSI-8

Table 8: Projections to 2030 of people aged 65 years and over predicted to have a learning disability



	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
2014	1,662	1,400	438	505	1,427	1,264	723	746	1,367
2015	1,705	1,432	448	510	1,443	1,281	740	767	1,388
2020	1,896	1,585	516	562	1,559	1,387	810	851	1,507
2025	2,081	1,731	575	632	1,712	1,513	875	943	1,633
2030	2,336	1,927	641	714	1,897	1,671	963	1,075	1,797

Source: POPPI-8

3.6 Moderate and Severe Learning Disability

PANSI data estimates are also available for two sub-categories of learning disability: 'moderate and severe' and 'severe' learning disability. These are the groups of people most likely to be in receipt of services, and numbers should therefore correspond to the 'known' or 'administrative' prevalence of learning disability.

Table 9 shows numbers with moderate or severe learning disability for each local authority

in C&M. Numbers are slightly different to the known prevalence data shown in Table 10.

There were estimated to be 5,159 people with moderate and severe learning disability in C&M in 2013. The majority of this number (7775, 93%) were known to the local authority.

In Warrington there were far fewer people known to services than would be expected from the estimated numbers (75%). Known numbers are also less than expected in an additional four local authorities (Liverpool, Sefton, Cheshire East and Cheshire West) whilst the remaining five local authorities had more people known to services than were estimated (see last column, Table 10).

Table 9: Numbers predicted to have a moderate or severe learning disability aged 18-64

Local Authorities	2014	2015	2020	2025	2030
Halton	425	424	414	406	400
Knowsley	495	494	481	465	453
Liverpool	1,747	1,746	1,729	1,712	1,720
Sefton	876	873	853	827	809
St. Helens	586	586	582	578	576
Wirral	1,030	1,028	1,008	988	973
Liverpool city region	**5,159**	**5,151**	**5,067**	**4,976**	**4,931**
Cheshire East	1,210	1,208	1,197	1,184	1,165
Cheshire West and Chester	1,094	1,090	1,068	1,047	1,026
Warrington	698	701	713	721	723
Cheshire	**3,002**	**2,999**	**2,978**	**2,952**	**2,914**
C&M total	**8,161**	**8,150**	**8,045**	**7,928**	**7,845**

Source: PANSI-8

Table 10: Numbers with learning disability known to Local Authorities age 18-64 years, 2013/14

Local Authority	2013/14	% predicted number
Halton (321)	465	109.4
Knowsley (315)	680	137.4
Liverpool (316)	1425	81.6
Sefton (317)	805	91.9
St Helens (318)	700	119.5
Wirral (319)	1110	107.8
Liverpool city region	5185	100.5
Cheshire East	1005	83.1
Cheshire West And Chester (327)	1060	96.9
Warrington (322)	525	75.2
Cheshire	2590	86.3
C&M	7775	95.3

Source: NHS IC ASCCAR L2 (1st data column)

Table 11 shows future predicted numbers of those with severe learning disabilities. Between 2014 and 2030, numbers are expected to fall or remain constant in each local authority, with the exception of Warrington, where numbers are likely to rise from 184 in 2014 to 191 in 2030.

Table 11: Numbers predicted to have a severe learning disability aged 18-64 years

Local Authority	2014	2015	2020	2025	2030
Halton	112	112	109	107	106
Knowsley	131	130	127	123	121
Liverpool	477	476	469	465	469
Sefton	229	229	223	217	214
St. Helens	155	154	152	152	152
Wirral	270	270	263	259	257
Liverpool city region	1374	1371	1343	1323	1319
Cheshire East	316	315	310	308	306
Cheshire West and Chester	288	286	280	275	272
Warrington	184	184	186	189	191
Cheshire	788	785	776	772	769
C&M	2162	2156	2119	2095	2088

Source: PANSI-8

3.7 Profound and Multiple Learning Disabilities (PMLD)

There is local data available on known numbers of children with PMLD.

3.7.1 Children

There is some school census data on children with profound and multiple difficulties, but this is likely to be different to the number with disabilities (see discussion in Section 1.2 and start of Section 2). Table 12 shows the numbers of children aged between 7 to 15 expected to have profound and multiple learning difficulties in C&M. This is modelled data, calculated by IHAL, based partly on Spring term school census data. As the educational needs of these children are unlikely to be met in mainstream schools, the variation in numbers is possibly due to the existence of special schools in some areas – although IHAL may have taken this into account when they calculated their estimates. Liverpool was the local authority with the highest rate of children with PMLD per 1,000 population (1.54) and the largest number of children (107).

Table 12: Number of children aged 7-15 years expected to have profound and multiple learning difficulties, 2013/14

Local Authority	Number of pupils	Number with profound and multiple learning difficulties	Rate per 1,000
Halton		*	*
Knowsley		*	*
Liverpool	69316	107	1.54
St. Helens	26385	30	1.14
Sefton		*	*
Wirral	50641	63	1.24
Warrington	31540	26	.82
Cheshire East	53708	63	1.17
Cheshire West and Chester	51070	55	1.08

Source: IHAL

Where rows are blank values have been suppressed by PHE for disclosure control due to a small count

Data from the annual school census, made available by Wirral for 2015, shows that there are less children with profound and multiple learning difficulties than predicted in the IHAL estimates (Table 13). The IHAL data was based partly on the school census (see previous

paragraph). The number reported by Warrington was slightly lower than the number predicted in table 12.

Table 13 School Census data Pupils with PMLD with Statements and School Action Plus, 2015

Local Authority	Number of children	
Wirral	Primary	53
	Secondary	5
	Total	58
Warrington	Total	24

Source: Local Authorities

Local authorities are not required to maintain registers of children with learning disabilities. As a proxy, some local authorities have looked at data on children with statements of educational need (SEN) and learning difficulties. However, this does not reflect the spectrum of disability and is only a weak proxy measure for severity (St. Helens JSNA, 2012). It is also likely that there are different definitions of each level of learning difficulty used by each school.

Table 14 below shows data provided by Local Authorities on the numbers of children who have either Statements of Educational Need or School Action Plus status for learning difficulty. Children with learning difficulties who leave school at 16 will not be captured. Data for Liverpool was not available for 2015 so data from the previous needs assessment (2012 school census) has been included to give an indication of the numbers; however caution must be taken when comparing this data with other local authorities.

Table 14: Pupils with Statements and School Action Plus

SEN Need Type	Moderate Learning Difficulty	Profound & Multiple Learning Difficulty	Severe Learning Difficulty	Specific Learning Difficulty
Liverpool, Jan 2012	1,529	76	389	1,068
Wirral Jan 2015	542	88	363	642

Source: Liverpool City Council and Wirral Borough Council, School census

Table 15: Pupils with Statements

SEN Need Type	Moderate Learning Difficulty	Profound & Multiple Learning Difficulty	Severe Learning Difficulty	Specific Learning Difficulty
Warrington Jan 2015		24		
Wirral Jan 2015	329	50	359	231

Source: Warrington Borough Council, Wirral Borough Council; School Census

There is data available on learning disability amongst children from the Joint Health and Social Care Self-Assessment Framework (SAF); data from local authority level returns is summarised in Table 16 below. Across C&M, 11% of people reported to the SAF were aged between 0 and 17 years. There was some variation in the proportion of 0-17 year olds across Local Authorities with the highest number seen in Sefton where just under one in five

(19%) reported in the SAF were aged 17 years and under. The numbers reported by local authorities are considerably lower than the numbers of children predicted by IHAL to have learning difficulties (Table 11).

Table 16: Number of children (0-17 years) with learning disabilities, 2013

	0-13 years	14-17 years	Total aged 0-17 years	Total population with LD reported	% of total population aged 0-17 years
Halton	26	29	55	732	8%
Knowsley	50	47	97	989	10%
Liverpool	144	131	275	2198	13%
Sefton	108	110	218	1152	19%
St Helens	65	49	114	929	12%
Wirral	91	93	184	1731	11%
Cheshire East	42	51	93	1100	8%
Cheshire West and Chester	48	46	94	1224	8%
Warrington	47	35	82	745	11%

Source: Joint Health and Social Care Needs Assessment, IHAL, 2013.

Liverpool City Council (Adults & Children's Social Care & Education) is working in partnership with Merseycare NHS Trust, CCGs and external service providers such as Connexions towards producing a single dataset for children and young people. It is intended the single dataset will provide clear and comprehensive information on the needs and trends of children and young people with Special Educational Needs and Disability across services in Liverpool. To facilitate this, a scoping exercise is underway to identify what datasets already exist, who they are being held by and in what system. Preliminary discussions are taking place with stakeholders to determine what information sharing agreements are in place and to identify any gaps. It is expected that the dataset will be in place in 2015/16 subject to data governance issues being met.

3.7.2 53 week placement details

All areas have information available on 52 week residential placements. An example being provided by Wirral CCG who have identified 7 young people who are placed in residential schools out of area and there are 4 young people who are placed out of area in private foster placements.

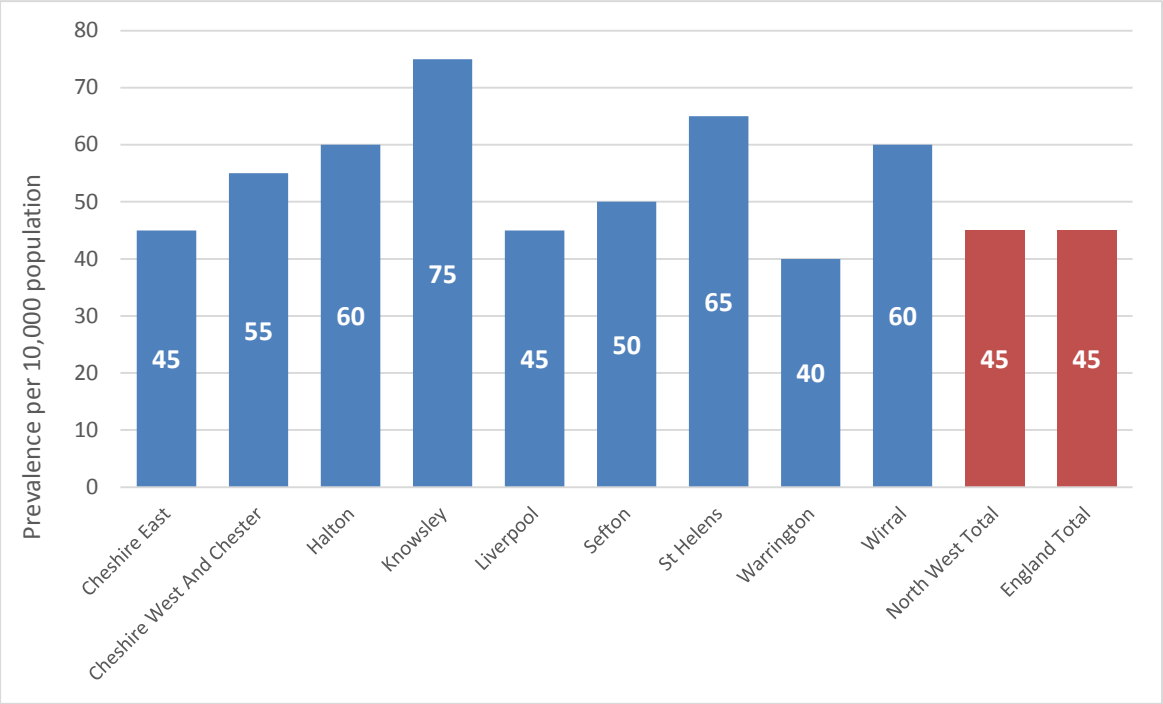
3.8 Adult Prevalence

Known prevalence data for ages 18-64 was obtained from the Adult Social Care Combined Activity Returns (ASCCAR, NHS Information Centre). Table 17shows the prevalence in each local authority per 10,000 general population (aged 18-64 years). Rates of learning disability are highest in Knowsley, at 70 per 10,000 population and lowest in Warrington, at 40 per 10,000 population.

The numbers of people with learning disabilities known to local authorities in C&M is shown in Table 18 below, with a total of 7,775 adults across the whole area (4,530 males and 3,240 females). The data relates to people of working age (18-64) and is broken down by sex.

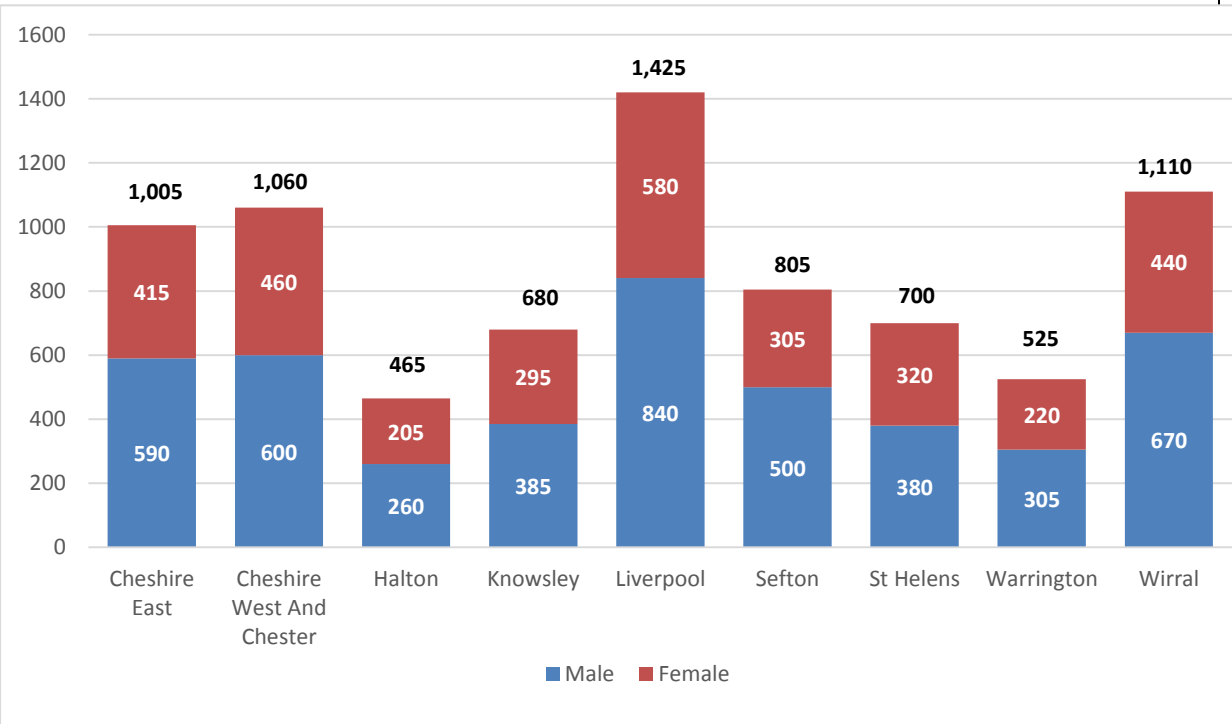
Table 17 : Prevalence of learning disabilities: People known to the local authorities as

having a learning disability per 10,000 population aged 18-64, 2013/14



Source: NHS IC NASCIS, ASCCAR L2

Table 18: Number of people with learning disabilities known to Local Authorities, 2013/14



	Male	Female
Cheshire East	59%	41%
Cheshire West And Chester	57%	43%
Halton	56%	44%
Knowsley	57%	43%
Liverpool	59%	41%

Sefton	62%	38%
St Helens	54%	46%
Warrington	58%	42%
Wirral	60%	40%
C&M	58%	42%
North West	58%	42%
England	58%	42%

Source: NHS IC NASCIS, ASCCAR L2

Data provided directly from Wirral Borough Council and taken from their Self-Assessment Framework (SAF) return in 2013/14, indicating that there were 1,470 people aged 18-64 with learning disabilities. This is higher than the 1,110 known to social services reported to the NHS Information Centre (ASCCAR) in 2013/14 (see Table 18 above).

Similarly the number of people provided directly by Liverpool City Council reported 1,559 individuals with learning disabilities known to the local authority in 2015 which again is higher than the number reported in Table 18 (1,425 individuals).

Data provided by Sefton states there are 1,606 adults aged 18-64 which again is substantially higher than the 805 individuals reported to the HSCIC in Table 18.

In Warrington the numbers provided directly from the local authority were also slightly higher than the number reported in Table 18 at 573 compared with 525.

Conversely, data provided by Cheshire West and Chester council and supplied directly from their information system reports that there were 852 adults with learning disabilities known to the local authority which is less than the 1,060 individuals reported to the HSCIC in 2013/14 (Table 18). The data provided by the local authority is based on the ASCOF rules which count only those receiving a service for a learning disability and this may account for some of this difference.

The number provided by St Helens for 2014/15 states that 682 adults aged 16-84 years with learning disabilities are known to the local authority which is slightly lower than number reported to the HSCIC in Table 18.

3.8.1 Adults Ages 65+

Data for those aged 65 and over with learning disabilities is not available from the Adult Social Care Combined Activity Returns (ASCCAR, NHS Information Centre); however data on the number known to each partnership board is reported to the Joint Health and Social Care Self-Assessment Framework (SAF) and data from the 2013 SAF is included in Table 19 below.

The prevalence of learning disabilities in adults aged 65 years and over was highest in Knowsley (36.9 per 10,000) and lowest in Cheshire East (13.6 per 10,000 population). The overall prevalence of learning disabilities in C&M among older adults was 19.7 per 10,000.

Table 19: Prevalence of learning disabilities in older adults (aged 65 years and over)

	Adults with LD aged 65 plus	Total population aged 65 plus	Prevalence per 10,000 population
Halton	52	21013	24.7

Knowsley	90	24365	36.9
Liverpool	205	69305	29.6
Sefton	104	61153	17.0
St Helens	59	34845	16.9
Wirral	128	65998	19.4
Cheshire East	112	80564	13.9
Cheshire West and Chester	112	67564	16.6
Warrington	48	36066	13.3
C&M Total	910	460873	19.7

Source: Joint Health and Social Care SAF, IHAL, 2013 and ONS mid-2014 population estimates.

Data provided directly from Liverpool local authority reports 205 individuals with learning disabilities aged over 65 years of which 72% are aged between 65 and 74 years, 23% are aged between 75 and 84 years and 5% are aged 85 years and over.

Data provided directly from Sefton reports 249 adults aged 65 years and older known to the local authority which is considerably higher than the number reported to the SAF in (Table 19).

Data provided directly by St Helens reports 35 individuals aged 65-84 which is lower than the 59 reported to the SAF (Table 19)
Warrington data reports 37 individuals known to the local authority aged 65 years and over of which 95% were aged between 65 and 74 years. This is again lower than the number reported in the SAF (Table 19)

Data provided by Wirral on adults with learning disabilities aged 65 years and over for 2013/14 is slightly higher (148 individuals) than the number reported in the 2013 SAF (128 individuals)(Table 19) and this number has increased to 163 in 2014/15.

3.8.2 Known prevalence aged 18+ (GP data): learning disability C&M

Table 20 shows that across C&M in 2014-15, levels of learning disability recorded in general practice were equal or higher than the national average of 0.44% in eight out of 12 CCGs. The four CCGs with prevalence below 0.44% were all in Cheshire namely: East Cheshire, South Cheshire, West Cheshire and Warrington. Levels were highest in Knowsley and Halton, at 0.63% of the total practice population aged 18 plus in both CCGs. As would be expected, levels and patterns are similar to local authority learning disability register data, where percentages were highest in Knowsley (0.75 %) and lowest in Warrington (0.40%).

Table 20: Number of adults with Learning Disability and ASD, 2013

	Number of people with Learning Disability and ASD	Total people with learning disability	%
Halton UA	54	732	7%
Knowsley	114	989	12%
Liverpool	101	2198	5%
St Helens	56	1152	5%
Sefton	135	929	15%
Wirral*		1731	
Warrington UA	121	745	16%
Cheshire East UA	81	1100	7%

Cheshire West And Chester UA*		1224	

*Source: Joint Adult and Social Care Self-Assessment Framework, IHAL, 2013 *Data field not completed*

Table 21 also includes numbers on the register and practice level variation in prevalence. Variations between practices are most notable in Southport & Formby, where the percentage of the practice population aged 18 plus on the learning disability register is as high as 2.11% in one practice. In the other 18 practices, the proportion on the register varies from 0.15% to 1.05%. In Liverpool, the prevalence in one practice was 1.52%, with the rest ranging from 0.06% to 1.40%.

Table 21: Number and percentage on the GP Learning Disability Register, and range of learning disability (LD) prevalence across practices, 2014-15, ages 18+

CCG Name	Estimated List Size 18+	Learning Disability Register	Prevalence Rate (per cent)	Lowest practice prevalence	Highest practice prevalence
NHS EASTERN CHESHIRE CCG	165,944	635	0.31	0.06	0.66
NHS SOUTH CHESHIRE CCG	143,009	614	0.34	0.11	0.83
NHS VALE ROYAL CCG	81,631	448	0.44	0.25	0.68
NHS WARRINGTON CCG	168,431	838	0.39	0.11	0.71
NHS WEST CHESHIRE CCG	209,906	939	0.36	0.09	0.88
NHS WIRRAL CCG	265,696	1,909	0.57	0.15	1.37
NHS HALTON CCG	100,147	802	0.63	0.2	0.87
NHS KNOWSLEY CCG	127,066	1,019	0.63	0.29	1.21
NHS SOUTH SEFTON CCG	119,067	654	0.44	0.11	1.01
NHS SOUTHPORT AND FORMBY CCG	101,119	749	0.61	0.15	2.11
NHS ST HELENS CCG	152,668	937	0.49	0.16	0.9
NHS LIVERPOOL CCG	409,607	2,468	0.49	0.06	1.52

Source: NHS IC QOF

Actual numbers on the GP learning disability register are higher than numbers recorded by local authorities. This is partly because GP data counts all those aged 18+, and data readily available from local authorities is for ages 18-64 only.

However, some of the differences appear to be larger than would be expected, for example in Liverpool there are 2,468 people on the GP learning disability registered compared with 1,425 on the local authority register. Similarly Wirral GP register data reports 1,909 adults with learning disabilities compared with 1,110 on the Local Authority register.

These differences could be partly due to the fact that GP registers are capturing more people with learning disabilities, as they will include those not necessarily known to local authority services. They could also be due to the fact that data is not directly comparable, because GP registered populations are different to local authority resident populations.

GP data was obtained for Wirral for 2014/15 which includes ethnic group. There were 23 people on the GP learning disability register from a minority ethnic group. This dataset also included numbers with learning disability by age groups 0-13; 14-18; 19-25; 26-64 and 65+

which is provided (Table 22). This data is available because Wirral has set up a service level agreement (SLA) with GPs for improved recording of learning disability. It has had the effect of increasing figures on GP databases and has the potential to capture those not currently receiving services from the local authority.

Table 22: Wirral: Numbers on the GP learning disability register by age group

Age group	Number of people with a Learning Disability	
	2013/14	2014/15
0-13 inclusive	144	180
14-17 inclusive	90	113
18-34 inclusive	563	706
35-64 inclusive	907	999
65+	148	163

3.9 AUTISTIC SPECTRUM DISORDER (ASD)

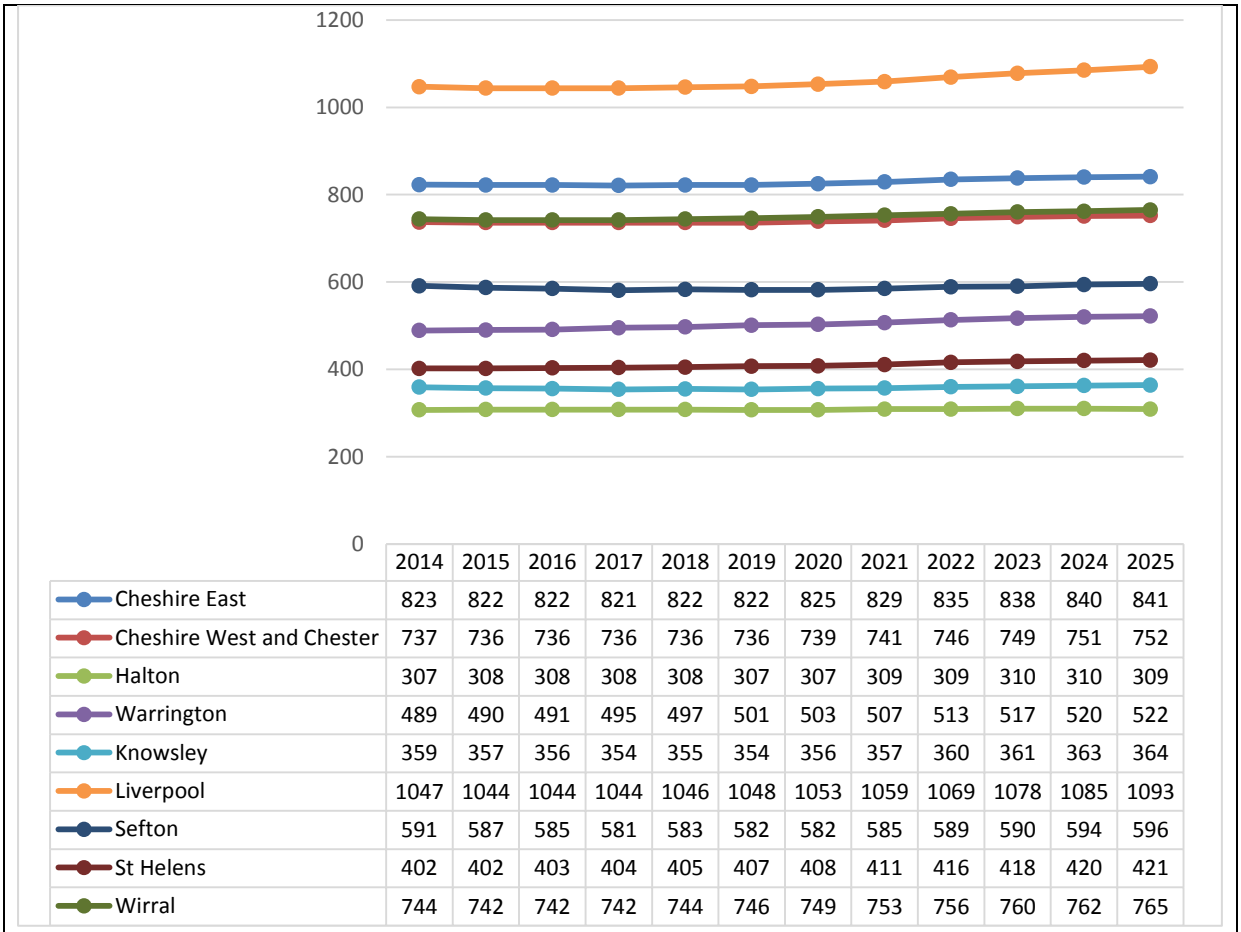
3.9.1 Learning disability and autism

Autistic spectrum disorders are shown by between 20%-33% of people with learning disabilities known to the local authorities (Emerson et al, 2012).
There is even more variation in estimates of the proportion of people with ASD who have a learning disability. Emerson and Baines (2010) suggested that the estimate amongst children was somewhere between 40% and 67%.

3.9.2 ASD in children

Expected numbers of children with ASD have been estimated by applying the prevalence rate of 1% reported by the National Autistic Society (2013) to local populations.
Table 23 shows the numbers of children aged under 18 estimated to have autism across C&M, projected to 2025. In 2015, there were 5,488 children predicted to have autism. Numbers are set to rise slightly in each local authority across the region. By 2025, projections indicate that there will be 5,663 children with ASD across C&M.

Table 23: Projected estimates of numbers of children with ASD, 2014 to 2025



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Cheshire East	823	822	822	821	822	822	825	829	835	838	840	841
Cheshire West and Chester	737	736	736	736	736	736	739	741	746	749	751	752
Halton	307	308	308	308	308	307	307	309	309	310	310	309
Warrington	489	490	491	495	497	501	503	507	513	517	520	522
Knowsley	359	357	356	354	355	354	356	357	360	361	363	364
Liverpool	1047	1044	1044	1044	1046	1048	1053	1059	1069	1078	1085	1093
Sefton	591	587	585	581	583	582	582	585	589	590	594	596
St Helens	402	402	403	404	405	407	408	411	416	418	420	421
Wirral	744	742	742	742	744	746	749	753	756	760	762	765

Based on 1% prevalence estimate applied to 2012 population projections (ONS, 2014)
Known prevalence: Data on the number of school pupils with statements or school action plus for ASD is recorded in the school census which is published in the special educational needs dataset by the department of education (Table 24).

Table 24: Pupils with ASD as primary special educational need (SEN), 2015

	Autistic Spectrum Disorder	
	Number	% of all children with a statement of need
Cheshire East	17	6.0
Cheshire West and Chester	241	29.1
Halton	129	44.6
Knowsley	127	31.1
Liverpool	322	25.3
Sefton	233	41.4
St. Helens	156	39.4
Warrington	89	30.2
Wirral	210	20.9

School census published in Special Educational Needs in England, 2015, DofE

Data on pupils with ASD was provided directly by just two local authorities. The Warrington 2015 census found that there were 315 pupils with ASD with statements. In Wirral there were 850 school children known to have ASD of which 132 had School Action Plus, 494 had a statement, 10 had an Education, Health and Care Plan. Overall 1.4% of school pupils were

known to have ASD and 16% of children with statements or school action plus were known to have ASD. The data from both local authorities was considerably higher than the number published by the Department of Education but this may in part be because this data only publishes information based on primary SEN.

Table 25 gives estimates of numbers aged 7-15 expected to have different levels of learning difficulties in each local authority in C&M, excluding those with a mild learning difficulty.

Table 25: Number of children aged 7-15 expected to have learning difficulties, 2010

LA	All pupils	Severe learning difficulties	Profound and multiple learning difficulties	Moderate learning difficulties	Autism spectrum disorder
Halton	13,553	45	16	656	132
Knowsley	16,917	64	23	886	140
Liverpool	42,951	160	57	2224	384
Sefton	26,641	88	31	920	261
St Helens	18,049	66	73	753	177
Wirral	33,016	104	38	1352	329
Liverpool city region	151,127	527	238	6,791	1,423
Cheshire East	33405	100.8	33.8	836.7	322.2
Cheshire West and Chester	31,453	98	34	977	309
Warrington	21,145	62	22	604	212
Cheshire and Warrington	86,003	260	89	2,417	844
Total C&M	237,130	787	327	9,208	2,267

3.9.3 ASD in adults:

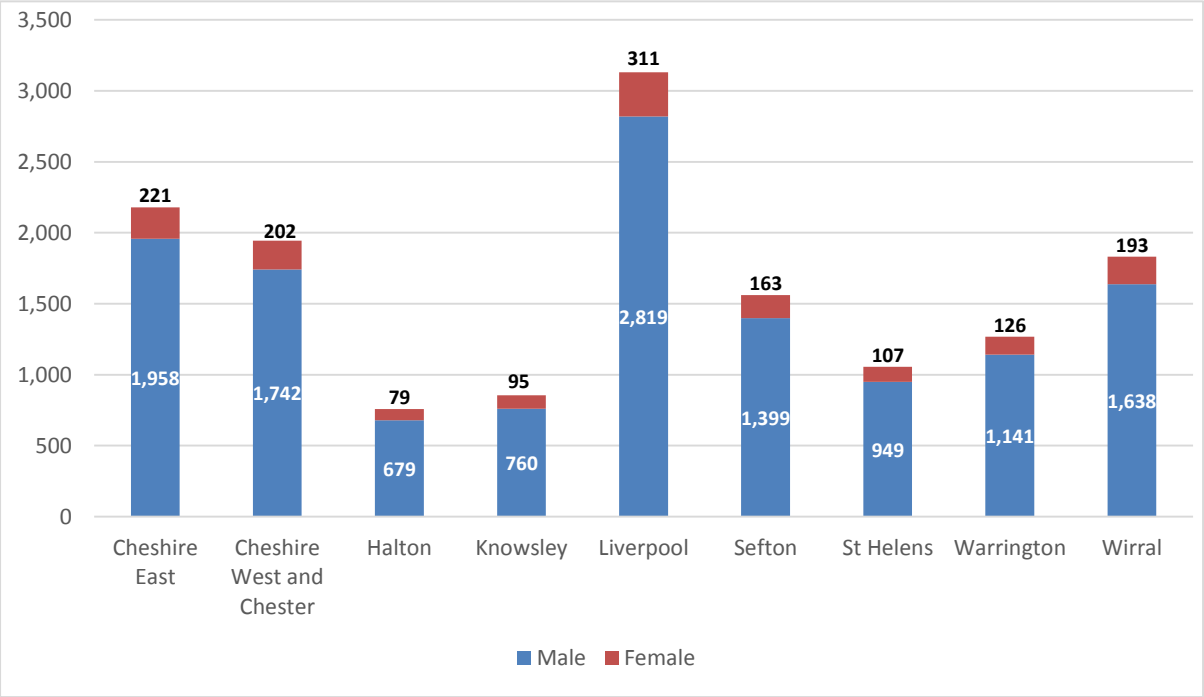
An assessment of the issues arising from completion of the local authority autism self-assessment framework in 2011 was undertaken (Roberts et al, 2012a). Issues included the identification of a major gap in local information about people with autism, such as the number of people with autism, and what services they use.

In the absence of known numbers, estimates can be calculated using the national morbidity survey on autism in adults. This survey found the prevalence of ASD to be 1.0% of the adult population (HSCIC, 2009). The rate among men (1.8%) was higher than that among women (0.2%), which fits with the profile found in childhood population studies, according to the HSCIC.

In the PANSI database, these prevalence rates have been applied to ONS population estimates of the 18 to 64 male and female population to give expected numbers predicted to have autistic spectrum disorder.

Table 26 shows the expected prevalence of ASD amongst adults aged 18-64 across C&M, with 1,497 females and 13,085 males (14,582 total). There are around nine times more males than females expected to have autism. This is much higher than in learning disability as a whole, where expected prevalence rates amongst males are only slightly higher than amongst females (Table 2 above).

Table 26: Males and Females predicted to have an Autism Spectrum Disorder (ASD)



Source PANSI, 2015

Data obtained directly from some local authorities was not always consistent. Where data was available, some data systems do not distinguish between learning disability and autism. Also, it was not common practice to specify separate numbers with Asperger's syndrome.

In **Knowsley** in 2013, there were reported to be **858** adults known to services with autism including **222** aged **65+.** This is substantially higher than the numbers provided in the previous needs assessment suggesting that these numbers may be based on projections rather than the numbers known to the LA.

Data obtained from **Cheshire West and Chester** reported that there were 65 people with autism. This is considerably lower than the number projected in figure 8 but the Local Authority acknowledged that this number is likely to be an underestimation due to data categorisation from health services.

Self-Assessment Framework data from South Sefton for 2014 indicated that there were 205 adults aged 18+ with learning disabilities who also had autism and were known to general practice.

Amongst children with autism, it is expected that at least half will have a learning disability that would lead to them being identified by the authorities (see text following Table 25). Numbers of adults with autism who are known to services (where available) are far smaller than the estimated prevalence of autism shown in (Table 26). This would suggest that there

are a large number of adults with autism unknown to the local authorities who may be in need of additional support.

3.10 Autism and learning disability

The Joint Adult and Social Care Self-Assessment Framework (SAF) shows the numbers of individuals having both learning disability and autism. Amongst adults with learning disabilities, between 5% and 16% also had a diagnosis of autism.

3.10.1 Asperger's Syndrome

Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language. (Source: The National Autistic Society, www.autism.org.uk).

There is no readily available data on numbers of people with Asperger's. GP data is coded for Asperger's but this data was not readily available. Data from two providers reported around 580 people with Asperger's on their caseload for 2015.

In C&M there are two specialist Asperger's teams based in Liverpool and Sefton. Many other local authorities in the country do not have such support available. However, these teams do not deal with people who have Asperger's with a learning disability; these individuals would be the responsibility of the learning disability team so these numbers are likely to underreport both the number of individuals with Asperger's known to services and the number in the overall population.

In 2015, there were a total of 302 people on the Liverpool and Sefton Asperger's Team caseload of which 62% were resident in Liverpool CCG, 21% were resident in Southport and Formby CCG and 16% in South Sefton CCG. There were 123 referrals to the two specialist Asperger's Teams in 2015.

Cheshire and Wirral Partnership also provided data on the number of individuals with a primary or secondary diagnosis of Asperger's. There were 288 people with Asperger's who had contact with the service in 2015 of which 19 also had a diagnosis of learning disability. The majority of adults with learning disability were resident in Wirral CCG (43%).

Table 28 below shows the number of people with Asperger's accessing Mersey Care and Cheshire and Wirral Partnership (CWP) in 2015. The total number for each service is lower than the totals given above as both services have a small proportion of individuals accessing from outside of C&M. It is also possible that the totals given could represent some double counting if any individuals have moved across the two services during the year. Data from 5 Borough Partnership was not available at the time of publication and so the numbers for Knowsley, Halton, St Helens and Warrington are likely to be much lower than the numbers actually known to services.

Table 28: Individuals with Asperger's known to services, 2015

	Mersey Care	CWP	Total
NHS EASTERN CHESHIRE CCG		40	40
NHS SOUTH CHESHIRE		33	33

CCG			
NHS VALE ROYAL CCG		12	12
NHS WARRINGTON CCG		<5	<5
NHS WEST CHESHIRE CCG		40	40
NHS WIRRAL CCG		125	125
NHS HALTON CCG		<5	<5
NHS KNOWSLEY CCG	<5		<5
NHS SOUTH SEFTON CCG	47	<5	<50
NHS SOUTHPORT AND FORMBY CCG	63		63
NHS ST HELENS CCG		<5	<5
NHS LIVERPOOL CCG	188	13	201

Source: Mersey Care and Cheshire and Wirral Partnership

3.11 Mortality and Age at Death

A study published in 2009 by Tyrer and McGrother found mortality rates amongst people with moderate to severe learning disabilities to be almost three times higher than in the general population. Mortality was especially high in young adults, women and people with Down's syndrome, although the life expectancy of those with Down's syndrome has increased more rapidly recently, compared to those with other types of learning disability (Emerson et al, 2012).

It was not possible for the authors to say how many of these deaths would be unexpected, as they noted that people with learning disabilities often have significant co morbidity, such as physical impairments, congenital heart malformations and mental disorders, which all incur a greater risk of death. However, this would not explain all the difference (Tyrer and McGrother 2009).

Recent data on individuals with learning disabilities who died in C&M was unavailable. The LDSAF returns include information on the number of people with learning disabilities who have died in the last year (2013-14). However as numbers under 5 are supressed the information is very limited (see table 29). No data were available for Warrington or Wirral. Sefton and Liverpool saw the highest number of deaths however without full unsuppressed data it is not possible to compare mortality rates.

An area of good practice highlighted in a mortality audit of learning disability related deaths is currently being undertaken across South Cheshire and Vale Royal CCGs following a number of recent cancer related deaths. The findings of the audit are expected in the second quarter of 2016.

Table 29: number of people with learning disability who died in year to March 2014 by local authority.

	Cheshire East	Cheshire West & Chester	Halton	Knowsley	Liverpool	Sefton	St Helens
Aged 0-13	0	0	0	0		0	0
Aged 14-17	0	0	0	<5		<5	0

Aged 18-34	<5	0	<5	<5		<5	<5
Aged 35-64	<5	5	<5	6	8	8	7
Aged 65 & over	5	<5	<5	<5	11	11	5

To stop identifying patients any numbers under 5 have been supressed and numbers 1-4 have been replaced. Therefore columns cannot be totalled.
The Learning Disability Observatory (IHAL) examined mortality data for the period 2006 to 2010 and calculated the median age at death of people with learning disabilities (i.e. the midpoint of the ages of all the people who have died). IHAL noted that data may be incomplete because often, doctors do not record learning disabilities on death certificates if they consider it had no relationship to the person's death.

Table 30: Median age at death for people with learning disabilities, 2006-2010.

	Age at death	Number of deaths
Knowsley	60.5	16
Liverpool	55.0	51
Sefton	60.5	40
Wirral	54.0	29
North West	55.0	610
England	55.0	4,667

Results for four of the local authorities in Merseyside and North Cheshire are shown in Table 30. Values were only recorded where the number of deaths is greater than 10, which is probably why data for Halton, St. Helens and Warrington was unavailable.

In Liverpool, the median age at death was the same as the national and North West figure of 55 and in Wirral, it was just under, at 54. In Knowsley and Sefton, people with learning disability lived longer, with a median age at death of 60.5 (although differences to the national figure were not significant).

3.12 Community care

Table 31 below shows the extent to which local authorities are providing community services for people with learning disabilities known to them. Community based services are services commissioned and provided by social services or and NHS Health Partner as part of a care plan following a Community Care Assessment and include home care, day care, meals, direct payments, short term residential care (excluding respite), professional support and equipment and adaptions. Nationally, just over eight in ten (82%) of those aged 18-64 years with learning disability were receiving community services in 2013/14. Across C&M, rates were higher than the national average with the exception of Sefton and St Helens where around three quarters (73% and 76% respectively) received community services.

We are aware of the level of need and referral criteria into LD community services, there are more likely to be referrals for the cohort of people with Challenging Behaviours and /or mental health needs. So this data gives insight into the cohort need within each locality. A percentage of these people will be at risk of a crisis and admission to hospital this information can be cross referenced with the admission data to understand demand for inpatient /intensive response type services.

Table 31: Community Based Services received by those with learning disabilities, aged 18 to 64, 2013/14

	Numbers receiving learning disability community services	Total population with a learning disability known to the local authority aged 18-64	% of all learning disability clients receiving community services
Halton	395	465	85%
Knowsley	640	680	94%
Liverpool	1405	1425	99%
Sefton	590	805	73%
St Helens	530	700	76%
Wirral	955	1110	86%
Liverpool City Region	**4515**	**5185**	**87%**
Cheshire East	945	1005	94%
Cheshire West And Chester	850	1060	80%
Warrington	430	525	82%
Cheshire	**2225**	**2590**	**86%**
C&M	**6740**	**7775**	**87%**
North West Total	**18080**	**20130**	**90%**
National Total	**117025**	**141980**	**82%**

Source: NHS IC NASCIS, RAP P1

3.13 People with learning disabilities in the criminal justice system

The Bradley Report (DH Bradley Report, 2009) highlighted the disproportionately high number of people with learning disabilities and mental health problems in the criminal justice system (CJS - a term used to mean the police, courts, prison and probation). It has been estimated that the proportion of people in prison who have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system is around 20-30% (Loucks, 2007, Talbot, 2008).

For those aged under 18, Hindley is where the majority of male young offenders from the Merseyside area are sent to if they are sentenced to custody. There are no YOI institutions in Merseyside. Female offenders are sent elsewhere in the country, and are likely to be held further from home. There is one secure children's home for offenders in St Helens (Red Bank). There are no secure training centres. For over 18s – there are no female prisons on Merseyside.

The estimated proportion of people in prison who have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system is around 20-30%. Many are unidentified.

Across Merseyside;
Prisons – Current healthcare provision has been re-procured in HMP Liverpool and HMP Kennet, the new contract commenced in June 2015 meeting national specifications. A 5 + 2 year contract has been awarded.

Police Custody & Courts – The nationally specified liaison and diversion is being piloted in the Merseyside area, this scheme triages and refers anyone with a 'vulnerability', which includes LD, MH, behavioural, social care and SMS.

Gaps – current issues with access to MH beds and facilitation of MH Act assessments, there appears to be some 'dis-connect' between community and NHSE commissioned services.

Plans – Introduction of the Engager programme at HMP Liverpool to work with individuals with lower level MH needs, referral to community services and support until engagement. Also, it is intended to continue to work with Merseyside Police to develop an integrated healthcare provision in police custody including L&D.

Across Cheshire;
Prisons - Current healthcare provision has been re-procured in HMP Risley, Thorn Cross and HMP Styal, with the new contract due to commence in April 2016 meeting national specifications. A 5 + 2 year contract has been awarded.
Police Custody & Courts –Liaison and diversion schemes are being developed in the Cheshire area; these schemes will triage and refer anyone with a 'vulnerability', which includes LD, MH, behavioural, social care and SMS.

Gaps – current issues with access to MH beds and facilitation of MH Act assessments, there appears to be some 'dis-connect' between community and NHSE commissioned services. Also, L&D in Cheshire is not working to national model with reduced hours in custody and court.

Plans – It is intended to continue to work with Cheshire Police to develop an integrated healthcare provision in police custody including L&D. Also, current schemes will incrementally develop until national rollout is approved by HM Treasury and funding is available

There are 3 male prisons on Merseyside – HMP Liverpool, Altcourse, and HMP Kennet. In Cheshire there are two male prisons HMP Thorn Cross and HMP Risley. Female offenders from the C&M area are sent to HMP Styal in Cheshire. The Alderley Unit in Cheshire is a low secure service unit for males with 15 beds for those with mild to moderate learning disabilities who have or are assessed likely to commit an offence.

As with other agencies, young people with learning disabilities are considered to be young people until the age of 25 years. Most youth offending teams will assess young people at 18, and make a decision as to their suitability for transfer and ability to cope with the adult system (Lewis and Scott-Samuel, 2013).

Local data: The Adult Social Care Combined Activity Returns (ASCCAR) from the NHS Information Centre include information on accommodation type for those people with learning disability who are known to local authorities. This includes:

- numbers in custody (prison/young offenders institution/detention centres), and also numbers in approved premises for offenders released from prison or under probation supervision (e.g., probation hostel)

Across both C&M and the North West as a whole there were no individuals known to have learning disability recorded as being in custody. There were ten individuals known to have a learning disability residing in approved premises in the community in 2013/14 all of whom resided in Wirral. This illustrates the under-reporting of learning disability for people in the criminal justice system and the need for improved screening at the point of first contact.

A health needs assessment for young offenders across the youth justice system on Merseyside (Lewis and Scott-Samuel, 2013) found that at HMYOI Hindley, in a 4 month period (1st August to 30th November 2011), there were 56 referrals to the learning disability service. It is not known what proportion of these referrals were of people from the Merseyside area. At the time of the needs assessment, there were two full-time learning disability nurses employed at Hindley.

There was found to be no direct provision for young offenders with learning disabilities at Red Bank home in St. Helens. There are some good examples, which future data could be sourced. As described below:

Joint working in Sefton

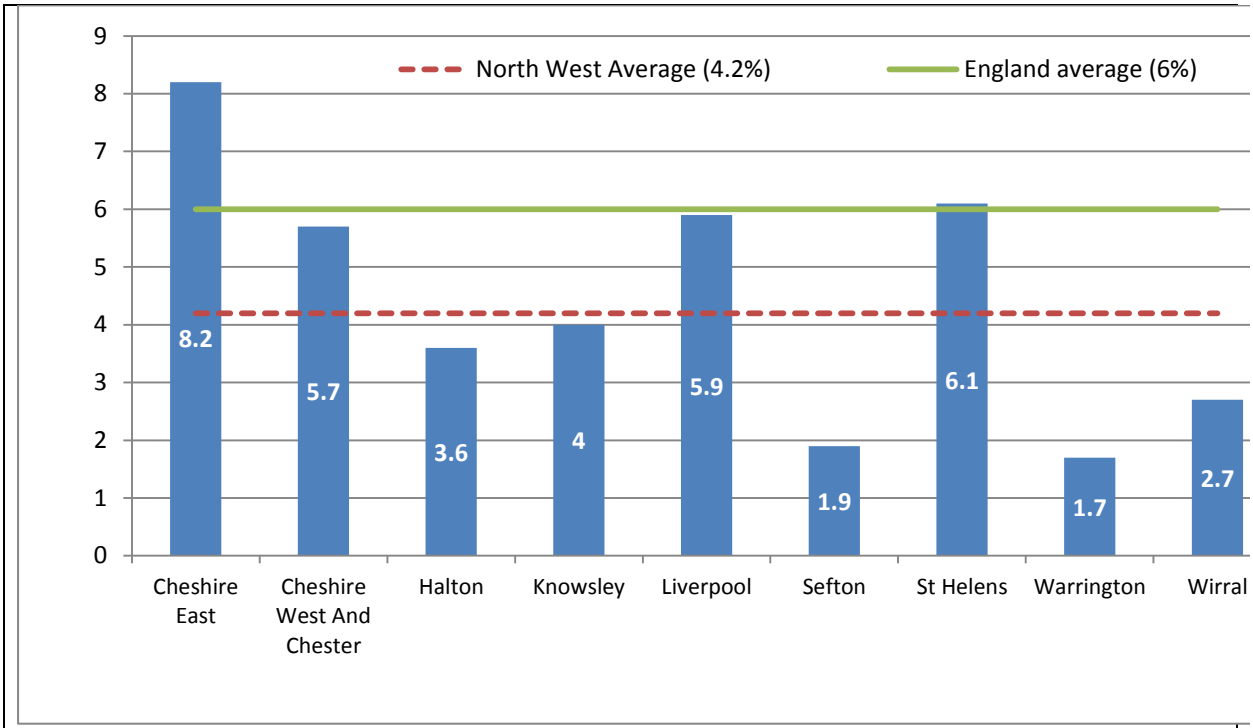
The Criminal Justice liaison system is in place between the Courts and Merseycare NHS Trust to enable vulnerable adults including those with ASC (autism spectrum condition) to receive appropriate NHS interventions. Joint planning with health partners is in place. The MARAC process is well established with all criminal justice agencies for vulnerable adults.
Sefton Autism Self Assessment, 2012

3.14 EMPLOYMENT

Levels of employment amongst people with learning disabilities are generally a lot lower than amongst the general population. In 2012/13, only 7% of working age adults with learning disabilities were in any form of paid or self-employment, part time or full time (9,845 individuals).

Data for C&M local authorities shows that employment levels are highest in Cheshire East (8.2%) and St Helens (6.1%)(Table 32). These levels are above the national average of 6% and well above the average for the North West of 4.2% (2014/15). Employment levels are very low in Warrington, Sefton and Wirral, at under 3% (2014/15).

Table 32: Proportion of working age adults with learning disabilities in any paid employment, 2014/15



Source: NHS Information Centre, Adult Social Care Outcomes Framework for 2014/15 (ASCOF measure 1E). Adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in paid employment at the time of their latest review.

3.14.1 Paid employment of 16 hours or more per week

In 2013/14, as few as 0.9% men and 0.4% women with learning disability worked for 30 or more hours per week. In Halton, Knowsley, Sefton, St. Helens and Warrington, there was no-one with a learning disability known to social services recorded as being in paid employment for 30 hours or more per week in 2013/14. In Liverpool there were 80 people, in Cheshire East there were 20, in Wirral there were ten and in Cheshire East there were five. Table 35 shows the numbers of adults with learning disabilities working 16 hours or more in 2013-14 in paid employment (at or above the minimum wage). There were none recorded in Halton. In St Helens, whilst no males or females were recorded the total for the local authority was 5 as values under 5 have been supressed. The local authority with the largest number of individuals working 16 hours or more was Liverpool (90 individuals) and the proportion of people with learning disability in paid work of 16 hours or more per week is three times the national average, at 6% of all those with a learning disability (2% nationally).

3.14.2 Gender

Amongst males in Liverpool and Cheshire East, 8% and 7% respectively are working 16 hours or more (considerably higher than the national average of 3%). For females. Cheshire East had the highest proportion working 16 hours or more (6%) with Liverpool (3%), Sefton (2%) and Warrington (2%) also above the national average (1%) (Table 35).

Table 33: Paid employment of 16 hours or more per week amongst male and female adults with learning disabilities Numbers in paid employment 16 hours+ as % of all those with learning disability of working age (18-64) and known to adult social services, 2013-14.

Paid work 16	Male	Female

hours or more per week	number in employment	% in employment	number in employment	% in employment
Cheshire East	40	7%	25	6%
Cheshire West And Chester	15	3%	5	1%
Halton	0	0%	0	0%
Knowsley	5	1%	0	0%
Liverpool	70	8%	20	3%
Sefton	5	1%	5	2%
St Helens	0	0%	0	0%
Warrington	5	2%	5	2%
Wirral	15	2%	0	0%
North West	305	3%	120	1%
England	2105	3%	835	1%

*Note: totals of less than 5 would have been recorded as 0, because of the suppression of small numbers.
Source: NHS Information Centre, Adult Social Care Combined Activity Returns data (ASC-CAR) for 2013/14. Adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in paid employment at the time of their latest review, receiving at least the minimum wage.

Examples Of Local Delivery: Employment

Sefton coast and countryside biodiversity and access project

The Biodiversity and Access Project values and involves people with learning disabilities and other hard to reach groups. The groups are involved in practical environmental projects along the coast and in the countryside. Individuals are offered the chance to improve their skills by being involved in the project. They can also learn new skills and improve their health and wellbeing, gaining qualifications and work experience along the way.

For more information, go to http://sefton.ldpb.info/data/file/file/BAP%20Transitions.pdf

Norton Priory museum, gardens and visitor centre, Halton

Halton Community Services have opened new work based opportunities across the borough which will enable people with disabilities to learn pre-employment skills in order to access the workplace. Resources were diverted from traditional 'bricks and mortar' based day care services to create opportunities structured for business and linked to the commercial world. This was made possible through strong links with Norton Priory Museum, a key service partner, which provides work experiences for those with learning disability and autism in various settings, including the Refectory Cafe, Tea Room, Ice-cream making Parlour, Norton Brewing (a real ale brewery), the Bottling Plant and the Craft Shop.

The 22 community venues across the borough provide meaningful daytime activity and multiple work experience opportunities for 145 adults with a learning disability or autism.

Contact: shirley.dempsey@halton.gov.uk

Achieving People: Sefton

'Achieving People' supports people aged 18 – 64 in Sefton who have a learning disability into unpaid work placements and paid employment.

Clients are supported on a one to one basis by a mentor in their chosen opportunity.

Further details:
http://www.volunteeringsefton.org.uk/index.php?option=com_content&view=article&id=105&Itemid=89

In Summary the demographic data is highlighting inconsistency between health and social care data. This is partially due to the LA using 18-64yrs and GP;s using 18-75+ for example. We need to consider aligning data collection age bands moving forward. This can be considered as part of the development of our dynamic risk registers.

Understanding health and social need is a good way of understanding choice and control in people's lives and an indicator of quality of life indicators.

Understanding data with regard to health and wellbeing will support indicators/outcomes of quality of care. We have included data with regard to mortality and physical health issues as these are often common themes which indicate lack of access to mainstream services and or complexity in need which often contribute to challenging behaviours.

The use of Care and Treatment Reviews has given an added understanding to the needs of people in long stay hospitals, and people at risk of admission. Triangulating the data to understand the cohorts and being able to use this to develop and plan services will be part of the priorities moving forward.

Further exploration of the children's data, with regard to identifying children with learning disabilities and 52 week placements is required and understanding children's pathways which result in them being at risk of being known to the criminal justice system. this will form part of initial developments of the 'offender pathway and early intervention for people with challenging behaviour.

3.15 Analysis of inpatient usage by people from Transforming Care Partnership

In recent years the commissioning and provision of LD services, both community and in-

patient provision across C&M have undergone significant change. C&M acute in patient and community learning disability provision is principally provided by the 3 Mental Health Trusts serving the area; Merseycare NHS Trust, 5 Borough Partnership NHS Foundation Trust and Cheshire Wirral Partnership NHS Foundation Trust.

The remaining A&T bed capacity is showing declining rates of activity, which will in time, enable a further reduction in capacity. However such an ongoing reduction may put at risk the viability of the current patterns of provision were A&T units/beds are available within the footprint of each trust / commissioning hub i.e. Cheshire, Mid Mersey, and North Mersey. The issue of viability will need to be considered as part of future planning within the Transforming Care agenda.

3.15.1 Assessment and Treatment units

Currently there are 4 acute assessment and treatment (A&T) units across the Cheshire & Merseyside footprint offering a total of 41 beds as outlined below:

- 9 Beds : Star Unit, Merseycare, Liverpool
- 10 beds: Byron Ward, 5 Borough Partnership ,Warrington
- 10 beds: Eastways, Cheshire Wirral Partnership, Chester
- 12 beds: Greenways, Cheshire Wirral Partnership, Macclesfield

Over the previous 5 years, LD bed usage across the Cheshire & Merseyside footprint has declined as a result of:

- the closure of an 8 bedded A&T unit, Willis House, Whiston 2011 (5 Borough Partnership),
- the closure of the 12 bedded A&T unit, Kent House, Upton 2013 (Cheshire Wirral Partnership)
- Reducing occupancy rates in the four remaining units.

In total, during the past five years (2010-2015), from the initial 61 A&T beds commissioned by C&M, 22 beds or 33% of capacity have closed

All providers have been subject to ongoing CQC inspection and all are rated 'Good'.

3.15.2 Mid Mersey Hub

As a result of the service design, a retrospective review of occupied bed days over the 5 year period 2011/12 to 2015/16 has demonstrated a reduction in occupied bed days in Assessment and Treatment (A&T) beds across Mid Mersey (Table 34 & 35).

In Warrington occupied bed days in A&T beds have reduced by 1300 bed nights annually or approximately 500% (table 2). Occupied bed days in A&T beds in Knowsley have also reduced by 1200 bed nights annually or approximately 400% (Table 35)

Table 34: Warrington A&T LD Occupied bed activity 2011-2015

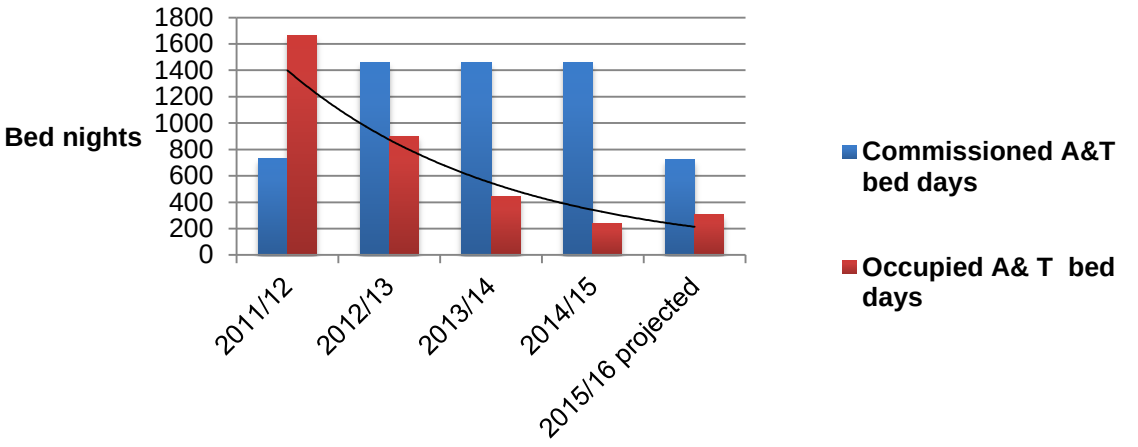
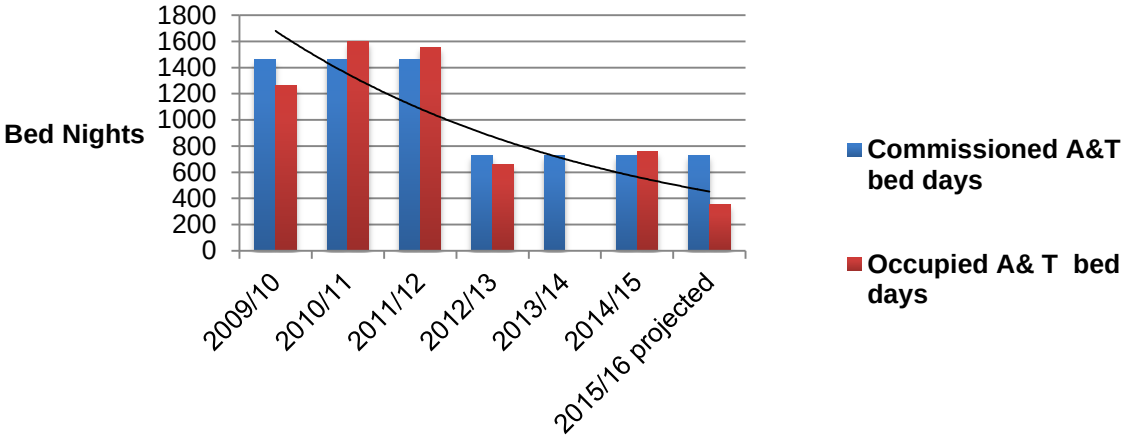
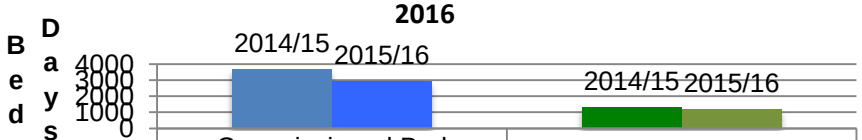


Table 35: Knowsley A&T bed days 2009-2015

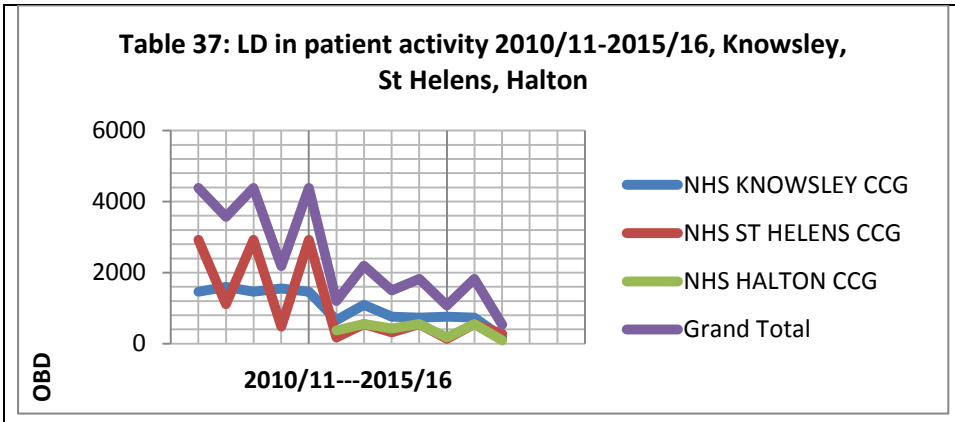


Tables 36 & 37 demonstrates that from the activity trends presented, Learning Disability occupied beds days within A&T units for the whole Mid Mersey area (Halton, St Helens, Knowsley, Warrington) is projected to fall by 128 bed nights, or 13% in 2015/16 compared to 2014/15.

Table 36: Mid Mersey LD A & T In patient activity 2014-2016



	Commissioned Bed days	Occupied bed days
2014/15	3650	1310
2015/16	2912	1182



3.15.3 Cheshire Hub

There are two Assessment and Treatment Units in the Cheshire and Wirral Delivery Hub area, therefore a proportion people requiring these services remain in the local area. The units are also used by some out of area commissioners where no Assessment and Treatment facilities are provided e.g. Trafford.

The overall inpatient Assessment and Treatment bed provision is 22 beds, of which 16 are commissioned by local CCGs (although there is no set allocation per CCG), the remainder being available for spot purchase by out of area commissioners.

Within the Cheshire footprint the overall occupancy for A&T unit bed activity has slowly declined over the last 5 years as demonstrated in Table 38

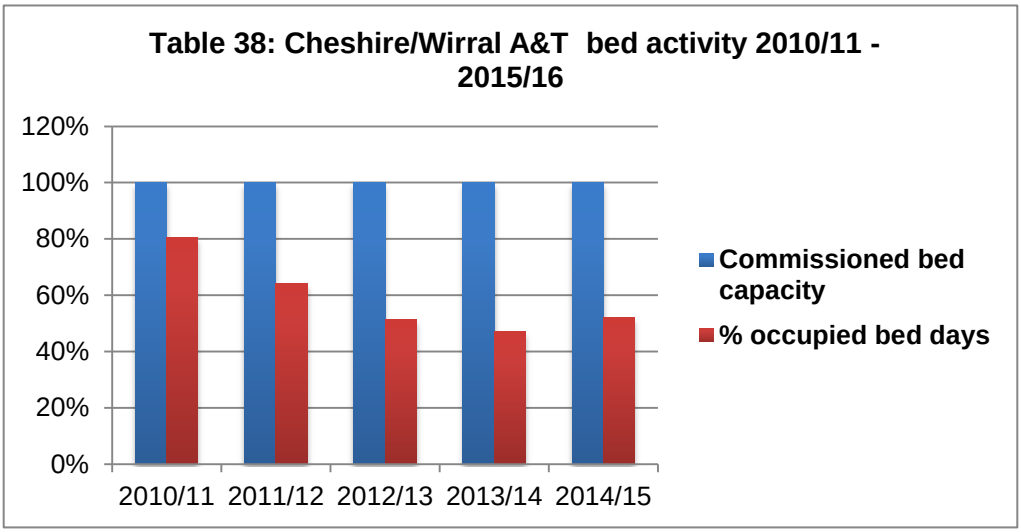


Table 39: CWP Ward specific occupancy rates

	2010/12	2011/12	2012/13	2013/14	2014/15
Eastway (10 beds)	87.89%	81.43%	58.88%	45.23%	51.03%
Greenways (12 beds)	80.14%	62.66%	50.57%	48.56%	52.69%

Kent house (12 beds)	74.91%	51.18%	43.78%	**Closed**	**Closed**

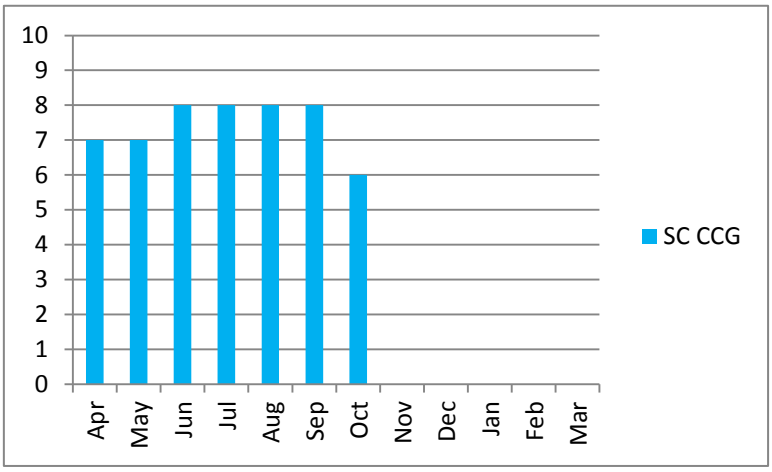
(Data Source Cheshire Wirral Partnership FT)

Because of falling occupancy rates, Kent House a 12 bedded A&T unit, based in Oxton, Wirral closed in late 2012/13, reducing A&T bed capacity in Cheshire and Wirral from 34 beds to the current 22. (Table 39)

Inpatient services are also commissioned out of area by all five Clinical Commissioning Groups.

NHS South Cheshire Clinical Commissioning Group
Inpatient figures for April 2015 onwards (Table 40) (to be updated to reflect figs until Jan 16):

Table 40.



NHS Vale Royal Clinical Commissioning Group
Inpatient figures for April 2015 (Table 41) onwards (to be updated to reflect figs until Jan 16):

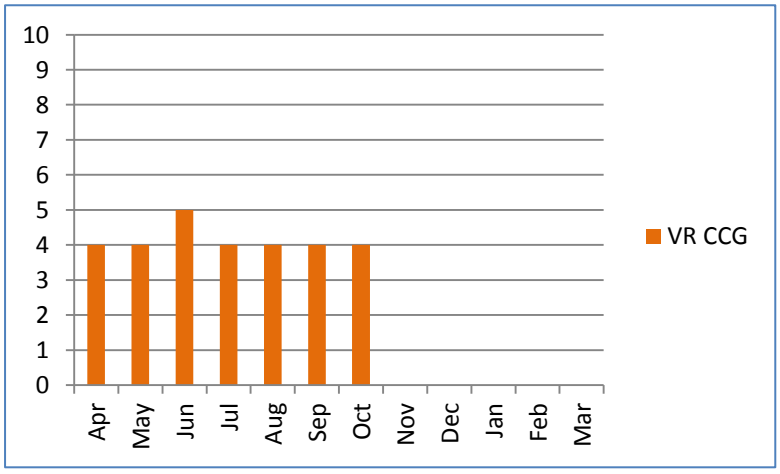


Table 41

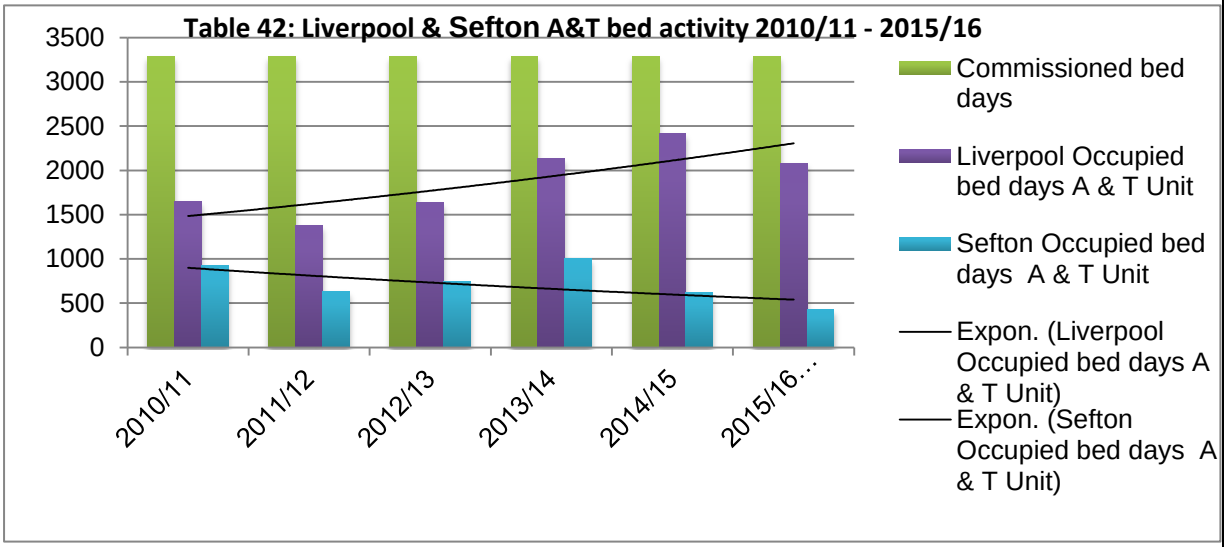
Admission and discharge data for all five Clinical Commissioning Groups is being collated for inclusion in the next draft of this plan.

3.15.4 North Mersey Hub

Within the North Mersey (Table 42) health economy, the pattern of A&T bed activity is more mixed. Sefton area is showing a considerable decline in bed usage over the previous 5 years from 921 bed nights in 2010/11 to a projected usage of 420 in 2015/16; a fall of 53%.

Sefton has throughout this period had a comprehensive community Learning Disability service that has supported individuals with a Learning Disability and Autism with challenging behaviour. The principle service provider is Merseycare NHS Trust.

Liverpool's pattern of activity in the same period has been more erratic with an increase in activity between 2013/14 and 2014/15, however a projected decline in activity of 13% during 2015/16.



(Date Source Liverpool CCG)

Independent data analysis of activity at Merseycare's inpatient facility over a 13 month period from October 2014 to November 2015 generated a number of findings that will be used to improve services going forward. Headline findings are detailed below with full document embedded in plan:

- A total of 18 people were admitted to the facility and 12 were discharged during the period of analysis.
- Two people were subject to delayed discharges at the point of analysis.
- Two thirds of people admitted were subject to legal detention and one was a Community Treatment Order recall.
- The majority of patients were not known to have a gateway assessment prior to admission (88.9%)
- Key factors behind admissions were placement breakdown (38.9%), mental ill health (83.3%), risks to self (83.3% and presenting risks to other people (72.2%)
- The majority of admissions were unplanned (77.8%)
- Half of admissions (50.0%) were regarded as inappropriate for the unit (see below for list of reasons
- Over one third (38.9%) of people had previously been admitted to the unit
- Over half (55.5%) had previously been admitted to other Mersey Care beds
- There was no discharge plan upon admission in a significant number of cases (44.4%)

- In over one quarter of cases there were problems with facilitating discharge due to accommodation or funding issues (27.8%)
- One third of people discharged (33.3%) were discharged to where they came from

Reasons that admissions were regarded as inappropriate
- Does not have a learning disability
- Environment & resources unable to needs
- Environment unable to meet long term needs, requires specialist service
- Environment unable to meet needs – isolation/LTS plan required
- No least restrictive option
- Primary need is mental health
- Recalled from CTO and no mental health bed available

Learning disability and diagnoses
- Over three quarters (77.8%) of people had a mild learning disability or no learning disability
- The primary diagnosis in admission was highly varied including various psychosis and non-psychotic conditions with five people diagnosed with autism
- Two thirds of people had a learning disability and mental illness (66.7%) and a number had a learning disability and personality disorder (11.1%)

Other issues
- 22.2% had a forensic history and 11.1% required security at some stage during their admission
- There were a wide range of negative aspects to being admitted for the person ranging from loss of liberty, routine and independence through to the placement being counter-therapeutic
- Transferred from mental health ward due to vulnerability

In summary the data presented here demonstrates that the client group being supported in the unit are not a homogeneous population and have a wide range of needs that are unlikely to be best supported in the same environment unless it is highly specialised and designed for purpose.

Furthermore, a significant number of people were regarded as unsuitably placed in the service at admission, some point during the admission or due to their discharge being delayed.

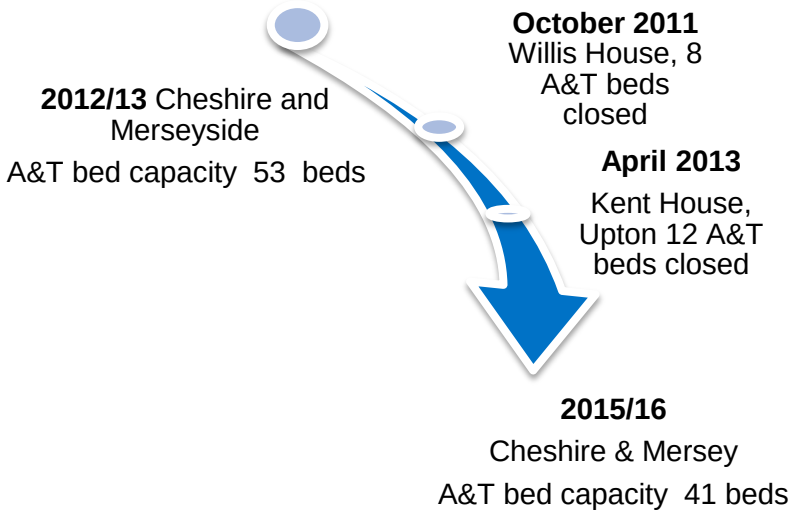
3.15.5 Summary

In total, during the past five years (2010-2015), from the initial 61 A&T beds commissioned by Cheshire and Merseyside, 22 beds or 33% of capacity have closed.

The remaining A&T bed capacity is showing declining rates of activity, which will in time, enable a further reduction in capacity. However such an ongoing reduction may put at risk the viability of the current patterns of provision were A&T units/beds are available within the footprint of each trust / commissioning hub i.e. Cheshire, Mid Mersey, and North Mersey. The issue of viability will need to be considered as part of future planning within the Transforming Care agenda.

Chart 2: Cheshire and Merseyside bed reduction timeline

2010/11: Bed provision in Cheshire & Mersey = 61 A&T Beds



3.15.6 National Planning Assumptions LD Assessment & Treatment Beds

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population (expressed as bed nights 3650 to 5475)
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population (NHS England 2015)

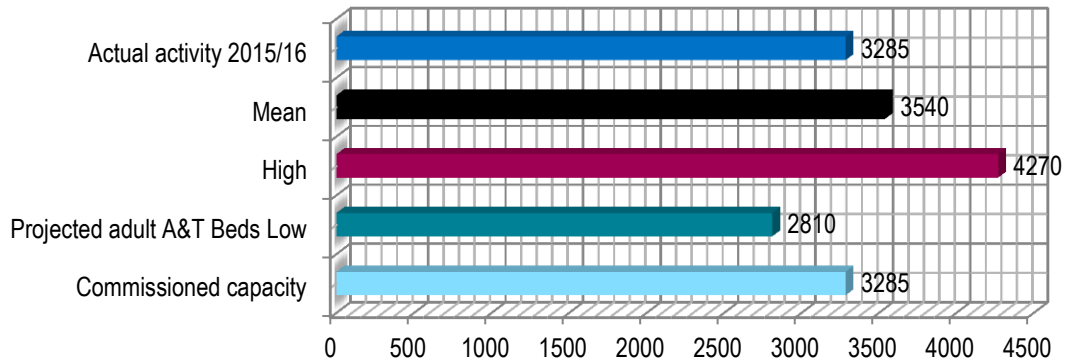
Table 13 below provides a projection of national planning assumptions onto CCG populations and onto Transforming Care commissioning delivery hub populations.

Figures are based on the lowest planning assumption of 10 beds per million population, the highest of 15 beds per million population and a mean of 12.5 beds per million population.

Applying the planning assumptions outlined in Table 13 to each delivery hub produces the ranges below.

3.15.7 North Mersey

Table 14: North Mersey projected LD A&T bed activity with Nation Planning Assumptions applied



North Mersey's current capacity of 9 beds or 3285 bed nights sits between the low projection of 2810 bed nights and the mean of 3540 bed nights. However this misrepresents to significant difference in activity between Liverpool CCG and Sefton CCGs.

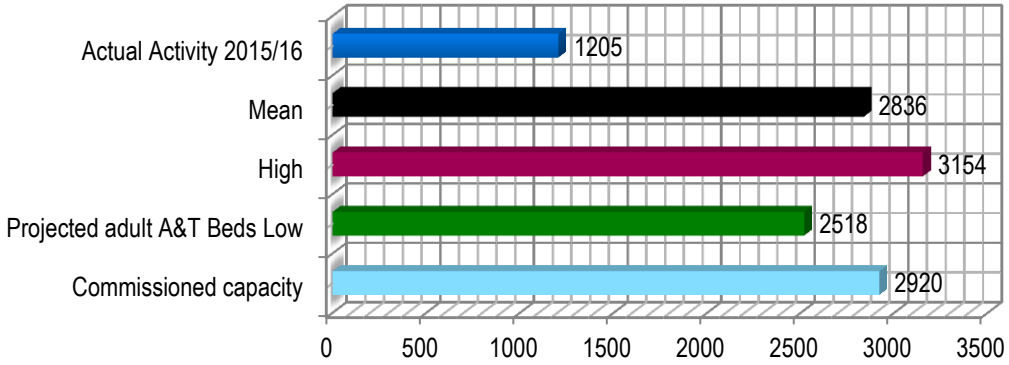
Sefton CCGs are utilizing approximately 450 beds nights per year, in keeping with the lower national projection, and Liverpool CCG utilizing approximately 2350 bed nights per year, which is below the highest national projection but above the national projected mean average.

For Liverpool to move to the national mean average, inpatient A&T activity should reduce by approximately 60 bed nights per year. If this was achieved A&T commissioning capacity could be reduced to 8 beds.

If Liverpool was to match Sefton at the lower projection, then A&T commissioned capacity for North Mersey **could reduce to 7.**

3.15.8 Mid Mersey

Table 15: Mid Mersey projected LD A&T bed activity with Nation Planning Assumptions applied

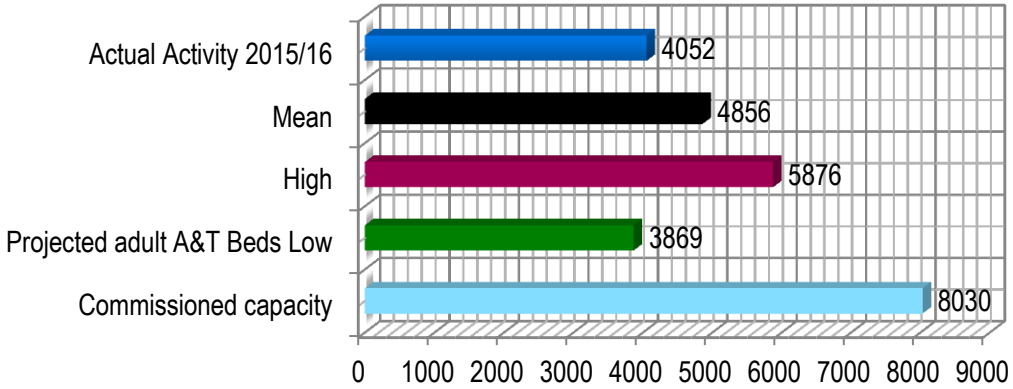


Mid Mersey's current commissioned capacity is 2920 beds or 90 bed nights above the mean

national projections for A&T beds. However actual activity for 2015/16 is projected to be 1205 bed nights or 3.3 beds, significantly below even the lowest national projection of 2518 bed nights for the Mid Mersey population. Therefore commissioned capacity could be reduced from the current **8 beds to 4.**

3.15.9 Cheshire/Wirral hub

Table 16: Cheshire/Wirral projected LD A&T bed activity with National Planning Assumptions applied



Cheshire have a current commissioned capacity of 22 beds or 8030 bed nights, but actual activity for 2015/16 is projected to require 4052 bed nights, or 11.1 beds. This activity rate is 190 bed nights above the lowest national projection **but comfortably below Mean average nation projection for Cheshire of 4856 bed nights, or 13.3 beds.**

3.15.10 Repatriation from Out of Area

Out of Area (OAT) placements across Cheshire and Merseyside pose a number of challenges to Transforming Care delivery hubs. Their use was central to the Winterbourne Incident (2012); an incident that encapsulates all that can go wrong with an OAT.

'Out-of-area placements can bring social dislocation for the service user from their home area, leading to isolation from family and friends. Placements are sometimes isolated from the community local to the facility and may provide little support to facilitate service users' accessing local community resources.

Reports of poor quality of care have been made about some OAT facilities. These include: a lack of documentation about the person's history, a lack of rehabilitative focus and poor adherence to the review processes of the care programme approach (CPA).' (Guide to Good Practice in the use of Out of Area Placements, Royal College of Psychiatrists, 2012)

Utilising data from the NHS England (C&M) Transforming Care Tracker (December 2015), there are 27 patients in CCG funded OATS outside Cheshire Mersey footprint, though most are on the borders of Cheshire Mersey.

In general each commissioned package will be considered high cost and potentially long term. The general reason for each individual OAT will differ, but will involve a lack of local capacity to provide an appropriate care package that adequately addresses the individuals needs presented.

Central to Transforming Care (2015) is the reduction of all inpatient activity, including OATS.

Transforming Care Partnerships and local delivery hubs should therefore consider the following

- A local definition of 'Out of Area' and 'In area', i.e. does 'In area' solely relate to a CCG/LA footprint or is it a Transforming Care Hub area i.e. Cheshire/Wirral, North Mersey or Mid Mersey
- Can packages of care in non-inpatient settings be developed to be delivered 'In Area'?
- Can money released from expensive OATs fund more locally delivered high quality care packages?
- Does capacity exist in local providers i.e. NHS & 3rd sector to deliver packages of care and can it be developed?
- Is there active care management in place for those in an OAT?
- Could national Dowries and over funding outlined in 'Building the Right Support' (2015) support discharge planning and service development?

3.15.11 Summary

There currently 41 Assessment and Treatment beds commissioned for Cheshire and Merseyside. Should all areas achieve an activity rate of 10 per million populations then beds could **reduce to 24 beds by 2019.**

Should all areas achieve the activity rates currently delivered in Mid Mersey then there is potential to reduce total capacity to 12 beds.

It is likely that that such a level may take a number of years achieve and that 24 beds presents a more realistic achievable goal within 2-3 years.

3.16 Secure service provision

The North of England Specialist Commissioning team currently commissions a range of secure/forensic services**.**

3.16.1 Low secure

Low secure learning disability provision has been provided by the Auden Unit, Hollins Park Hospital, 5 Boroughs Partnership FT and the Alderly Unit, Alderly Edge, Cheshire Wirral Partnership FT.

The Auden Unit has 10 beds for females.

The Alderly Unit is a 15 bed all-male unit. This provision is supplemented by use of highly specialist services such as Alpha Hospital, Bury, Alpha Care, with a low secure and medium secure deaf unit for learning disability.

As of December 2015 there are currently 23 individuals from C&M in low secure provision as outlined in Table 43.

3.16.2 Medium Secure

Medium secure learning disability provision is currently provided Calderstones Partnership NHS Foundation Trust. As of December 2015 there are currently 17 individuals from C&M in medium secure provision as outlined. All patients within this provision have been subject to Care and Treatment Reviews in the past year.

Table 43: Specialist Commissioning LD Activity, December 2015, C & M

CCG	Stepdown	LSU	MSU
East Cheshire		1	0
West Cheshire		3	0
Halton		0	4
South Cheshire		2	0
Vale Royal		0	0
Warrington		2	1
Wirral		2	2
Knowsley		1	1
South Sefton	1	4	3
Southport		0	0
St Helens		3	2
Liverpool	1	5	4
Total	2	23	17

(Data Source NHS England Specialist Commissioning Team 2015)

3.17 Out of Area Treatments (OAT) (Locked Rehabilitation Units)

Based on the monthly placement tracker for December 2015, Cheshire & Merseyside has 27 patients considered to be an LD Out of Area Treatments (OATs), in independent hospital services, commissioned by Clinical commissioning Groups (CCGs). Of the 27, all have a care coordinator in place and access to advocacy (Table 44). The distribution of individuals mapped against CCG area generally reflects generic population density.

Table 44: CCG funded Out of Area Treatments Independent Hospitals

CCG	Commissioned OATS In independent hospital	Likelihood of discharge	MH Act status
Liverpool	8	Low 2 Medium 1 Unsure 4	6 - section 3 MHA 1 - section 37, 1- 1 inf
Sefton	0		
Knowsley	0		
St Helens	1		1 section 37
Halton	0		
Warrington	3	High 2 Unsure 1	2 section 3 1 - section 37/41
Vale Royal	1	Low 1	1 – section 3
South Cheshire	3	Medium 2	1 - section 3 1 – section 37 1 – section 47/49

West Cheshire	6	Low – 1 Medium - 1	3 – section 3 2 – section 37/41 1 – inf
East Cheshire	3	Low -2	2 – section 3 1- 'other'
Wirral	2	High - 2	2 – section 3
Total	**27**		

(Data source, Transforming Care Tracker, NHS England)

Of the 27 patients:

- 23 are detained under the Mental Health Act, 1 being recorded as 'other'
- Of the 23
    - 3 are detained under section 37 with section 41 restriction
    - 4 are detained on section 37,
    - 1 detained under section 47/49 (all sections reflect a forensic history
    - the remaining 15 are detained under section 3 for treatment.

Only 2 out of the 27 OAT patients are in placements within the C&M footprint. The majority of the remaining 25 are cared for in hospitals on the borders of C&M in Staffordshire and North Wales, however the furthest placements away from C&M are in Sheffield and Birmingham.

Individuals cared for in secure settings are subject to mental health legislation; therefore, transfer for patients is dependent upon an improvement in their MH state and or risk profile. All patients are subject to the ongoing CTR process and that should ensure active treatment is being delivered and that individuals are progressing on a clear treatment pathway

3.18 Describe the current system

This service baseline is currently reported via the 3 delivery hubs as these are currently the natural patient flows across C&M.

3.18.1
Mid Mersey Commissioning Hub

The Four Borough Commissioning Alliance was established in 2010 to co-ordinate commissioning between the then 4 PCTs of Knowsley, Halton, St Helens and Warrington for Mental Health and Learning Disability Provision. The alliance was inclusive of PCTs and Local Authorities. This work has continued to date as 5 Borough Partnership and included Wigan. This will mean liaison with Greater Manchester plans to ensure alignment.

The Alliance aimed to redesign Learning Disability services by introducing a new Model of Care. This is based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,
- specialist health intervention innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care . Adults requiring additional inpatient support are assessed via the Green Light tool kit to sign post to the most appropriate service.

Repatriation of those in out of area placements.

The Alliance, in developing its Model of Care, consulted extensively with Local Learning Disability Partnership Boards, placing service users at the heart of this process. Its Model of Care was published in summer 2011. The principle service provider is 5 Borough Partnership NHS Foundation Trust. Across the footprint other current Health and Social Care provision is commissioned through Local Authorities, PBSS Services, Social Care Providers, Social Landlords, Independent Hospital Providers and the Voluntary/Third Sector.

The current model of care in recognises all of the 5 cohorts outlined in the national model, however it is recognised by Halton, Knowsley, Warrington and St Helens that further work is required in terms of redesign, commissioning and transformation to sustain positive performance, reduce where appropriate and to optimise outcomes for people with Learning Disabilities where appropriate.

A key challenge for all areas encompassed within this plan is to effectively capture and support individuals who are vulnerable and have lower level support needs, usually managed within the community with minimal or no Health or Social Care input.

The promotion and development of education, health and social care plans, is in line with the SEND reforms.

3.18.2 Cheshire/Wirral Commissioning Hub

Community Learning Disability Teams
Multi-disciplinary Community Learning Disability Teams operate in each locality. CWP has four Specialist Community Learning Disability Teams for Wirral and West Cheshire; with bases in Chester and Winsford, and for Cheshire East with bases in Macclesfield and Crewe

The team plan and provide a range of services for people with learning disabilities who experience additional health needs as well as advice and training for family, carers and support staff. These teams include community learning disability nurses, psychiatrists and clinical psychologists, speech and language and occupational therapists, physiotherapists, health facilitation nurses and Challenging Behaviour specialists.

Assessment and Treatment
CWP has two assessment and treatment units providing specific inpatient assessment and treatment for people with learning disability; the Eastway Assessment and Treatment Unit in Chester and the Greenways Assessment and Treatment Unit in Macclesfield. There are 22 beds across the two units, 10 at Eastway and 12 at Greenways. Some of these beds are designated for out of area patients.

Between, 2009 – 2014, 179 patients were admitted in 237 admissions; 37 were re-admitted within this period, 25 of which on more than one occasion. The shortest stay was one day; the longest stay was two years nine months and fifteen days.

Bed occupancy has declined from 80% in 2010 to just 51.93% 2014-15. NHS England modelling directs one CCG-commissioned bed per 100, 000 populations and therefore there is a current over-provision of A&T beds which must be reduced.

Health Respite Services
CWP also provide adult respite care at Crook Lane Respite Unit in Winsford and Thorn Heys Unit in Oxton, Wirral. The respite units provide short breaks for adults with learning disabilities who have additional complex needs such as profound and multiple disabilities or

challenging behaviour.

Short breaks services
The short breaks service in West Cheshire is led by Vivo the social care provider company from Cheshire West and Chester Council. CWP provides specialist health input. Clients of the service in East and Wirral have been assessed as not having primary health needs as outside their short breaks they live in other settings with family or carers.

Services for Adults with Autism
At present, the only NHS commissioned service for adults with autism (without learning disabilities) are diagnostic services. These are provided by an independent provider (Axia) for the population of Eastern Cheshire, South Cheshire and Vale Royal. This service is provided by CWP for people living in West Cheshire.

We recognise that there is a significant gap in provision for people with autism following diagnosis and this is included in our plans below.

Autistic Spectrum Disorder
For the population of NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups, the community paediatric team based at Mid Cheshire Hospitals NHS Foundation Trust provides diagnostic assessments for Autistic Spectrum Disorder up to 16 years of age but no routine post diagnosis follow up.

NHS West Cheshire Clinical Commissioning Group commissions paediatric services including ADHD and ASD diagnosis from the Countess of Chester Hospital.

Services for Children and Young People
Learning Disability Child and Adolescent Mental Health Services
CWP are commissioned by all five Clinical Commissioning Groups in the Wirral/Cheshire Hub to provide Learning Disability Child and Adolescent Mental Health Services for their population. This is a community based team that provides positioned support for children and young people aged 0-16 who have a severe learning disability, and whose behaviours cause difficulty for themselves and their parents/carers. Referrals to the team can be made by parents/carers or any professional who is working with the child.

Special Needs Nursing Services
East Cheshire NHS Trust provides Special Needs Nursing Services for the Eastern Cheshire, South Cheshire and Vale Royal area. CWP provide community services to the people with special needs within the NHS West Clinical Commissioning Group footprint.

Community Paediatric Services
In NHS West Cheshire Clinical Commissioning Group, the Community Paediatric Service provides assessment and medical treatment for children with Attention Deficit Hyperactivity Disorder and associated sleep difficulties. They also offer brief basic behavioural and sleep advice within the clinic setting and provide Attention Deficit Hyperactivity Disorder / behaviour/sleep leaflets. They refer to other services for associated comorbidities
The service provides assessment and diagnosis for children with autism as well as brief advice and medical treatment for associated sleep difficulties and refer to other services for associated comorbidities, Tier 2 Child and Adolescent Mental Health Service provide assessment and therapy.

The Learning Disabilities Team provide behavioural and sleep assessment and support for families and children who have severe learning difficulties
Speech and language therapy and occupational therapy provide their services based on need following a referral. Some initial work has taken place in West Cheshire on reviewing

the care pathways and some gaps have been identified.
Information re services for children with Autism in Eastern Cheshire and Wirral requested but unavailable within timescales.

Contracting arrangements
All five Cheshire hub Clinical Commissioning Groups hold standard NHS contracts with CWP which will be renewed for a three year term with effect from 1 April 2016. The terms of the contract and schedules will continue to be reviewed on an annual basis.

CWP services are currently commissioned on a block contract basis by all five Clinical Commissioning Groups. Service specifications are variable between Clinical Commissioning Groups.

Specialist commissioning
NHS England Specialised Commissioning is responsible for the 15 low secure learning disability beds provided by CWP at the Alderley Unit on the Soss Moss Hospital site. The modelling by NHS England suggested 20-25 secure beds per 100,000 and therefore these are at an appropriate level based on population.

Criminal Justice and Liaison Services
There is a Criminal Justice Partnership Board facilitated by NHS England (Greater Manchester & Lancashire). C&M Director of Commissioning is a member of this group. However, there needs to be strengthened relationships to ensure C&M TC Plans are realised moving forward. There is a newly established Health & Justice Quality Group and this for a will be utilised to engage the C&M TC Plans. Across the Cheshire and Merseyside footprint, NHS services work closely with the Police and Courts in providing assessment, support and diversion out of the criminal justice system for those deemed to be vulnerable through a mental illness and/or a learning disability.

The Liverpool and Sefton liaison service provided by Merseycare NHS Trust, in common with services in Cheshire, received additional funding in 2015/16, to support the Police and courts.

The additional funding has resulted in a greater level of detection of and support to individuals with a Learning Disability in contact with the Criminal Justice system. That support ensures referral into LD services for treatment and advice to the courts in regards to sentencing options including deflecting individuals away from custodial sentences and into treatment services.

This service provision, though primarily targeted at the mentally ill, provides those with LD an alternative to custody. For a small number of individuals a custodial sentence leads to deterioration in prison and referral to specialist low or medium secure LD beds commissioned via Specialist Commissioning. Criminal Justice Liaison services can provide an alternative to custodial sentences and direct this activity entry into local non forensic LD services.

3.18.3 North Mersey Commissioning Hub

Merseycare provide community rehabilitation and low, medium and high secure inpatient facilities. They have a collaborative commissioning arrangement with Liverpool CGG taking the lead commissioning responsibility on behalf of South Sefton, Liverpool, Knowsley and Southport and Formby CCGs.

- Secure division ie Ashworth, Scott and Garth Units

- Low secure services
- 4 community hubs
- Psychiatric liaison in all acute trusts across C&M
- Care & Treatment triage with Merseyside Police.
- Forensic outreach service (Excellent in CQC inspection)
- Assessment and treatment provision is provided at the 9 bedded STAR unit.

In South of Liverpool Merseycare LD staff currently provides additional support to those individuals with a learning disability who have complex physical health needs in an existing LD provision. The site currently consists of 3 bungalows for 6 people and 3 houses for a total of 6 people that through future adaptations could be used for independent living training.

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

There is a comprehensive estates mapping nearing completion outlying both NHS and independent provider properties. Full detail is available with outline information described at hub level below

3.19.1 Cheshire/Wirral hub

Wirral Local Authority has recently transferred assets along with service provision in its Local Authority Company which delivers day service provision, Wirral Evolutions. This includes 6 day centres. The company is a wholly owned subsidiary of the council currently with an ambition to move to Independence in 3 years

The council also has a 20 bed respite service provision, Girtrell Court which is currently an option for closure within the council's budget options proposals. We are aiming to have respite provided within the Independent sector, where people can use personal budgets to exercise choice and control

CWP have a 6 bed respite unit based at Thorn Heys in Birkenhead, where they provide respite care.

3.19.2 North Mersey

The North Mersey Delivery Hub has recognised that a full review of all estate will need to be carried out in line with the delivery of the plan. This will be factored in to programme management. Liverpool City Council has submitted plans as to the new specifications for residential and nursing care and support alongside how supported living arrangements will be developed.

3.19.3 Mid Mersey

Across the mid Mersey footprint Housing is provided by registered landlords and individuals have their own tenancies. Further adapted accommodation is being built in some boroughs to support repatriation and provide accessible accommodation to meet specific needs of those with LD and ASC.

Some boroughs have also developed core and cluster/core and flexi style accommodation, which focuses on independence, individualised tenancies in one complex with 24hr oversight from a support provider.

Small residential homes are also commissioned for people with LD.

Each area has existing framework agreements with their Social Providers. Some areas are also reviewing their existing frameworks.

3.19.4 Challenges

The challenges for our housing and market development will be in relation to meeting the needs of people with complex and high risk profiles coming out of long stay in patients including forensic services. There is a need to develop a range of housing opportunities and supportive care providers with resilience to meet the challenges of this cohort.

Work is already underway with CWP, Wirral CCG, Wirral Local authority and registered social landlord to develop an extra care housing facility in the community. See section 5.11 for further information.

3.20 What is the case for change?

Building the right support identifies the need to provide good services for people with a learning disability and /or autism.

Our case for change is based upon reviewing out current models of care and their effectiveness, assessing them against the national service model. Reviewing the findings of the Joint Strategic Needs Assessment. Assessing the evidence from a number of documents, strategies, national and local information sources. It also reflects feedback from local people, including self-advocates and carers, about what matters to them.

We have also considered

- Recommendations in national policy documents
- Priorities identified through the Learning Disabilities Self-Assessment Framework
- Local strategic information used to identify gaps in support
- The principles of the Integrated Personal Commissioning Pilot in Cheshire West and Chester
- Local partnerships, for example, Vision 2020 in Wirral, which sets out a 5 year vision for reduced dependency on traditionally commissioned services with people maximising the use of their locality assets and natural networks to act and be more independent.

Many of the principles and priorities within these are consistent with the nine core principles as outlined in Building the Right Support, and these form the basis of our vision.

3.20.1 How can the current mode of care be improved?

We recognise that there are areas of good practice identified within the Cheshire locality which include:

- Access to Learning Disability health facilitator across the area
- Local area coordinator's scoping available services
- Individualised Person – centred planning/integrated budgets including personal health budgets
- Improved communication between Hospitals and Primary Care
- Lots of work with Hospitals on reasonable adjustments, GP Training, Health Champions (Training)Services score high on CQC ratings for Caring and Effectiveness
- Service users are routinely involved in recruitment within CWP and in assessing Services
- We have seen a reduction in the number of people with learning disabilities in assessment and treatment services
- Ongoing commitment from partners to joint working on the Learning Disabilities Self-Assessment Framework
- National IPC pilot site

However there are some key opportunities to develop both health and social care / community facilities and support networks to develop better services, which will be about access to support based on an individual's needs, with an aim to

- Improve quality of life
- Keeping people safe
- Having choice and control
- Having good support and interventions in the least restrictive manner
- Achieving equitable outcomes comparable to the rest of the population

3.20.2 Health Provision

We have identified some significant gaps in terms of support to people who may be at risk of admission, including 24/7 crisis support and/or access to step up/step down facilities. We will be looking to develop pathways to ensure support from both mainstream Mental health services and learning disabilities services, providing flexible /enhanced ways of working to meet the needs of people. There are opportunities to build on current good practice found in localities and spread these across the 3 hubs to ensure consistency of approach and service provision for all of Cheshire & Merseyside (C&M).

This will include developing dynamic registers which can support multi-agency complex care planning, development of services, care and support including lower level support for people with low level needs, and Autism. Whilst also ensuring person centred contingency plans, to reduce risk of admission. Triggering early intervention and crisis response as required. This register will need to consider children and young people care needs.
Autistic Spectrum Disorder; development of these service will need to be explored in line with supporting access to mainstream services and supportive low lever need, along with consistent provision and support re diagnostic services

3.20.3 Physical health and wellbeing

There are areas of good practice within the Cheshire and Wirral delivery hub, supported by a willingness to consider joint working, and some of the priorities identified within Building the Right Support e.g. increasing uptake of health checks are areas where Cheshire and Wirral currently performs relatively well when considered in a national context. However, we will not be complacent about these elements of service provision and we will look to consolidate our position over the next three years and ensure that good practice is sustainable for the future. We will work with primary care to continually improve the uptake and quality of health checks. We will consider alternative ways to deliver these checks if improvements are not achieved. We will continue to work with Public Health England to improve uptake of cancer screening programmes among our population.
The Learning Disabilities Self-Assessment Framework and other local strategic information to inform us about gaps in support, and how we can deliver improvement to services.

Whilst there has been real improvement since 2011-12 there are three key areas where we need to continue to improve; these are:

- Recording of learning disability status by health services, e.g. GP practices and screening programmes. Evidence of reasonable adjustments by services, such as lifestyle support services, primary and secondary health services.Annual Health Checks and Health Action Plans completed by GP practices

We are currently carrying out a review of deaths among adults with learning disabilities, based on the findings of the Confidential Inquiry in 2014. The work will be completed in Summer 2016 and we will reflect the findings and recommendations in our plans.

3.20.4 Development of health and social community services

There is currently no consistent definition of the role and function of a Community Learning Disability Team. As a result, teams are based on models of support that pre-date much of the Transforming Care agenda. We will agree a consistent specification and standards for these services that will reflect the new service model and deliver a consistent quality of support whilst allowing enough flexibility to reflect local need. This will be considered with regard to meeting the need of all ages.

Key new roles have been identified such as the health and social care navigator; there is an opportunity to develop this role and explore how this role will work with the cohorts of people's needs.

3.20.5 Children and young people's services:
We will continue to develop support to parents and families, and ensure early intervention for children with Learning Disabilities and Challenging behaviour is accessible. Children and adult LD services are fragmented and there is an opportunity to develop pathways which support child to adult transition, ensure the appropriate service(s) is engaged early in Educational Health Care Plans, and throughout transitions along with supporting access to the appropriate service via alignment with CAHMS transformation programme.

3.20.6 Specialist commissioning
Working with Specialist Commissioning there will continue to be a need to develop pathways to support discharge of patients; this will include the need to continue to develop appropriate forensic support for people in the community and at risk of admission. We are aware of our current in patient numbers and people who require support for discharge. This is currently part of our CTR planning process with Specialised commissioning and are actively monitoring and progressing discharges in a safe and timely manner.

3.20.7 Access to preventative/ proactive interventions
There is a growing need to ensure criminal and justice diversion teams are accessible for people with a learning disability, and police liaison, street triage become a part of the offender pathway. Merseycare provide a care and triage service with Merseyside police.

3.20.8 Commissioning and contracting services
We will be looking to ensure Positive behavioural support is integral, and quality of life outcome measure are achieved. The aim will be to develop a provider framework, to ensure good standards of care and signing up to such a framework will be considered for inclusion within contracts and quality monitoring in the future. We will utilise learning from Mid Mersey.

At present, people are fitted into services, rather than the other way around. Commissioning of services for people with Learning Disabilities is fragmented and Processes are system led, with clients assessed for health and social care need services via separate systems. Commissioning is based on the scope of the services already in place as opposed to the specific and holistic needs of people within the cohort.

One of the main aims of the Integrated Personal Commissioning work in Cheshire West and Chester is to develop the provider market so that people have a greater range of options to choose from and the potential to design a person centred service that reflects their needs.

Commissioning is not always based upon delivery of person-centred outcomes, with block contracts and lack of pooled budgets. We would like to develop person centred commissioning as close to the person as possible, with the idea of offering personal health budgets and integrated health and social Care.

3.20.9 Personal health budgets

At present, only a small number of people with learning disabilities access Personal Budgets. The Integrated Personal Commissioning Pilot in Cheshire West and Chester provides us with an opportunity to share learning on the use of personal budgets to increase people's choice and control over the support that they receive.

3.20.10 Developing the provider market

Through the process of carrying out Care and Treatment Reviews, we have identified that many local providers are poorly equipped to deal with people in the event that their behaviour becomes more challenging. Development of care staff and providers to be more resilient and to be able to improve quality of their care. There is an opportunity to open up the market and develop opportunities, including developing community support for people with low level needs, not usually known to health or social care. This will include looking develop further opportunities for a good meaningful everyday life, supporting community resources, activities, education, training and employment.
Liverpool City Region (6 Local authorities) are currently undertaking a baseline mapping of social housing providers which will be utilised as part of this work .

3.20.11 Workforce development

Throughout the journey of development and delivery of the model, there will be a need to consider training and development needs of the workforce, people with and learning disability and their families. This will need to include training to meet current / future needs and new roles as they develop. For example: The health and social care navigator role will be developed to improve of access to services. Positive Behaviour support training has already been identified as a priority.

Positive behavioural support :We will develop a Positive Behaviour Support training framework to support independent and statutory providers with the aim of reducing hospital admission or use of alternative services due to placement breakdown.

3.20.12 Inpatient provision

There are areas of good practice within the Cheshire and Wirral delivery hub, supported by a willingness to consider joint working, and some of the priorities identified within Building the Right Support e.g. reducing the number of assessment and treatment beds where Cheshire and Wirral currently performs relatively well when considered in a national context. However, we will not be complacent about these elements of service provision and we will look to consolidate our position over the next three years and ensure that good practice is sustainable for the future. There will be a need to check viability within the current provider's footprints, as bed usage has reduced and is still reducing. We will have further dialogue with Greater Manchester about the shared provision of in patient provision at 2 of the 3 main providers across C&M.

3.20.13 Access to Education, Employment or Training

Engaging local employers, educational organisations and local communities we will focus on improving opportunities to people with learning disabilities to enable them to live full and active lives.

All of the above will be prioritised as part of our development plans and delivery of our new model of care and demonstrate the development needs within each of the hubs against their current practise. This will reflect service users and families priorities as described in out coproduction examples.

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

4. Develop your vision for the future

4.1 Describe your aspirations for 2018/19.

Our aspirations "Across C&M we are here to make a difference to the lives of people with learning disabilities and give confidence to their loved ones that we are going to do this."

The C&M Transforming care partnership vision is consistent with the national service model and is that:

"People with a Learning Disability and/or Autism, including people with complex and challenging behaviour, can lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support them and their needs in their local community, whenever possible."

This care and support will be:

- Closer to home
- In line with best practice models of care
- Personalised and responsive to individual needs over time
- Based on individuals' and families' wishes
- Value for money

The purpose of the C&M TC programme is to establish a new model of care for people with learning disabilities and/or autism and/or challenging behaviour and/or mental health, promoting prevention and early intervention and reducing admissions to hospital. This will include approaches to building community capacity and reducing dependence on non-settled accommodation. However we also need to ensure basic care and access to services is right for everyone with a learning disability and or Autism; having read the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust (sometimes referred to as the Mazars Report).

We have a number of shared principles identified in our strategy below for C&M. These are high level; however more specific outcomes have also been agreed for some other programmes of work within our delivery hub area.

The outcome aspiration in all 3 hubs is to:

- Improve quality of care
- Improve quality of life
- Reduce reliance on inpatient service (or realigning inpatient capacity as appropriate to the needs of the population)
- Improve Patient/carer/family experience.

By delivery of the strategy and the outcome measure to be considered.

4.2 Our Strategy

Our Strategy is based on the nine core principles described in Building the Right Support:

4.2.1 I have a good and meaningful everyday life.

- Local Authorities will commission supported employment services that can meet the needs of this group.
- Commissioners will work with and manage mainstream activities/services to find

ways to make them accessible, in line with Equality Act duties.
- Proportionate risk taking will be encouraged
- Commissioners will ensure that service specifications are based on person-centred outcomes.

4.2.2 My care and support is person-centred, planned, proactive and coordinated.
- Co-production will be embedded throughout commissioning processes.
- Commissioners will risk stratify their local population of people with a learning disability and/or autism.
- Micro-commissioners should ensure that the person they are supporting has a single person-centred care and support plan, not just those on the Care Programme Approach
- Commissioners will ensure that everyone is offered a local care and support navigator or key worker.
- Commissioners will ensure a multi-disciplinary approach to Education, Health and Care plans, not leaving this only to education

4.2.3 I have choice and control over how my health and care needs are met.
- Care will be provided in the community and as close to home wherever possible. In the event that care cannot be provided within the community, a clear rationale will be given.
- Commissioners will be planning for, and delivering the offer of, personal budgets, personal health budgets and integrated personal budgets beyond rights guaranteed in law.
- By April 2016, Clinical Commissioning Groups will have a 'local offer' for how to expand the use of personal health budgets; this will include people with a learning disability
- Commissioners will work across sectors to develop our community infrastructure, and will consider what additional or different local services are needed to ensure that people with personal budgets have a range of services to choose from.
- Service users will be at the heart of decision-making process and will be supported in managing their own personal budget. Person centred plans will be co-produced.
- Provision will be commissioned along individual care pathways to meet a robust outcomes framework
- Assessment processes will be streamlined
- Budgets and care plans will enable maximum choice and control for people with learning disabilities and/or autism
- Choice and control will be at the heart of all that we do and people will be supported much earlier to improve their quality of life
- Care and support will always be well coordinated, planned jointly and appropriately resourced
- Commissioners will be extending the offer of advocacy through investment in non-statutory advocacy services and should ensure statutory and non-statutory advocacy is available to people who are leaving a hospital setting.
- Commissioners will ensure that advocacy services, including peer advocacy, are independent and provided separately from care and support providers
- Community Learning Disability Teams are commissioned to provide training and

support to people with learning disabilities and their families in order to help them regain control over their own lives and make their own decisions (e.g. the champions health programme)

4.2.4 My family and paid support and care staff get the help they need to support me to live in the community.

- Children's commissioners will ensure availability of early intervention programmes, including evidence-based parent training programmes.
- Children's commissioners will ensure availability of a range of support and training for families and carers.
- Children's commissioners will provide flexible and creative short break/respite options.
- Children's commissioners will work with their local providers to develop models of alternative short-term accommodation.
- Commissioners will develop a group of social care preferred providers that meet the needs of people with a learning disability and/or autism.
- Local authorities will develop Market Position Statements with an explicit focus on this group.
- A provider will be commissioned to provide training and consultancy to local providers, in order that local organisations have confidence to support people during episodes of challenging behaviour.
- An enhanced provider market including the development of social capital and investing and working in true partnership with local voluntary community groups
- Elimination of waste, and delivering greater efficiency and value for money across the whole system
- Robust and consistent performance and quality management of the provision of care
- Better integration and quality of care and support, including better user and family experience of that care.

4.2.5 I have a choice about where I live and who I live with.

- Our aspiration to support everyone to have their own front door, if this is their preference
- Commissioners will co-produce local housing solutions leading to security of tenure that enable people to live as independently as possible, rather than in institutionalised settings.
- Clinical Commissioning Groups CGs will consider allowing individuals with a personal health budget to use some of their budget to contribute to housing costs if this meets a health need and is agreed as part of the individual's care and support plan.
- Commissioners will work with housing strategy colleagues to ensure strategic housing planning.

4.2.6 I get good care and support from mainstream health services.

- We will support people to develop self-reliance and live independently in their community by keeping them physically and emotionally well and supporting self-management;

- Commissioners will ensure that people with a learning disability are offered Annual Health Checks.
- Commissioners will ensure that everyone has the option of a Health Action Plan, and are promoting the use of Hospital Passports.
- Commissioners should ensure that the Green Light Toolkit audit is completed annually, and an action plan developed.
- Commissioners will ensure that practices and care and support pathways within mainstream primary and secondary NHS services are 'reasonably adjusted' to meet the needs of this group, in line with Equality Act duties, and are routinely monitoring equality of outcomes.
- In the event of an unexpected death, this will be reviewed in line with the recommendations of the recent Mazars report and learning will be shared with services involved.

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

- Commissioners will ensure the availability of specialist integrated multi-disciplinary health and social care support in the community for people with a learning disability and/or autism, covering all ages.
- Specifications will reflect a focus on earlier intervention and prevention and avoiding crisis to ensure that people are supported in the community wherever possible.
- Commissioners will ensure that health and social care support in the community is provided by people that have the right skills and capacity to provide the necessary care management support to this group.
- Commissioners will ensure that specialist health and social care support includes an intensive 24/7 support function provided by staff with appropriate skills who are able to respond in the event of a crisis
- Commissioners will ensure inter-agency collaborative working, including between specialist and mainstream services.
- People with more complex needs, including those in receipt of Continuing Health Care, receive enhanced service coordination to reflect the complexity of their conditions/needs.
- Commissioners will agree a consistent service specification and performance monitoring arrangements for Community Learning Disability teams across the locality.
- Ensure that a provider is commissioned to deliver Positive Behaviour Support Training and ongoing support to the provider market.
- Use risk registers to identify people most at risk of admission due to challenging behaviours in order to prioritise Positive Behaviour Support Training and proactively offer support to providers working with these clients.
-

4.2.8 If I need it, I get support to stay out of trouble.

- Commissioners will ensure that mainstream services aimed at preventing or reducing anti-social or 'offending' behaviour are making reasonable adjustments to meet the needs of people with a learning disability and/or autism, in line with Equality Act duties, and are routinely monitoring equality of outcomes.
- Commissioners will ensure the availability of specialist health and social care

support for people with a learning disability and/or autism who may be at risk of or have come into contact with the criminal justice system, offering a community forensic function for this group.

- We will review capacity within existing diversion schemes to ensure they are able to cover the whole of the C&M footprint

4.2.9 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.

- Commissioners will ensure that hospital admissions are supported by a clear rationale of assessment and treatment, and desired outcomes, and that services are as close to home as possible.
- Commissioners will agree a service specification for Assessment and Treatment services across the locality, to include performance monitoring tools
- Commissioners will be working with individuals, families/carers, clinicians and local community services to ensure that the discharge planning process starts from the point of admission, or before.
- Commissioners will be ensuring the appropriate CTR are taking place and are of a high quality, in line with NHS England policy.
- Commissioners will ensure that support for families and carers are part of any commissioning framework
- Commissioners will ensure that there are viable alternatives to hospital admission are available within the locality. These may include crisis respite facilities (step up / down) and would also build in a safety net for times that people need a break from their current living arrangements but hospital admission is not required.
- A local process will be agreed locally to address delayed discharges including shared definitions and escalation processes
- Ongoing liaison with commissioners of secure services to chart progress & plan for discharge
- Resources released by reducing demand for inpatient will be re-invested into alternative models of support that are proactive and focus on crisis prevention and avoidance of hospital admission.

4.2.10 Outcome Measures

See trajectories and possibility for extending bed closure programme up to 2019 in section 3.

What outcomes will change?	What will change be?	How improvement against each of these domains will be measured
Reduced reliance on inpatient services Reduced admissions to in patient LD beds	50 % reduction in admissions to in patient LD beds	To monitor reduced reliance on inpatient services, we will;

Reduced LD inpatient beds in line with national assumptions Reduced Length of stay Increased use of IPC Increased use of personal budgets Development of alternative models of support, including crisis prevention, step up/step down provision Systematic use of Positive Behaviour Support models to prevent escalation up to crisis point	People who are currently in hospital are discharged to less restrictive settings Reduction in number of admissions to inpatient learning disability beds Reduced length of stay Local decision re closure of learning disability inpatient beds in line with national assumptions Increased uptake of alternative models of support	Establish baseline standards and monitor performance Target to be set once current average length of stay has been mapped Use the Assuring Transformation data set To monitor reduced reliance on inpatient services, we will use ; the Assuring Transformation data set uptake of IPC
Improved quality of care Compliance with national Care and Treatment Review policy	100% of people eligible for a Care and Treatment Review will receive review within agreed timescales and with a full panel 100% of people in inpatient settings will have discharge plans (including dates) in place from admission % increase in the uptake of health	To monitor quality of care, we are supporting the development of a basket of indicators exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use by local commissioners of quality checker schemes and Always Events

Continued year on year improvement in health checks and health action plans Commissioned learning disability eye pathway across C&M Increased uptake in screening programmes including Immunisations and vaccines Increased use of personal budgets including Integrated Personal Commissioning	checks in primary care Quality of health checks can be monitored, benchmarked and reported back to GP practices % reduction in people experiencing complications from long term health conditions People with eye conditions have reasonable adjustments made when accessing optometry services % reduction in the number of people with learning disabilities who die of cancer % increase in the number of people who access personal budgets	Health equalities Framework ? Benchmark data to be used to set standards and aspirations for each of these areas locally
Improved quality of life Implement the findings and recommendations from the Cheshire Learning Disability Mortality review (Summer 2016) Use of Personal budgets Commissioning to give individuals greater choice and control Commission support, training and consultancy to providers on Positive Behaviour Support to reduce incidence	% reduction in avoidable and premature deaths Local processes agreed for ongoing review of unexpected deaths % increase in the number of people who access personal budgets	Data on Personal budget uptake numbers Service user feedback Evaluation of Positive Behaviour Support training Health Equality Framework data

of placement breakdown Use of Health Equalities Framework by Community Learning Disability Teams Access to Education, Employment or Training will increase Individualised housing tenancies will increase. Carers respite and support	 Service user experience of using personal budgets Reduction in number of placements breaking down Evidence that Positive Behaviour Support training is being used to prevent escalation Evidence of positive outcomes based on Health Equality Framework Scores	Jobcentre statistical database. Registered Social Landlord tenancy agreements. Increase in respite packages and Carer support.
Improved service user /family experience Increase in reasonable adjustments People will have the opportunity to be involved at every stage of planning and delivering their support.	People give positive feedback about their experience of using services	Learning Disability Self-Assessment Framework Feedback from service users and family forums Coproduction feedback Friends and family test

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

4.3 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.

To deliver this requires that we, as the organisations commissioning and providing care and support in C&M will work to a set of overarching principles as described above as part of our strategic deliverables and this incorporates experts by experience views:

- Improve quality of life
- Keeping people safe
- Having choice and control
- Having good support and interventions in the least restrictive manner
- Achieving equitable outcomes comparable to the rest of the population
- Service users and their families will be at the heart of decisions about their care, providing them with more choice and control over their care including promoting a culture of positive risk taking
- We will assume a person has the mental capacity to make decisions about their care,

unless it is established that they lack capacity for that specific decision – and all practicable steps will be taken to support them to make their own decisions
- We will establish the extent of a person's mental capacity as soon as there is any doubt as to whether the person has the mental capacity to make decisions
- Services will be commissioned which promote prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, including from the Criminal Justice System
- We will encourage the use of mainstream services as the starting point for care and support, available and accessible for those with a learning disability and/or autism
- Where mainstream services are insufficient to meet a person's needs then we will provide access to specialist multi-disciplinary community based housing and support expertise
- We will work in partnership across health and social care commissioners to ensure people's homes are in the community and that service users maintain their own tenancies.
- Commissioners and providers of care and support across C&M will collaborate and share knowledge and experience to achieve the best outcomes for service users, including collaborating regionally across the wider and with NHS England specialised commissioners where appropriate
- People involved in implementing the plan will use a problem solving 'can do' approach
- We will develop cost effective services which promote individuals independence
- We will provide support in the least restrictive setting possible that is therapeutic and safe for all. Where restrictive interventions are required they should be for the shortest time possible
- We will proactively use intelligence from a range of sources to identify and respond to commissioning gaps and to facilitate and shape the local health, social care and housing market
- We will protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise
- We will offer education, employment or training opportunities to ensure full and active life aspirations are achieved.

In particular we will be focusing some work around developments in hubs: having completed a SWOT analysis at the stakeholder engagement events.

4.3.1 North Mersey Hub

Development of positive behavioural support service so that delivery is proactive and systematic for when appropriate. This will be an all age service which aims to intervene early and prevent/mitigate the need for hospital admission.

The impact of transition cannot be underestimated. Education, Health and Care Plans, developed in partnership with young people, their families and carers, provide a written overview of the holistic health, education and social care needs and will be crucial to transition.

A full review of the community learning disability team, alongside a review of respite and supported living services has been undertaken and these findings will be used to develop a system whereby individuals are supported at the right time, in the right place and by the right people.

4.3.2 Cheshire/Wirral Hub

We will commission Positive Behavioural Support training for independent and statutory

providers who support people with behaviour that challenges.
NHS Wirral Clinical Commissioning Group have already developed proposals for the delivery of such training, based on the following principles which could be rolled out to the rest of the delivery hub.

The detailed training plan has been developed and is specific to Wirral, however options to adopt a similar approach across the rest of the area will be considered as one of the potential priorities over the next three years.

- Promoting resilience (e.g. parents/carers and workforce), prevention and early intervention, via work with nurseries/children centres and the Child Development Service.
- Providing care and support to the most vulnerable children/young people with learning disabilities and/or autism who display behaviours that challenge, based on individual need so as to promote “Equitable Outcomes”
- Improving care for children/young people in crisis, so that their needs are met in the right place at the right time and as close to home as possible (“Strengthening community support”). Thus reducing the need for often expensive out of borough placements and unnecessary hospital admissions.
- Improving access to effective evidence-based support, via the delivery of specialists training (e.g. positive behavioural support, person-centred planning, developmental difficulties and autism)
- Parent/carer feedback and patient journeys have identified (i) a lack of Learning Disabilities knowledge and understanding of behaviours that challenge across services, in particular early years’ services and (ii) gaps in services working together. Children/young people with learning disabilities and/or autism and behaviours that challenge quickly become the joint concern of various professionals in the systems that surround them. This provides several opportunities for splitting, breakdown in communication and this cohort falling through the net.
- The provision of workforce development across agencies including health, education and social care, as well as the voluntary sector organisations. Thereby, promoting joint working across all agencies “Sharing good practice” and informing Education, Health and Care Plans (EHCP).
- Improving access for parents/carers to evidence-based programmes of intervention and support. Thus empowering parents/carers in the role as “Experts by Experience” and supporting NHS England’s drive towards the co-worker model (e.g. complementary combination of skills, strengths and experience).

4.3.3 Mid Mersey Hub

The Alliance aims to continue too redesign Learning Disability based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,

- specialist health intervention, innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible
- admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care
- Repatriation of those in out of area placements.

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

5. Implementation planning

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

5.1 Overview of your new model of care

The model of care presented below is founded on the principles of Transforming Care (DH 2015) and those enshrined in Valuing People (DH 2001), re-affirmed in Valuing People Now (DH 2009) of 'Rights, Independent Living, Control and Inclusion', with services delivered in a person-centred way with a focus on enabling service users to access mainstream services including mainstream health services wherever possible. This model reflects those enshrined in the National Service Model outlined in 'Building the Right Support' (2015).

The model is intended also to promote the key objectives of Putting People First(DH 2007) and High Quality Care for All (DH 2008) , which include encouraging choice and control, personalisation, health and well-being, prevention, early intervention, enablement, and delivering services as locally as possible.

There is a significant focus on meeting the needs of people with challenging behaviour and this has taken its direction from the "Mansell report" (DH 2007). The elements of the model concerned particularly with 'repatriation' from out of area placements have been informed by the Key Principles of 'Commissioning service close to home'(DH 2004).

The model of care makes particular reference to:

- Principles and Practice
- Management Support and Commitment
- Workforce Development
- Transition Arrangements
- Community Services
- In-Patient Services
- Repatriation from Out of Area

The core elements of the Learning Disability Self-Assessment Framework (LDSAF) provide a whole system audit of a local area's capacity to support those individuals with a Learning Disability and/or Autism. Therefore the ongoing development of LD services and the inherent Model of Care needs to reach beyond health provision and draw on the collective resources of local communities within which individuals live. Within each locality this is reflected in measures outlined in the LDSAF.

5.2.1 Principles and Practice
Good quality learning disability services will have an approach based on strong community support services, planned around people in the environment that they are in, focusing on person-centred care, and looking at each individual's needs. This approach should be applied to all, including people with very complex needs. The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs.

5.2.2 Management Support and Commitment
Successful services are well organised and managed and deliver an individualised service through skilled staff. They will have a committed group of professional and front-line staff, working with the sustained support of senior policy-makers and managers, (Mansell 'Characteristics of exemplary services').

5.2.3 Workforce Development
Good services invest in training for the direct care staff of the service. Where services have accepted that people with complex needs and challenging behaviour should be a priority they will ensure that all staff are competent in working with them, and are equipped to understand the behaviour and to respond appropriately.

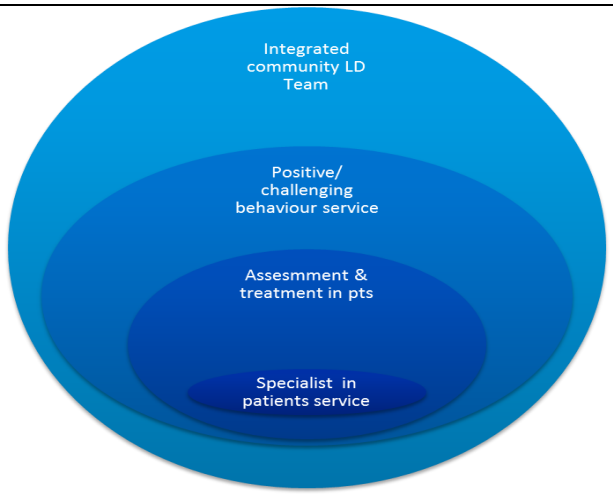
5.2.4 Transition Arrangements
Each area will have in place robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults.

Young people with behaviour that challenges should be the subject of focused attention and support. The arrangements will specify that no young person is placed in a distant residential school or other distant placements when their needs can be met effectively nearer to home.

Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support should be based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation.

5.2.5 Community Services
Comprehensive community support requires:
- An appropriately resourced Community Learning Disability Teams with accessible specialist professional support
- Education, work and day opportunities
- The capacity to respond to crises 24 x 7
- Accessible resources to facilitate effective support for people with complex and challenging behaviour
- Policies and protocols for the prevention of placement breakdown
- Respite / short breaks for carers of people with challenging behaviour
- In patient service the provides timely Assessment and treatment leading to discharge



The model is based on the premise that people with a learning disability or Autism, including people with complex and challenging behaviour, should lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support people with learning disabilities. They will sometimes have physical or mental health problems and should be supported to access mainstream health services. All generic health and social care services should be encouraged to extend the current number and range of Learning Disability/Autism champions to improve the care experience.

There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.

Where they need more specialist support, including specialist support arising from complex and challenging behaviour they will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support.

C&M will make person centred care the default, non-negotiable offer. The use of personalised budgets and the adoption of an all age approach will allow us to build on progress to date.

The overarching principles and strategies will go across the whole of C&M however the hubs will have distinct plans to meet the needs of the local people and the stages of development within the hub.

This will include looking to develop/commission services in a different way , developing the provider market and commissioning new services to meet the needs of all patient groups, including children, young adults, and those with more complex needs, working closely across multi-agencies.

The population data, and the demographics in relation to the cohorts of needs of people, Children and young people, people with challenging behaviours and mental health needs. Autism and people at risk of admission along with people who have contact with the criminal justice system using our specialist commissioning bed gives us a good understanding to the type of service development required to meet their needs whilst also being in line with service model and Building the Right support.

5.3 Models in the hubs

5.3.1 Cheshire/Wirral Hub

Our preferred model of health care would reflect;

- Positive access to and responses from mainstream services
- A focus on positive risk taking rather than risk avoidance
- Support to people with learning disabilities and challenging behaviour that is inclusive of those who have Autism who do not have a defined learning disability, but who still display behaviour that challenge and would benefit from professional intervention
- Targeted work with individuals and services enabling others to provide effective person centred support to people with learning disabilities and their families/carers
- Specialist, time-limited, support for people with complex behavioural and health support to support a quick return home or to an alternative package of care.
- Ability to respond quickly to crisis situations
- Quality assurance and strategic service development in support of commissioners

Assumptions: Commissioners anticipate that the main provider, CWP, will continue to provide a significant proportion of services in the future but consideration should be given to integrated working with providers from other sectors (including social care and the voluntary, third and independent sector) as well as with service users and families.

Commissioners will also be working towards developing the market to ensure a broader range of options are available to people who wish to have more choice and control over the support they receive.

CWP has reviewed its learning disability services to inform future planning. It should be noted that whilst the proposed model broadly reflects national recommendations, it has not been approved by commissioners and as it only reflects health provision, it only represents part of the picture. It is included in this plan as an indication of the way forward, not as an agreed approach at this stage.

5.3.2 Mid Mersey Hub

St Helens, Knowsley, Halton and Warrington are working closely and have developed a core set of strategic objectives which are pertinent to each area, some of which can be developed and implemented using a collaborative approach.

The objectives include:

- Accommodation & Support for people from across the mid Mersey footprint (St Helens, Halton, Knowsley, Warrington) with complex presentations and/or linked index offences who currently are placed in secure settings. Warrington has a facility which is due to be opened in 2016, which could potentially meet the needs of St Helens, Knowsley, Warrington and Halton patients. ASH House Rehabilitation and resettlement service. This is focused at optimising outcomes for the individual patients, their Carers and Commissioning organisations.
- Post Diagnostic Support for ASD /ADHD- a model for ASD has been proposed by 5 Boroughs Partnership NHS Foundation Trust, which focuses on augmented services and support for people once they have received a diagnosis. This is currently a service gap across St Helens, Halton, Knowsley and Warrington. The development of such services is cited in the “Think Autism” national strategy. The focus of this type of service model is community orientated prevention/integration and to avoid the deterioration of people’s Mental Health.
- Supporting People’s challenging behaviour –further support for people in their home and for families requiring psycho therapeutic intervention support (to compliment PBS) across the footprint. In the specific context of PBS Halton and Knowsley

currently have PBS Services in place commissioned via Halton Borough Council. St Helens does not currently have a dedicated or specialist Positive Behaviour Support (PBS) Practitioner employed within or supporting the local Learning Disability Service offer. Whilst practitioners within existing Community Learning Disability teams may have skills pertinent to the assessment for and delivery of behavioural interventions, this is part of the generic skills mix and no dedicated support is provisioned. It is recognised that a dedicated practitioner role within existing services with a remit to coordinate local resources and professional groups could enhance current delivery of and deployment of a PBS model of working within St Helens. Warrington currently has systems in place via the LD Nursing Team, which is currently adequate and fit for purpose.

- Primary Care health checks / Acute Liaison LD Nurse and/or health facilitators in those boroughs that do not currently have this provision. This is to ensure that the Physical health needs of people with Learning Disabilities are addressed (including the cohort of people with LD/Autism 14-18 in transition requiring Health checks), and to ensure that patient mortality is given the level of priority it deserves. The focus of enhancing such services is to address any health inequalities that people with Learning Disabilities and/or Autism face, to reduce health deteriorations which could potentially contribute to admissions and to improve quality of life to reduce the potential for premature deaths as far as possible.
- Peer Advocacy which includes enhancing capacity into the system. It is important to strengthen and enhance the existing offer, in order for people with Learning Disabilities and Autism to continue to contribute to the respective LD/ASD agenda's across Health and Social Care. Co-production is of paramount importance.
- 24/7 – crisis response for people for LD/ASD (e.g. Operation Emblem). Street triage services can potentially be developed or redesigned for the LD /ASD population to avoid admissions where appropriate, and to avoid people with LD/ASD entering the Criminal Justice system.

Commissioners will ensure that the objectives are aligned to the national model and also the national SEND reforms.

Some areas have enhanced operations around Clinical Coordination and CTR's to oversee repatriation and ensure timely discharge from inpatient units is achieved moving forward. The role will include coordinating "blue light reviews" as appropriate and post admission CTR's. Each area needs to consider operations around this going forward to enhance efficiency.

Local Authorities and CCG's are working closely around funding arrangements for people who are detained/admitted under the Mental Health Act or at risk of an admission.

The investment of NHSE Transforming Care funding would be integral to the development and support of these initiatives, in order for St Helens, Knowsley, Halton and Warrington to not only current sustainability but continued progression.

5.3.3 North Mersey Hub

Merseycare are aware that they may not be best placed to be the provider of choice in the future. In order to develop the new models of care a focus on opening the market up to NHS, Independent, third and Voluntary sector organisations to redesign care pathways in:

- Inpatient facilities in the STAR Unit
- Wavertree House Bungalows
- Supported Living Schemes
- Community Learning Disability Teams

A SWOT analysis attempts to capture the summary of views that were obtained from interviews with staff, service managers, senior Trust personnel, service users and commissioners about the future of each of the four service elements. Commissioners who participated were from the CCGs and Local Authorities of both Sefton and Liverpool. Families of service users have not yet been involved in the discussions but plans to do so are in place.

The focus will be on Care Closer to Home, Independent Living and Support and a Hub and spoke service delivery.

5.4 Outline proposals for transforming health provision

As part of the transformation the 3 main NHS Mental Health and Learning Disability Providers, which are:

- Cheshire and Wirral Partnership NHS Foundation Trust (CWP).
- Merseycare NHS Trust
- 5 Boroughs Partnership NHS Foundation Trust

will work in partnership as part of a provider hub to develop and deliver the transformation. This work will be undertaken at scale across the C&M geographical area.

The CWP vision is to move forward using an integrated provider hub model, incorporating personal budgets commissioning where appropriate, based on a robust range of stepped community services that wrap around individuals' and families' needs, to support people with learning disabilities and/or autism to live fulfilling lives at home in their local areas. Through early intervention and crisis prevention, hospital care should rarely be required and when it is, it is only for the shortest period of time.

Discussions have commenced with Providers with regard to economies of scale and lead provider arrangements; this has been considered in a favourable light to date. Examples of discussions have been with regard to community forensic outreach, CAMHS and Positive Behaviour Services.

5.4.1 Short Breaks

A new model for short breaks would be an integrated service, led by social care across the Cheshire Hub area. The model would provide four types of support:

- **Complex** – planned short term support for people with complex physical health needs and behaviour that challenges, which live with carer's in the community. Support would be delivered by social care with specialist health input as and when required from a multi-disciplinary community LD team.

- **General** – planned short term support for people who live in the community with family or carers. This would give carers a break from their caring responsibilities. Personal budgets could be considered as a way to access short breaks away and holidays. Services would be provided by social care and partner agencies experienced in this field.

- **Step-up and Step-down** – Step-up services through integrated delivery led by social care, with input from an intensive support team/function and community services when and individuals' needs cannot be met at home during a time of crisis. Step-down services would provide short-term step-down from a hospital setting when assessment and treatment is complete, as part of the transition to a community setting, or when an individual becomes homeless following a hospital admission.

5.4.2 **Emergency**

Unplanned support when an individual cannot remain in their own home due to carer illness

or other emergency situation, until appropriate community support can be reinstated.

5.4.3 **Intensive Support**
Locality-based intensive support teams would be charged with providing emergency and planned urgent support to prevent hospital admissions. Intensive support would include existing specialist nurses and associate practitioners in community teams, working closely with assessment and treatment and short breaks services. Intensive support could be developed as specialist teams, or as a function within existing Community Learning Disability Teams or as a function within existing Crisis Resolution and Home Treatment Teams which currently operate in mental health services, to provide a seamless crisis pathway.

5.4.4 Complex Rehabilitation & Care Team – Finding Opportunities for Complex Users of Services
Finding Opportunities for Complex Users of Services – the need to FOCUS – would be an extension to the role of the existing Complex Rehabilitation & Care team, incorporating health care coordinators and social workers and other professionals such as housing. The function would be involved in the strategic planning of support systems for clients with highly complex needs; to prevent people being placed out of area and returning people from out of area placements where appropriate. It would work closely with any complex care function and monitor care packages.

5.4.5 Assessment and treatment and complex care
Developing a stepped range of community support services to enable people to live at home in the community will prevent unnecessary hospital admissions and support the reduction of inpatient beds to the appropriate level based on population. To operate the two current assessment and treatment units in line with the appropriate bed numbers (within the range 11-16 for the Cheshire Hub area) would not be viable. Therefore, one assessment and treatment unit could provide a wide range of assessment and management options through a full MDT, in an enhanced personalised environment. Stays would be as short as possible, with close links to the intensive support function and step-down services.

A review of patients with extended stays in assessment and treatment has been started to establish the reason for the length of stay. In some cases there is evidence to suggest that some individuals would have benefited from complex care/rehabilitation support. There may be a basis – possibly regional – for developing a small number of complex care beds with a full MDT. Working with LD professionals the focus would be on developing support packages to settle people back in the community and used as part of a step down process for people placed out of area as part of a transition plan, as well as preventing people from going out of area. Funding would be on an individual basis agreed with commissioners.

5.3.6 Forensic Services
Forensic services operate across the Cheshire Hub area and need to concrete links to other teams and build bridges for people within the service to return to the community, providing a robust forensic pathway. The existing low secure service at the Alderley Unit is within the appropriate bed numbers for the population.

5.3.7 Child and Adolescent Mental Health Learning Disability Service
There are currently no inpatient beds for children and young people with learning disabilities in North West England resulting in individuals being placed out of area. Subject to modelling there may be case to develop a small number of these specialise beds to support our children and young people close to the area. Note that commissioners have made no commitment to this proposal and would expect to see data to demonstrate the need for this service.

5.3.8 Autism

Dedicated training must be provided to staff across health, social care and other services to help them understand the needs of people with autism – those with a learning disability and autism and those with autism but no learning disability.

5.3.9 Universal Services

Universal health services such as primary care, GPs, dentistry and optometry should all have an awareness and understanding of how to support people with learning disabilities and/or autism and address their needs as they would with any other customer or user of services. The same principle should apply to other universal services such as libraries and housing services. The role of universal services will be crucial in supporting people to live fulfilling lives in the community and awareness-raising and basic training could be used to help address issues following a stock take of issues and barriers.

5.3.10 System-wide transformation

Delivering the transformation agenda to make fundamental and positive changes for people with learning disabilities and/or autism will require a single vision with the scope for local needs to be addressed across commissioners and providers in health and social care, as well as housing providers and the voluntary and independent sectors, as well as ensuring a understanding of the needs of people with learning disabilities and/or autism throughout universal services.

5.3.11 Other Components

Other components within a future model of care not described in the CWP proposal above will include the following.

5.3.12 Community Learning Disability Teams

An appropriately resourced Community Learning Disability Teams with accessible specialist professional support, working to a consistent specification and quality standards across Cheshire and Wirral, delivering four key components of care:

- Work with those individuals who present as challenging and those at risk of admission ensuring appropriate management plans, including crisis plans are in place and delivered.
- Support Primary Care and Hospital services in delivering high quality health services to promote and maintain good health and well-being for people with learning disabilities. This includes access to mainstream health screening services, encouraging individuals to attend of GP Health checks when offered and supporting health providers to make reasonable adjustments to promote inclusivity of those with a learning disability and / or autism
- Proactively work with adolescents about to transition to adulthood to ensure such a transition is smooth and well managed.

5.3.13 Management Support and Commitment

We will ensure that services are well organised and managed and deliver an individualised service through skilled staff. They will have a committed group of professional and front-line staff, working with the sustained support of senior policy-makers and managers, (Mansell 'Characteristics of exemplary services').

5.3.14 Workforce Development

We will ensure that our services invest in training for the direct care staff of the service. Where services have accepted that people with complex needs and challenging behaviour should be a priority they will ensure that all staff are competent in working with them, and are equipped to understand the behaviour and to respond appropriately.

5.3.15 Transition Arrangements & links with other Transformation Plans

We will ensure that we have in place robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults. Links with Greater Manchester with regard to Cheshire and Mid Mersey Commissioning Hubs has already taken place but will require closer working arrangements to realise the alignment necessary.

Young people with behaviour that challenges will be the subject of focused attention and support. The arrangements will specify that no young person is placed in a distant residential school or other distant placements when their needs can be met effectively nearer to home.

Effective transition support will be based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation.

We will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs, specifically children, young adults, and those in contact with the criminal justice system.

5.3.16 Other transition/crisis points
CWP would need to play a key role in helping to support and plan for clients at particularly vulnerable periods of their life, for instance, interaction with the criminal justice system, and for those clients that are also known to mental health services. Where plans are put in place for such individuals, it will be expected that CWP would be a key contributor to these.

5.3.17 Specialised Commissioning
We would want CWP to develop a robust pathway with specialised commissioned services (e.g. forensic units), so that people are able to be stepped up and down as appropriate, with early and co-ordinated discharge planning.

5.3.18 Joint working
Where it is necessary to devise a package of care to ensure that an individual can be supported safely and effectively within their own home or a community setting, we would expect CWP to work together with other professionals to plan this package and to review its effectiveness over time. As part of this we would be looking for CWP to build up a good knowledge of and relationship with community assets and partners, to further promote independence and keep the person safe and well within the community.

5.3.19 Outcomes based commissioning
Commissioners are looking to move towards more outcomes-based service delivery, and services without age boundaries, and we would be looking for CWP to work with us to achieve this, supporting us to develop and measure against meaningful outcomes.

5.4 What new services will you commission?

5.4.1 Cheshire/Wirral Hub

Specialist Challenging Behaviour Function

- All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role.
- Increase the capacity of community based support to prevent people being admitted to hospital. Development of Positive Behaviour Support framework including training for a wide range of providers.

- People whose behaviour presents a serious challenge to services will be identified, and the services that are assessed as necessary to meet their needs developed, through a person centred planning process. The plans will be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back up resources can be made available to sustain arrangements through difficult periods.
- There will be access to specialists who are knowledgeable about challenging behaviour who can provide specific support with individuals and more general advice, information and training.

NHS Wirral Clinical Commissioning Group intend to commission LD services that would encompass the following characteristics:

- Coproduction with services users and carers
- Integrated MDT approach
- Colocation of Local Authority and Health Teams
- Co-commissioning with the Local Authority
- Extra care housing
- Crisis beds
- Additional staff to undertake all the reviews of the LD packages of care, this we would look to match fund. The cost of which would be the equivalent of 4 band 7's (£203,181, Please note this is based at 15/16 pay scales, top of scale, and includes 24% on costs) both Local Authority and Health would employ dedicated staff to undertake this work stream. The outcome of which would be that people would receive a more appropriate and up to date package of care with built in person centred outcomes.

5.4.2 North Mersey Hub

- Positive Behavioural Support will be offered proactively and systematically. We are aware of the model utilised in Mid Mersey and are exploring whether this is transferable to North Mersey.
- Defined services to support safe transition from children to adult services. This will involve close working with Alder Hey Children's NHS Trust and Children's Disability Services. Much work is being undertaken for assessment, diagnosis and support for children and young people who may have ASD. Closer links will be developed over the next 6 months to ensure that this work is reflected in Transforming Care.
- Pooled budget arrangements will be progressed across health and social care.
- Introduction of personal health budgets- we are aware that Cheshire and Wirral have examples of good practice with the use of PHBs and uptake is low in North Mersey.
- The strategy will include the development of an outcomes based framework for commissioned services.
- Care and Treatment Reviews will become systematic and the necessary infrastructure developed to support their delivery. We are currently encouraging our providers to explore reciprocal arrangements with other Trusts to ensure effective use of resources.
- The plan will look to address delayed discharges and develop an appropriate escalation policy and process that triggers appropriate and proportionate to the needs of the individual.
- Development and delivery of step up/step down care.
- The Single Assessment Framework will be used to identify gaps in provision and services developed accordingly.
- The review of the Community Learning Disability Team will be used to inform new model of care and delivery that releases capacity and appropriate levels of care and support- this will include review of how a Positive Behaviour service fits/aligns with

this.

5.4.3 Mid Mersey Hub

St Helens, Knowsley, Halton and Warrington are working closely and have developed a core set of strategic objectives which are pertinent to each area, some of which can be developed and implemented using a collaborative approach.

The objectives include:

- Accommodation & Support for people from across the mid Mersey footprint (St Helens, Halton, Knowsley, Warrington) with complex presentations and/or linked index offences who currently are placed in secure settings. Warrington has a facility which is due to be opened in 2016, which could potentially meet the needs of St Helens, Knowsley, Warrington and Halton patients. ASH House Rehabilitation and resettlement service. This is focused at optimising outcomes for the individual patients, their Carers and Commissioning organisations.
- Post Diagnostic Support for ASD /ADHD- a model for ASD has been proposed by 5 Boroughs Partnership NHS Foundation Trust, which focuses on augmented services and support for people once they have received a diagnosis. This is currently a service gap across St Helens, Halton, Knowsley and Warrington. The development of such services is cited in the "Think Autism" national strategy. The focus of this type of service model is community orientated prevention/integration and to avoid the deterioration of people's Mental Health.
- Supporting People's challenging behaviour –further support for people in their home and for families requiring psycho therapeutic intervention support (to compliment PBS) across the footprint. In the specific context of PBS Halton and Knowsley currently have PBS Services in place commissioned via Halton Borough Council. St Helens does not currently have a dedicated or specialist Positive Behaviour Support (PBS) Practitioner employed within or supporting the local Learning Disability Service offer. Whilst practitioners within existing Community Learning Disability teams may have skills pertinent to the assessment for and delivery of behavioural interventions, this is part of the generic skills mix and no dedicated support is provisioned. It is recognised that a dedicated practitioner role within existing services with a remit to coordinate local resources and professional groups could enhance current delivery of and deployment of a PBS model of working within St Helens. Warrington currently has systems in place via the LD Nursing Team, which is currently adequate and fit for purpose.
- Primary Care health checks / Acute Liaison LD Nurse and/or health facilitators in those boroughs that do not currently have this provision. This is to ensure that the Physical health needs of people with Learning Disabilities are addressed (including the cohort of people with LD/Autism 14-18 in transition requiring Health checks), and to ensure that patient mortality is given the level of priority it deserves. The focus of enhancing such services is to address any health inequalities that people with Learning Disabilities and/or Autism face, to reduce health deteriorations which could potentially contribute to admissions and to improve quality of life to reduce the potential for premature deaths as far as possible.
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- 24/7 – crisis response for people for LD/ASD (e.g. Operation Emblem). Street triage services can potentially be developed or redesigned for the LD /ASD population to avoid admissions where appropriate, and to avoid people with LD/ASD entering the Criminal Justice system.

Commissioners will ensure that the objectives are aligned to the national model and also the national SEND reforms.

Some areas have enhanced operations around Clinical Coordination and CTR's to oversee repatriation and ensure timely discharge from inpatient units is achieved moving forward. The role will include coordinating "blue light reviews" as appropriate and post admission CTR's. Each area needs to consider operations around this going forward to enhance efficiency.

Local Authorities and CCG's are working closely around funding arrangements for people who are detained/admitted under the Mental Health Act or at risk of an admission.

The investment of NHSE Transforming Care funding would be integral to the development and support of these initiatives, in order for St Helens, Knowsley, Halton and Warrington to not only current sustainability but continued progression.

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

5.5.1 Cheshire/Wirral
We aim to reduce the number of people placed out of area, through the development of good alternative that are closer to home and a repatriation process as well as a focus on preventing admissions

Any resources saved in as a result of the repatriation process will be reinvested in local community based services

Commissioners will not cease any of its LD or Autism services but as outlined above would be commissioning services that would be in line with the national guidance as listed at the beginning of this section.

We would stop commissioning respite beds in order to support the provision of crisis beds.

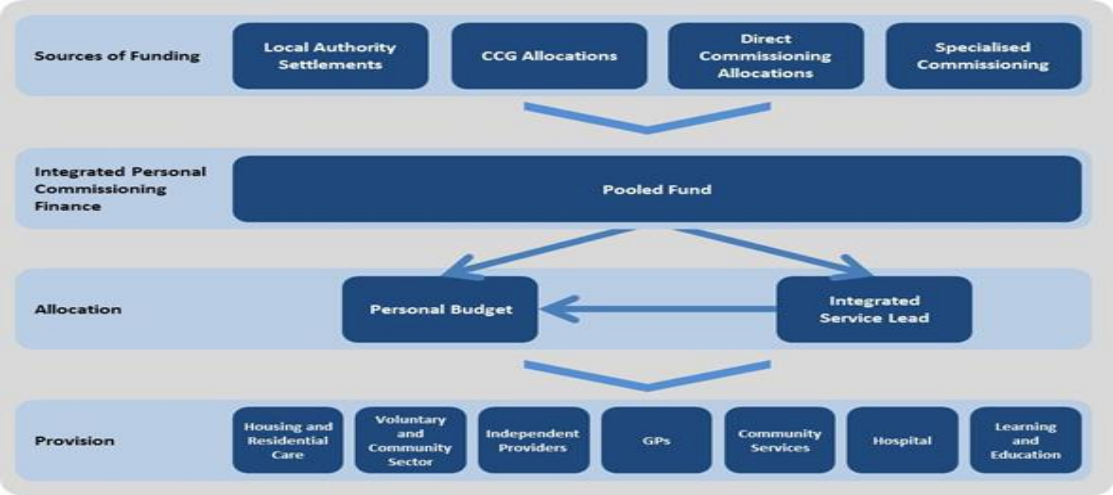
5.5.2 North Mersey
There will be a review of models of delivery to allow for better usage – e.g. forensic support.
There will be reductions in general residential placements, that allow for a more personalised approach to commissioning support
Reduced use of A&T beds

5.5.3 Mid Mersey
Less Residential Schooling Placements.
Less out of area Hospital and Acute Placements including rehab.

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

5.6.1 Cheshire/Wirral Hub
Within each locality within the hub we are working together to ensure that monies across the economy are used effectively for people and would be aiming to achieve an integrated approach depicted in the diagram below which is based on the current Integrated Personal Commissioning Model.

Whilst it is acknowledged that not all areas within the hub are direct members of the IPC, the approach is open to all and should the IPC be deemed successful this could well be the way that we will be directed to use resources in the coming few years.



Commissioners expect services to adopt a more integrated and multi-disciplinary team approach with colocation, where appropriate, with the relevant Local Authority Teams.
We aspire to provide a more wrap around service with facilities to step and step down as required.
We would also commission CWP to be more inclusive of people with Autism and challenging behaviour.
We would expect to have a reduced number of inpatient beds.

5.6.2 North Mersey

An integrated approach to commissioning services will reduce duplication of effort and allow for a whole systems approach. NICE guidance will be used to self -assess against pathways. 'Always events' will be developed with service users to improve experience of care.

Transition has been recognised as a gap and will be a key focus for improvement – the use of the transition CQUIN will help to support this improvement.

The development of a Learning Disability CQUIN with providers will strengthen the infrastructure in universal services.

The Youth Mental Health Strategy will also support improvement.

For those areas without any current out of area placements, consideration will need to be given in relation to the long term sustainability of maintaining the status quo.

Access to capital monies will support in improving the estate and environment in which people receive care.

5.6.3 Mid Mersey

- More pooled budget arrangements.
- Mid Mersey commissioning hub approach.
- Outcomes based Commissioning.
- Ensuring Social Value is intrinsic in the relevant services.
- Greater consistency in terms of costs and charges to Providers.

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

5.7.1 Cheshire/Wirral Hub

The proposed model will be based on commissioning on individual outcomes rather than inputs, and shifts the emphasis away from systems and processes and onto the quality of the service and the impact on the individual.

Key to this will be skilling up staff within both statutory and third sector organisations to understand the available options and to ensure successful brokerage. In order to do this, we have aligned our current work into mutually re-enforcing components so that we can re-design the care model; the processes within it, the staffing structures, workforce development, system and infrastructural requirements.

We will also build upon the work we have undertaken, as one of the first pilot sites in England to introduce Personal Health Budgets, to align to ongoing re-design of social care services in order to deliver this work. Based on this we have a bold aspiration to offer all identified service users a personal budget by 2017. As the financial modelling exercise will be running alongside the development of the care model, we are currently undertaking a scoping exercise to understand the implications, constraints and potential of building a new financial model that moves away from silo block contracts towards framework agreements. This work will be supported alongside our work to build and incentivise the provider market, and work in partnership with the voluntary and community sector.

At the heart of our commissioning approach, is a holistic and personalised care and support planning offer involving a different conversation between people and professionals, tailored to the individual's level of knowledge, skills and confidence. The overall aim is to identify the health and wellbeing outcomes that are most important to the person, and ensure that the care and support they receive is designed and coordinated around their desired goals.

Personalised care and support planning is a meeting of experts where the person's lived experience is valued equally alongside clinical and professional expertise. It builds on each person's strengths and personal resources rather than focusing only on their needs, ensuring that they are in the driving seat of decision making. The plans people develop will cover all their health and wellbeing needs will replace multiple and duplicative processes and bring all the care and support people need together through a single, person-centred and coordinated planning process which includes planning for the prevention of crisis and hospital based care.

Wirral will be seeking to increase the use of personal health budgets and will monitor this via the contractual process within the Quality Schedule. There may even be an opportunity to also monitor via the various funding panels that we currently operate.
By extending the use of personal health budgets and direct payments and by supporting people to use and manage these effectively, people will have increased choice and control over all aspects of their life.
To support the increased use of these we would ensure that there are easy read documents in place to support the use of this along with access to independent advocacy and advice. Many of the support requirements are detailed in the 2014 Care Act.
Wirral Borough Council have increased the number of the Direct Payment provision with an externally commissioned service to complement its in house team. Numbers have increased across the whole sector by nearly 200 over the last 18 months. The council is ambitious to increase the number of Direct Payment recipients to a 1000 within a 12 months period

5.7.2 North Mersey

It should be noted that children and young people with a learning disability who are eligible for an Education, Health and Care plan should also be considered for a personal health budget, particularly for those in transition and those in 52-week placements.
This process aligns with the 'local offer' areas are developing for personal health budgets and integrated personal commissioning (combining health and social care) in March.

Those children and young people who are eligible for continuing care (0-18) and have an Education Health and Care Plan will be able to consider the possibility of a personal health budget, including a direct payment where appropriate.

Via the Liverpool SEND Partnership, a subgroup of the Liverpool Children's and Families Board, the development of personal health budgets and integrated personal commissioning of joint health and care packages is established. Packages for children and young people who are eligible for continuing care are already jointly commissioned.

The Liverpool Local Offer has been jointly developed between the Local Authority and Health, and details of available provision, including information on personal budgets is fully available.

5.7.3 Mid Mersey
Consideration of those children with EHC plans having personalised integrated budgets.
Consolidate the use of integrated complex care budgets.
Enhance the infrastructure in place for integrated budgets.

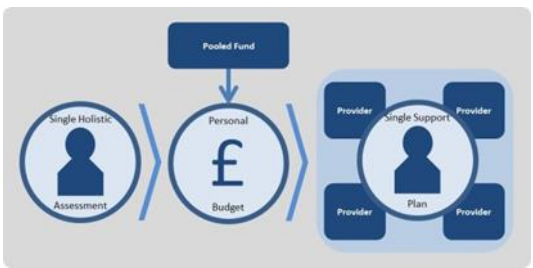
5.8 What will care pathways look like?

5.8.1 Cheshire/Wirral Hub
We recognise that the proposed model will mean commissioning becomes transformational rather than transactional. In order to move to this position, we will have invested time and resources to manage the significant culture change that will be required.

Services will not be defined by organisation but by need of the person and measured by the delivery of outcomes. There will not only be empowered staff but also empowered patients and Carers with a clear understanding of what services are available and how they can be accessed using their Personal Budget.

By March 2017 we will have turned our vision and values into the qualities, behaviours and skills that create a care environment filled with confident and capable staff working with a diverse range of individuals, families and communities. We will have a completed a series of joint training sessions which will include health and social care staff with staff from the voluntary and community sector to co-design the future model.

The diagram below attempts to describe how we will support people to be in control of their own resources with the support to do this is this is what they want to do.



We recognise that we need to agree a definition for a delayed discharge and the

mechanisms that we can use to ensure that these are avoided. We also need to agree whether penalties will be imposed in the event of delayed discharges.

Pathways need to be established for those individuals placed out of area, whatever the setting. There will be agreed input from local community services as appropriate to the needs of the individual and plans will reflect any risk factors associated with returning to area and/or living in a community setting.

Pathways need be coproduced and outcome based. They will build on person centred values
Future pathways will focus on supporting people within their own community and reducing reliance on inpatient services.
The pathways need to be based on two pathways of care: targeted early intervention and crisis avoidance. The pathway also needs to reduce the length of time people spend in in-patient beds.

5.8.2 North Mersey
NICE guidance and SAF will be used to benchmark current provision and gap analysis informing future commissioning and pathway development.

5.8.3 Mid Mersey Hub
MDT/CTR approach to provide clarity of where roles and responsibilities sit.
5BP pathways need to be reviewed to ensure that the pathways are still relevant and efficient. Improvements need to be made where appropriate.

5.9 How will people be fully supported to make the transition from children's services to adult services?

5.9.1 Cheshire/Wirral
Our approach to this work will be for all those with learning disabilities and/or autism regardless of age so that we can work on intervening early and ensuring we get the best for the people we serve. It is clear that if we intervene in childhood we can prevent crisis and deterioration in later life.

As part of our CAMHs transformation bids we will be seeking to change referral criteria, and promote early planning for, and partnership working with, adult services to ensure that there are no gaps through which children and young people are able to fall.

This will be particularly important around transition and will require us to develop robust transition protocols between children and adult mental health services, and the transition to an all-age disability service, in line with the Local Authority's vision.

Through our CAMHs (CWP) transformation bid monies we would look to be inclusive of Autism with challenging behaviour within an all age disability service by 2020, this is a 5 year plan.

Further detail about how these changes will be brought about, the impact of changing the criteria and milestones will be included in the next draft of this plan.

Wirral Borough Council and NHS Wirral Clinical Commissioning Group will commission and "All Age disability" service during 2016/2017 which will provide a comprehensive assessment and response service for those with the most complex needs

5.9.2 North Mersey

The introduction of Education Health and Care Plans from 0-25 will provide the key vehicle in terms of supporting the planning of transition from children's to adult services. All young person's education, health and social care needs are defined and recorded in a single document that include outcomes to be achieved and provision to be delivered. In addition, the implementation of personal health budgets, including the element of direct payments where appropriate, will enable improved choice that will transition from childhood into adulthood.

Particular initiatives include:

- Transition CQUIN
- LD CQUIN
- Integrated approach
- Personal health budgets
- Pooled budgets and jointly commissioned packages
- Closer working – CCC and CHC

5.9.3 Mid Mersey

Transition strategy and protocols are under review in some areas. Including a more whole of life approach.

Enhancement of MDT/CTR approaches. Some areas have Transitional Operational Groups to discuss individual cases.

Some areas have integrated Departments to there is strategic and operational oversight of transitional processes. For example St Helens have recently integrated Children and Young People's Services and Adult Social Care and Health Departments into a single People's Services Department. This will provide greater consistency moving forward. Other areas also have similar arrangements in place. Continue to develop our plans

5.10 How will you commission services differently?

As part of devolution we expect there will be a focus on developing a Cheshire and Merseyside model of commissioning in line with the agreed Sustainable Transformation Partnerships This will include a lead commissioner taking responsibility for a key service development area. Part of this work will include using current best practice in localities, scaling up and implementing across all of Cheshire Mersey footprint as appropriate.

Within this there will be discussions about development of integrated H&SC budgets, use of dowries, pooled budgets and outcome based commissioning as identified in Building the Right Support .where possible the aim will be to provide commission as close to the person as possible and development of micro commissioning . In particular the 3 local delivery hubs have identified specific areas of commissioning differently

5.10.1 Cheshire/Wirral

We would be commissioning LD services that would encompass the following characteristics:

- Coproduction with services users and carers
- Integrated MDT approach
- Colocation of Local Authority and Health Teams
- Co-commissioning with the Local Authority
- Co-production will involve linking to LD Partnership Board
- Would look to present to our HWW board
- Look to create integrated teams that are collocated, via current providers CWP and Local Authority, details to be worked on, i.e. specifications

- Co-commissioning- to have pooled budgets, details to be worked on
- Increase the use of PHBs.
- Would look to the LDSAF in order to drive up performance of GPs in health checks etc.
- Co-production will involve linking to LD Partnership Board and to Health and Wellbeing board

Wirral Borough council with its wider partners are working on Vision 2020, where a key strategy is "People with Disabilities lead Independent lives" The strategy sets out a 5 year vision for reduced dependency on traditionally commissioned services with people maximising the use of their locality assets and natural networks to act and be more independent.

Wirral is currently developing a joint commissioning strategy for LD to support the ambitions of both the TCP Programme and Vision 2020

Further agreement is needed re the preferred Integration model e.g. horizontal, Health & Social Care or vertical (all health teams one provider), co-location and service specification issues

5.10.2 Mid Mersey

- More pooled budget arrangements.
- Mid Mersey commissioning hub approach.
- Outcomes based Commissioning.
- Ensuring Social Value is intrinsic in the relevant services.
- Greater consistency in terms of costs and charges to Providers.

5.10.3 North Mersey

We have an established Section 75 for other services but no pooled budgets for LD services. Therefore we will explore within 16/17, the potential to pool budgets in 17/18 and beyond.

5.11 How will your local estate/housing base need to change?

We will expect to ensure we have a work stream that focuses on working on our housing needs and ensure we have a rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities. Our plan will include this work over the coming months

5.11.1 Wirral CCG

Recently Wirral CCG have been successful in obtaining £1million pounds as part of a capital bid, from NHS England, this will be match funded by Wirral Local Authority. The proposal will be to undertake the following project:

- The extra care schemes consist of self-contained flats and care staff are based on site 24 hours a day to support the needs of the residents. The schemes offer a real alternative to residential and nursing home care for older people and adults with learning or physical disabilities.

The project is an extension of the current programme to develop extra care housing units in Wirral with Strategic Housing Delivery Partners to support people to live independently. A current procurement exercise is with Housing colleagues to establish a framework for

delivery. This first stage is in progress with Wirral DASS and Housing ambition to deliver an additional 100 units of extra care over the period 2015-2017 which has already been granted capital funding of £4m. It is unlikely there will be any capital spend in 2015/16. Indications are that this number could be increased considerably with potential to increase up to 300 over the next 5 years, should more funding become available. This will contribute significantly to the shift required from residential and nursing care placements, to community based living options including supporting the need to develop alternative models of care for people with disabilities in supported living accommodation.

5.11.2 North Mersey
Liverpool City Region is currently undertaking a base line mapping of social housing provision with the aim of commissioning differently.

5.12 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?

5.12.1 Cheshire/Wirral

Bridge Meadow
Currently 350 people with learning disabilities are placed out of the Cheshire Hub footprint at a cost of £24million and this is an increasing trend due to lack of local services. If appropriate local services were available, this would reduce the demand for out of area placements, provide better solutions for individuals and reduce costs to the health and social care system.

Through developing community support, reducing inpatient beds and returning people to their home areas there will be a requirement for appropriate residential accommodation.

To this end, a bid with the support of CWP, CWAC, West Cheshire CCG and Vivo Care Choices was submitted to NHS England for £483,000 to fund the refurbishment of 'Bridge Meadow' a former Cheshire West and Chester Council Children's home in Ellesmere Port into three bespoke apartments to support people placed out of county due to lack of appropriate local provision to return and prevent others from being placed out of area.

The benefits anticipated are:

- People with learning disabilities and/or autism are supported to live fulfilling lives in their community
- People with learning disabilities and/or autism are supported in appropriate settings which are person-centred
- People with learning disabilities and/or autism are supported at home with links to communities
- Delivering a personalised pathway to enable people with learning disabilities and/or autism as individuals to maximise their potential in society.
- Meeting needs of individuals with complex needs through offering high quality, accredited specialist local provision, tailored to their needs.
- Enhanced assurance and accountability for commissioners that services are focussed on meeting the needs of individuals and achieve best value for money.
- Supports the principle of the wider model in preventing hospital admissions through working in partnership to maintain people in their own home.
- Value of commissioner spend is maximised to deliver positive outcomes across the pathway.

The bid has been approved in principle and we are awaiting confirmation from NHS England for the next steps.

5.12.2 North Mersey
There are currently 3 individuals in North Mersey Delivery Hub who will need to be 'resettled'. We have recognised the complexity of both the needs of these individuals and in having the appropriate provision established to meet need. In depth case reviews will be undertaken of these individuals to allow for commissioning the support they need to move closer to home.

5.12.3 Mid Mersey
Mid Mersey will making use of Dowries where appropriate and aim for the repatriation of out of area individuals using barriers tool and MDTs

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

- Healthy Liverpool Programme and Shaping Sefton are the local transformation plans that will further support delivery of this agenda.
- Liverpool City Region plans will allow for commissioning on a larger geographical footprint when cost effective to do so.
- The NHS Planning Guidance for 2016/17-2020/21 mandates local commissioners to come together and develop sustainable plans with stakeholders.
- North West Clinical Networks currently implementing the findings of the C&M QSG Mental Health Thematic Review against the Mental Health Strategy 2016-2021
- National Autism Strategy, particularly the development of post diagnostic services.
- Valuing People Strategy and Death by indifference reports, particularly around the area of Health Facilitation.
- Wirral Vision 2020.
- Joint all age LD strategy
- Autism Strategy
- CAMHS Transformation Plan
- Crisis Care Concordat

Any additional information

6. Delivery

Plans need to include key milestone dates and a risk register

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

6.1 Cheshire and Merseyside will have some overarching themes which will require work

Plans:

- Workforce
- Estates
- Communications and Engagement
- Finance
- Health Provider hub (Engagement with main 3 health providers)
- Hub work plans - It is the intention that each hub will have its own implementation and delivery plan.

Each Hub will develop a programme of work that encompasses their model of care and aspirations within the Building the right support and national service model.
The following work streams have been suggested to date, but are subject to agreement within each hub: the aim of these work streams will be to share best practice, identify gaps and feed into the hub implementation plans.

- Access to mainstream services (Physical and mental health and wellbeing)
- Positive Behavioural Support Framework
- Review of CLDT including wider systems: Intensive Support(including Forensic and criminal justice)
- Short breaks /respite
- Inpatients/Outreach/extra care facilities
- Out of Area Placements
- Children/Transition (to review transition protocol and strategy/early intervention/alignment with CAMHS)
- Autism / ASC strategy – integrated
- Personal Budgets/Integrated Personal Commissioning

For commissioners there will be some work to be achieved around how we commission and contract services to ensure the delivery of the model.

6.2 Pooled or aligned budgets

Across C&M we do not have pooled budgets in place for those with a learning disability/autism. There will be a move to pooled or at least aligned budgets for health and social care spend for the population concerned during the course of the Transforming Care Fast-track programme and work needs to take place to scope how we move to this arrangement for the whole LD population linked to our commitment to progress integrated assessment, carer management and commissioning.

6.3 Integration of health and social care

There are strong benefits from integrating health and social care through joint and shared plans and assessments. There will be a study as part of the early work of the Transforming Care to evaluate and agree the most cost-effective approach to integrate health and social care for those with a learning disability and/or autism.

Enablers: We collective agree are that the following enablers need to be in place across Cheshire and Merseyside for this system to operate: these are enablers which should already be in place and /or require further development. As part of the delivery of the hub plans they will review their localities and develop action plans to ensure these are adequately in place, as a basic requirement to starting transformation.

6.4 Proactive care and support:

6.4.1 Register for those at risk of admission to hospital

This has been addressed and is in process of being implemented across the three delivery

hubs. The registers will identify adults most at risk of admission to hospital so that care and support teams, especially the new enhanced support and crisis support team, will take proactive, preventative action. These risks will include the development and identification of behaviour that challenges, as well as the development of psychiatric disorders. After the initial register is implemented, it will further developed for children, ensuring it is integrated into all aspects of children's services, and it is also anticipated that further development will be required for those with autism, particularly those who do not have a learning disability. This will develop into a Dynamic register which can be used for proactive plan and prevention.

6.4.2 Annual Health Check
Everyone with a learning disability over the age of 14 will have an Annual Health Check, resulting in a Health Action Plan integrated into the single person-centred care and support plan. Although Annual Health Checks are currently in place across GP practices in Cheshire and Merseyside, practice is variable due to a lack of skills in helping to diagnose a learning disability. The extension of health checks down to the age of 14 will increase the existing capacity issue in delivering the checks. The programme will work with the GP community to understand how best they can support GPs to deliver a consistent approach to Annual Health Checks from the age of 14 for those with a learning disability.

6.4.3 Care and Treatment Reviews
Care and Treatment Reviews (CTRs) have been undertaken across Cheshire and Merseyside which have provided useful information on how people may alternatively be accommodated in the community. A consistent implementation of CTRs as part of standard operations is now is place across the three delivery hubs. It is our intention to continue to work with Pathways to develop a peer support expert by experience hub to support families and individuals ensuring the actions form CTR have been implemented.

6.4.4 Carer support
The impact on families and carers can be especially severe for those with a learning disability and/or autism, particularly if they display challenging behaviour. Support is particularly important for carers and families to lead a full family life and to maintain their physical and emotional resilience. The recently enhanced duties and responsibilities towards carers will be particularly important. Those working with people with a learning disability and/or autism will make good use of the enhanced carer support to help families and carers improve their quality of life, and to sustain the caring relationship.

6.5 Choice and control:

6.5.1 Person-centred care and support plans
Everyone with a learning disability and/or autism, who receives specialist learning disability support, will have a person-centred care and support plan which they and their carers will have been involved in drawing up. There will be a supporting service plan which will reflect the person-centred care and support plan. Both will be focused on better meeting an individual's needs and increasing their quality of life in a way that reduces the likelihood of behaviour that challenges occurring in the future. The plan will include physical and mental health needs and additional needs such as sleep difficulties and sensory impairments, addressing these needs in a positive and proactive approach.

6.5.2 Information and advice
The Care Act has introduced new duties and responsibilities for local authorities around information, advice and support for those with learning disabilities and/or autism. Existing capability needs to be built on to ensure that people receive the right information at the right time, and the information and advice is able to be understood.

6.5.3 Independent advocacy and support to communicate
Through the Care Act there is a new duty for Local Authorities to provide independent advocacy at any point if it is felt the person with learning disability and/or autism would have substantial difficulty in being involved in the assessment process in four areas – understanding the information, retaining the information; using or weighing up the information as part of the process of being involved, and communicating the person's views, wishes or feelings. Effective advocacy is central to safeguarding vulnerable people across the life course and needs to be tailored according to mental and physical capacity. Advocacy will become a much more important part of the support provided to those with a learning disability and/or autism, focusing on outcomes which are how advocacy services are already commissioned.

6.5.4 Personal budgets
By 1st April 2016 Personal Health Budgets will be available to those with learning disability and/or autism, and personal budgets are already on offer for social care spend. During the course of the delivery of the transformation, personal budgets and personal health budgets will be brought together, such that by 2020 they will be integrated personal budgets for all those with a learning disability and/or autism.

6.6 Co-ordinated, integrated care:

6.6.1 Safeguarding
Policies and procedures to support whistleblowing and other activities will be embedded consistently across all specialist learning disability and/or autism services as well as mainstream services that may prevent or lead to the early detection of abuse or inappropriate treatment. An initial study will be done as part of the programme to identify the current reach and consistency of safeguarding policies and procedures in relation to those with a learning disability and/or autism across Cheshire and Merseyside, and action will be taken through the programme to address any gaps that are identified.

6.6.2 Discharge to Assess
The 'Discharge to Assess' approach in mainstream NHS services will be adopted for those in inpatient services with a learning disability and/or autism. This will help ensure that people with a learning disability and/or autism are discharged when it is appropriate for them to be discharged. The Trusted Assessor model will ensure that discharges are not held up due to decisions about whether health or local authorities are to fund the care and support for the person concerned.

6.6.3 Care coordinator
A local care coordinator will be offered to everyone with a learning disability and/or autism receiving specialist support, not just those on the Care Programme Approach (CPA). This person is likely to be someone from either existing support teams for social care, Section 117 care and continuing healthcare, or from the new enhanced support and crisis support teams. The care coordinator will integrate services and ensure timely delivery of a wide range of services in the plan, working closely with the person and their family. In hospital the care coordinator will work closely with the Discharge to Assess Trusted Assessor around decisions on both H&SC funding.

6.6.4 Transition
There will be improved coordination between children's and adult services around the transition of children with a learning disability and/or autism, with better support to people with a learning disability and/or autism and their family and carers through this time. A simple step by step guide will be produced to support people and carers through the process.

6.5 Accessing mainstream services:

6.5.1 Hospital passport
This will be introduced within the Health Action Plan in mainstream NHS services to help staff make reasonable adjustments for someone with a learning disability and/or autism, including accommodating behaviour that challenges.

6.5.2 Liaison staff in universal NHS services
Clearly identified and readily accessible liaison staff in universal NHS services, with the specific skills to work with people with a learning disability and/or autism, supported in achieving these by the enhanced support and crisis support team.

6.5.3 Tackling access barriers
Work with local authorities, wider transport bodies and housing providers around influencing improvements that will improve access to those with a learning disability and/or autism e.g. transport links, gritting during the winter.

6.5.4 Housing
Engaging with Registered Social Landlords to make available suitably adapted properties to support individuals in community settings is essential to reducing the need for bed based provision. The links between good housing and good health and proven for all groups and this includes people with learning disabilities.

6.6 Commissioning quality:

6.6.1 Quality checker schemes
These will be introduced to ensure that mainstream and specialist services serve people with learning disabilities and/or autism well.

6.6.2 Engagement of people with a learning disability and/or autism and their carers and families
Friends and Family tests: There will be an increased emphasis on close working with people with a learning disability and/or autism and their carers and families in commissioning activities, including the monitoring of contracts. This will help ensure that concerns around services are quickly understood and acted on, and that people's voices are heard and acted on in commissioning the shape and structure of care and support services.

6.6.3 Mental health audits
Regular audits will take place in mainstream mental health services in relation to how the mainstream services serve people with a learning disability and/or autism and improvements will be made as a result, using the Green Light Toolkit.

6.6.4 Values and attitudes/ Workforce(Skills and culture)
The model requires a workforce that has the relevant skills, knowledge and appropriate values to deliver high quality care and support and the culture is one of fairness, accountability and reflection, learning from experience both within C&M and externally. As described earlier there will be a consistent approach to addressing challenging behaviour and the reasons for these being displayed, using techniques such as positive behavioural support. A competency framework for positive behavioural support developed by Health Education North West will be implemented to provide this consistency of approach across different health and social care organisations. There will also be improved skills and greater awareness in the workforce as to how to manage those who have been in contact with the Criminal Justice system.

6.6.5 Use of intelligence /Micro commissioning

The workforce will also routinely use intelligence to challenge and improve how it progresses services, awareness of provider landscapes and where additional support or expertise is required. Data from CTRs is already starting to inform and shape services. Cheshire and Merseyside TCP and delivery hubs will build on this to shape services based on a better understanding of needs, particularly around children and autism, the experience of people who use the services, and information relating to how services are delivering to meet people's needs and desired outcomes.

6.7 Communications and Engagement

A full communication and engagement plan will be developed including a programme of delivery; this will indicate communication methods and strategies within both professional /providers/wider communities and stakeholders and with individuals and their families. Governance mechanism will ensure that the process keeps to plans and opportunities for challenge occur. Engagement strategies and co- production are integral to this plan as previously stated.

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

As agreement has yet to be reached about the workstreams, no leads have been identified, however we anticipate that leads will come from across different sectors and organisations.

The supporting team will be made up of staff members from within the delivery hub partnership.

To date, we have identified a chair for Delivery Hub partnership meetings, part time Project Manager Support and part time Administration support.

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

All key milestones have been identified in our Route map

At this present time we are unable to identify when particular services will open or close in light of local commissioning intentions and approval of LD capital bid monies.

We aim to deliver the new model with hubs taking responsibility for their local areas and therefore it is important that the local hubs have the opportunity to develop local plans including key milestones.

We expect our key milestones will be:

- Establish TCP board by Feb 2016
- developing the PMO function by May 2016
- development of workstreams to enable delivery with key milestones identified as part of overarching themes WITHIN 2016
- hub delivery plans will be in place by July 2016 with a with target of delivering new services by Q1 2017
- Comms and engagement plan in place by Jul 2016
- Health Provide Hub agreed by Jun 2016

6.10 What are the risks, assumptions, issues and dependencies?

The prospect of a Liverpool City Region Devolution and a Cheshire Devolution have implications for this plan, in that there will be changing geographical implications in commissioning arrangements.

6.10.1 Key risks identified at this stage include:

- Lack of easy access to financial information and limited engagement from finance leads in Transforming Care to date
- Commitment from all partners at a strategic level to put resources into delivering this plan
- No commitment at this stage to ring fencing funding for learning disabilities for reinvestment within the system
- Financial pressures on statutory organisations as well as third sector providers
- Reduction in funding to peer advocacy services
- Conflicting demands for many organisations alongside limited capacity
- Potential for delivery hub area to be split as a result of devolution

6.10.2 Assumptions:

- People directly involved in the delivery hub are committed to change
- There is a level of consensus about what needs to change at a high level
- There is significant, although not total, agreement between commissioners and CWP about service redesign
- There is a track record of effective joint working in different localities, although less experience of working across the wider delivery hub footprint
- All localities will want to retain a local flavour for their services to reflect local need

6.10.3 Dependencies:

- Caring Together (Cheshire East/NHS Eastern Cheshire Clinical Commissioning Group)
- Connecting Care (Cheshire East Council, Cheshire West and Chester Council, NHS South Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group)West Cheshire Way (Cheshire West and Chester, NHS West Cheshire Clinical Commissioning Group)Wirral 2020 (Wirral Borough Council, NHS Wirral Clinical Commissioning Group)
- Integrated Personal Commissioning
- Development of Integrated Provider Hub Model in Eastern Cheshire and in South Cheshire & Vale Royal
- Development of local housing strategies
- Local authority devolution

6.11 What risk mitigations do you have in place?

Risks will be mitigated under the auspices of the Cheshire and Mersey Governance arrangements via the C&M Transforming Care Partnership Board. Use of existing governance structures e.g. Integrated Personal Commissioning delivery group to monitor and manage the risks associated with the care model delivery and change in cultural practices.

A risk register and log will support in identifying and mitigating risk as the programme of work develops and Commissioning Hubs will develop and report by exception on a monthly basis to the Board.

Flexible budget arrangements will support in sharing of any financial risks to programme delivery.

Although C&M A&T bed capacity is showing declining rates of activity, which will in time, enable a further reduction in capacity, such an ongoing reduction may put at risk the viability of the current patterns of provision were A&T units/beds are available within the footprint of each trust / commissioning hub i.e. Cheshire, Mid Mersey, and North Mersey. The issue of viability will be considered as part of future planning within each local hub
Any additional information